Approved Provider of Continuing Education
Information Change Report

Change is to (check all that apply): ☐ Name of Provider ☐ Contact Person

☐ Record Keeper ☐ Address(es) ☐ Phone # ☐ Email Address

Name of Provider: **Date:**

Provider Number: ABNP

Physical Address:

Mailing Address:

Program Director (contact person responsible for ABNP# and program approval)**:**

Name: **Telephone:**
Fax: **Email:**

Name of Record Keeper:
Telephone: **Email:**

Name of RN Nurse Consultant: **License#:**

Person Completing Form:
Title: **Telephone:**

Administrator:
Title: **Telephone:**

Please send the completed form to:

Alabama Board of Nursing
Continuing Education Division
P.O. Box 303900
Montgomery, AL 36130
Fax: (334) 293-5201
Joyce.Jeter@abn.alabama.gov