



NOTIFICATION OF CHANGES FORM

Providers are required to notify CAPE **within 15 days** of the change to the organization's CE Administrator and/or the change to any relevant contact information.

Provider Name _____

Provider Number _____ Change effective as of (date) _____

New Contact Person _____

New Contact Address _____

New Phone Number _____ New Fax Number _____

New Email Address _____

Preferred Contact Method (check only one): Email Phone Mail Fax
In the event that contact cannot be established by the preferred method, other methods will be attempted.

If applicable:

Alternate Contact Person _____

Alternate Contact Person's Email Address _____

Alternate Contact Person's Phone Number _____

Please return this form to: **California Accreditation for Pharmacy Education
c/o Pharmacy Foundation of California
4030 Lennane Drive
Sacramento, CA 95834**

FAX: (916) 779-1411

Email: spresidio@pharmacyfoundation.org

For office use only:

Date Received _____

Date Entered _____