



CHANGE OF CONTACT INFORMATION FORM

I request that the Maryland Prescription Drug Affordability Board update its records to reflect the following change in address and/or contact information:

- 1) I, _____ (name) am over 18 years of age and am competent to request this change.
- 2) I am the/a _____ (position title) for the assessed entity and the following information is true and correct:

Assessed Entity Name: _____

PDAB Vendor ID #: _____

Permit/NAIC Number(s): _____

Contact E-mail: _____

Contact Phone: _____

Mailing Address: _____

I solemnly affirm under penalty of perjury that the contents of this document are true and accurate to the best of my knowledge, information and belief.

Signature

Date

Printed Name