

This form may be completed online, printed and mailed to the address listed below.

Department of Health and Human Services

Division of Public Health, Licensure Unit

P.O. Box 94986, Lincoln NE 68509-4986

Phone: (402) 471-2115

REQUEST FOR REISSUANCE OF LICENSE OR CERTIFICATION DOCUMENTS

1.	NAME:	First	Middle	Last
2.	ADDRESS:	Street/PO/Route		
		City	State	Zip
3.	DATE OF BIRTH:	Month/Day/Year		
4.	PROFESSION:			
5.	LICENSE/CERT NUMBER:			

I hereby request reissuance of medication aide registration card(s):

Number of Documents Requested: _____

Reason(s) for requesting that license/certification document(s) be reissued.

Check one: Name Change Lost
 Address Change Stolen
 Duplicate Copy Printed with the wrong name/address
 Never Received Other (explain):
 Destroyed by Accident

NOTE: YOU MUST SUBMIT \$10.00 FOR EACH REISSUED DOCUMENT REQUESTED.

State of _____
County of _____

I, _____, hereby solemnly swear that I am the Medication Aide registrant listed above. I have requested the additional registration card(s) documents.

Dated this _____ day of _____ of 20__.

Signature of Licensee: _____

Subscribed and sworn before me this _____ day of _____, 20__.

Notary public signature: _____

Notary public seal/stamp: