

Certificate Reprint



Mail your transfer and appropriate fees (in U.S. dollars) to: AFP Certification, P.O. Box 64714-C, Baltimore, MD 21264.

Forms with credit card payment may be sent to AFP via fax at 301-907-2864. To avoid a duplicate credit card charge, the form should be mailed OR faxed, not both.

REASON FOR REPRINT REQUEST

LOST OR DAMAGED CERTIFICATE NAME CHANGE (DOCUMENTATION REQUIRED) OTHER _____

CHECK ONE: CTP FPAC

1. AFP ID #: _____ AFP MEMBER? YES NO

2. NAME: _____
LAST FIRST MIDDLE

3. CHANGE NAME TO: _____
LAST FIRST MIDDLE

4. TITLE: _____

5. ORGANIZATION: _____

6. MAILING ADDRESS PREFERENCE (HOME BUSINESS) WE SHIP UPS – NO P.O. BOXES, PLEASE. NOTE: YOUR CERTIFICATE WILL BE MAILED TO THIS ADDRESS.

BUSINESS ADDRESS: _____

CITY: _____ STATE/PROV: _____ ZIP/POSTAL CODE: _____ COUNTRY: _____

HOME ADDRESS: _____

CITY: _____ STATE/PROV: _____ ZIP/POSTAL CODE: _____ COUNTRY: _____

7. PHONE: _____ FAX: _____

8. E-MAIL: _____

9. CERTIFICATE REPRINT: \$15.00 (RESIDENTS OF CANADA ADD 5%, MD RESIDENTS ADD 6%, VA RESIDENTS ADD 5%):

10. METHOD OF PAYMENT: CHECK AMERICAN EXPRESS MASTERCARD VISA DISCOVER CARD

CARD NUMBER: _____ EXPIRATION DATE: _____

Please complete this form and send it to recertification@afponline.org to securely submit your credit card payment.

I certify that I have read and will abide by the Association for Financial Professionals' Standards of Ethical Conduct (www.afponline.org/ethics). Any false statements made on this application will constitute a violation for which my certification may be revoked. I certify that the information contained in this application is true, complete and correct to the best of my knowledge and is made in good faith.

SIGNATURE: _____ DATE: _____