NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES
Licensure Unit
P O Box 94986
Lincoln, NE 68509-4986
(402) 471-2117
E-Fax: 402-742-1106

MONTHLY PRACTICE REPORT FOR AN AGGREGATE THIRTY (30) DAYS OF PROFESSIONAL SERVICES AS A PSYCHOLOGIST WITHIN ONE YEAR

Name: ______________________________

Address: ______________________________
(Street/P.O. Box/Route)

____
(City) (State) (Zip)

Practice Report for the month of: ______________________________

Date(s) worked during month: ______________ ______________
______________ ______________
______________ ______________

OR

☐ I did not work in Nebraska during this month

____
Signature

Please return this form to the above address by the 5th day of each month.

This form may be photocopied