BOARD OF REGISTRATION IN PHARMACY
FACILITIES LICENSE/REGISTRATION DUPLICATE LICENSE REQUEST FORM

Use this form to request a duplicate license.
Mail requests to the address above to the attention of the Board.
For information about DBA Name Changes, contact the Board directly.

Check all that apply:
PHARMACY/PHARMACY DEPARTMENT  WHOLESALE DISTRIBUTOR (WD)  “BROKER” OF PRESCRIPTION DRUG PRODUCTS (WD)  NUCLEAR PHARMACY

Print/type clearly the information as it CURRENTLY SHOWS on your license:

Name: ____________________________________________
Address: __________________________________________
City/Town: _____________________________
State: _______________  Zip Code: ________________

Lic. No: ________________________________

Lic. Type: Check the license type(s) held for which you are requesting a duplicate license:
Pharmacy Permit  Pharmacy Controlled Substance Registration
Pharmacy Certificate of Fitness  Wholesale Distributor Permit
Wholesale Distributor Controlled Substance Registration
Broker of Prescription Drug Products Permit

FID No: (Mandatory): ____________________________
Expiration Date: ________________________________

For official use only:
Fee: ________  Date Received: _____________
Date Reviewed: ________________________________
Name: ________________________________________

If your current license has been lost or stolen, please check here. _____

Under the penalties of perjury, I declare that the information provided herein is a truthful and complete statement of the information required.

___________________________________________  FEE:
Signature  1. Duplicate License $17.00 each type

___________________________________________
Telephone Number

______________________________  Make check or money order payable to the Commonwealth of MA.
Date  DO NOT SEND CASH OR ELECTRONIC FUNDS TRANSFERS