

DHHS - Licensure Unit
301 Centennial Mall South
PO Box 94986
Lincoln NE 68509-4986
402-471-2118

**Certification Request
Radiographer**

Applicant: Complete top portion of this form and send to the regulatory agency of each state (excluding Nebraska) where you are currently licensed, certified, or registered to practice radiography. Before sending, check with each state to see if fee is required for this service.

Your Name _____ Date of Birth _____

Your Address: _____

State Where License Is Held: _____ License # _____

To Be Completed by State Official: A substitute form may be used if it contains the same information requested below.

State: _____ License, Certificate, or Registration Number: _____

Date Issued: _____ Expiration Date: _____

Has the above license/certificate/or registration ever been suspended, revoked, or otherwise disciplined? (Circle One) Yes No

If Yes, Please Explain:

Name of state licensing official completing this form

Title of state licensing official completing this form

Signature

Date

(State Seal)

Mail to the Nebraska Department of Health and Human Services at above address