MINNESOTA
BOARD OF PHARMACY

Minnesota Board of Pharmacy
335 Randolph Avenue, Suite 230
St. Paul, MN 55102
Email: pharmacy.board@state.mn.us
Protecting the Public Since 1885

Individual Change Form: Name, Address, Employment, SSN

Name on Current License/Registration: ____

Current MN License/Registration #: __________________________

To Report a Name Change:

Complete the information below and sign page two of this document. Along with this form, **provide a copy of proof** of your legal name change (marriage certificate, divorce decree, court order.) If submitting a correction, include a copy of a government issued ID. Do not send originals.

New Name: First, Middle, Last: ____

Effective Date: __________________________

Reason for Name Change:

Marriage Divorce Registration Error Other _________________________

To Correct a Social Security/Tax ID Number:

If the SSN or ITIN associated with your account is incorrect/incomplete, complete the information below and sign page two of this document. Along with this form, **provide a copy of proof** of your SSN or ITIN.

Current SSN/ITIN: ________________________________

Corrected SSN/ITIN: ______________________________

To Report New Contact Information:

Address, telephone number, and email address can be updated through your Online Services Account. If you are unable to access your account, complete the fields below.

New Address Type: Mailing Physical Both
Note that your mailing address is considered public information

New Street Address:____

City: _______________________________________ State: ______ Zip: __________

Email: ___________________________ Home#: ___________________ Cell#: _________________

Effective Date: __________

Check this box to request a **duplicate card** reflecting your name and/or address changes.
The duplicate card fee is $30.00. Include a check payable to the Minnesota Board of Pharmacy along with any required documents.

To Report New Employment:

Employment can be updated through your Online Services Account. Simply log in, locate your license or registration card, and select 'Update License Information' to do so. If you are unable to access your account, complete the fields below.

Previous Employer Business Name: ____

Previous Employer's MN License # ________________ Employment End Date: ___________________

New Employer Business Name: ____

New Employer's MN License # ________________ Employment Start Date: __________________

Part-Time   Full-Time   Unemployed   Retired

Check the Business Category of your New Employer:

Retail	Nuclear	Pharmacy Benefits Manager
Hospital	Manufacturer/ Wholesaler	Clinical Pharmacy
Long Term Care	Teaching/ Government	Other – Pharmacy Related
Paternteral/ Enteral Home Health Care	Relief	Other – Non-Pharmacy

By signing this form, I declare that the information above is true and correct, and I am authorizing the changes to be made to my record.

Signature ____ Date: ________________________