PCY Rev 8/18

STATE OF CONNECTICUT
DEPARTMENT OF CONSUMER PROTECTION
DRUG CONTROL DIVISION
COMMISSION OF PHARMACY
Email: dcp.dcugcontrol@ct.gov
Web site: www.ct.gov/dcp

For Official Use Only

APPLICATION FOR A CHANGE OF PHARMACY NAME FOR AN IN-STATE PHARMACY

INSTRUCTIONS:

1. All spaces on this form must be completed.
2. This application must be accompanied by a check or money order in the amount of **$90.00** made payable to "*Treasurer, State of Connecticut.*" Application fees are non-refundable.
3. Attach a copy of your prescription label with the name change.
4. If applicable, complete all the appropriate change forms as needed based on the changes to your business.
5. Mail this completed application, fee and all required attachments to:
   Department of Consumer Protection, License Services Division, 450 Columbus Blvd, Ste. 801, Harford, CT 06103

Pharmacy Information

Current Pharmacy Name		CT Pharmacy License #	
Pharmacy Address	City	State	Zip Code
Telephone Number	Email Address to be used for all correspondence		

New Pharmacy Name

New Pharmacy Name	Effective Date

Certification

By signing this form, I certify that the information contained in this application is the truth to the best of my knowledge and have attached all of the documents required that are applicable to this license.

Printed Name & Title	
Signature	Date