

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 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 CCM CTPA CTP(CD) FP&A

Please print clearly or type

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

2. CURRENT NAME: MR. MS. MRS. DR. _____
LAST FIRST MIDDLE

3. CHANGE NAME TO: MR. MS. MRS. DR. _____
LAST FIRST MIDDLE

4. TITLE: _____

5. COMPANY: _____

6. MAILING ADDRESS PREFERENCE (HOME BUSINESS)

BUSINESS ADDRESS: _____

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

HOME ADDRESS: _____

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

7. PHONE (OFFICE): _____ FAX: _____

8. E-MAIL: _____

9. **CERTIFICATE REPRINT: \$15.00** (MD and VA residents only add applicable tax)

10. METHOD OF PAYMENT: Check American Express MasterCard VISA Discover Card

CARD NUMBER: _____ EXPIRATION DATE: _____
(PLEASE SIGN BELOW)

CGCB FOR AFP OFFICE USE ONLY

ID# _____ Amt \$ _____

Order# _____ LB Date _____

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: _____