DHHS Division of Public Health
Licensure Unit
PO Box 94986, Lincoln NE 68509-4986

APPLICATION TO AMEND A MAIL SERVICE PHARMACY PERMIT

--Change of Ownership--

(No Fee Required)

Name of Pharmacy: _____ Nebraska Permit#: _____

Current Physical Address (street/city/state/zip):_____

Contact Person's Name & Title: _____

Contact Person's Telephone #: _____ Contact Person's email: _____

REQUEST TO AMEND THE OWNERSHIP INFORMATION:

Effective Date of Change of Ownership: _____

- Previous Owner: _____
- New Owner: _____

NOTE: IF YOU ARE ONLY CHANGING THE OWNERSHIP STRUCTURE, NOT THE NAME OF THE OWNERSHIP, DO NOT SEND THIS AMENDMENT FORM. PLEASE SEND A LETTER OF NOTIFICATION STATING WHAT CHANGE HAS TAKEN PLACE.

The application to amend must be signed and dated by (place a check mark in the appropriate box below):

- ☐ The owner or owners if the applicant is a sole proprietorship, a partnership, or a limited liability company that has only one member;
- ☐ Two of its members if the applicant is a limited liability company that has more than one member;
- ☐ Two of its officers if the applicant is a corporation;
- ☐ The head of the governmental unit having jurisdiction over the business if the applicant is a governmental unit; or
- ☐ If the applicant is not an entity described above, the owner or owners or, if there is no owner, the chief executive officer or comparable official.

I DO SOLEMNLY SWEAR AND AFFIRM THAT IAM THE PERSON(S) AUTHORIZED TO SIGN THIS APPLICATION TO AMEND A MAIL SERVICE PHARMACY PERMIT AND THAT ALL STATEMENTS MADE ARE TRUE AND CORRECT IN ALL RESPECTS.

_____	_____	_____
(Printed Name & Title of Applicant)	(Signature of Applicant)	(Date)
_____	_____	_____
(Printed Name & Title of Applicant)	(Signature of Applicant)	(Date)