



STATE OF MISSOURI
 DIVISION OF PROFESSIONAL REGISTRATION
DUPLICATE LICENSE REQUEST

MAILING ADDRESS:
 MISSOURI BOARD OF PHARMACY
 P.O. BOX 625, JEFFERSON CITY, MO 65102
 (573) 751-0091, (573) 526-3464 (FAX)

DELIVERY ADDRESS:
 3605 MISSOURI BOULEVARD, JEFFERSON CITY, MO 65109

INSTRUCTIONS: 1. The person completing this form MUST be the licensee, pharmacist-in-charge or manager-in-charge of the license for which a duplicate is being requested. 2. A duplicate license will be issued for replacement purposes only - see Reasons For Request below. 3. Complete the information requested below. Please type or print in black ink. 4. Have your signature notarized. 5. Mail the completed form and \$20 processing fee payable to the Missouri Board of Pharmacy to the above address. (NOTE: An additional \$25 returned check fee will apply to insufficient funds checks.) 6. Allow three (3) weeks for processing.	FOR OFFICE USE ONLY DATE REQUESTED DATE MAILED
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NAME AS IT APPEARS ON THE LICENSE, REGISTRATION OR PERMIT	LICENSE, REGISTRATION OR PERMIT NUMBER
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ADDRESS (STREET)

CITY	STATE	ZIP CODE	TELEPHONE NUMBER
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DUPLICATE LICENSE, REGISTRATION OR PERMIT REQUESTED (CHECK ONE)

<input type="checkbox"/> Pharmacist	<input type="checkbox"/> Pharmacy
<input type="checkbox"/> Technician	<input type="checkbox"/> Drug Distributor
<input type="checkbox"/> Pharmacy Intern	<input type="checkbox"/> Drug Manufacturer/Registrant

REASON FOR REQUEST (CHECK ONE)

NOTE: A duplicate license will be issued for replacement purposes only. Requests for additional copies of licenses will not be processed; any fee submitted with a request for this reason will be forfeited.

<input type="checkbox"/> License was lost	<input type="checkbox"/> License was destroyed
<input type="checkbox"/> License was stolen	<input type="checkbox"/> License never arrived in mail
<input type="checkbox"/> Wallet card was lost/stolen (5x7 license must be returned with this form to process request for duplicate wallet card)	
<input type="checkbox"/> Other _____	

I, the undersigned, do solemnly swear or affirm that I am the (check one)

Licensee Registrant Pharmacist-in-Charge Manager-in-Charge

of license number _____, and I hereby request a duplicate of that license, registration or permit. I further attest that the information provided herein is correct to my knowledge, and that this request is for replacement purposes only.

SIGNATURE

NOTARY PUBLIC EMBOSSEER OR BLACK INK RUBBER STAMP SEAL	STATE	COUNTY (OR CITY OF ST. LOUIS)
	SUBSCRIBED AND SWORN BEFORE ME, THIS	
	DAY OF	YEAR
	NOTARY PUBLIC SIGNATURE	MY COMMISSION EXPIRES
NOTARY PUBLIC NAME (TYPED OR PRINTED)		