



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

APPLICATION TO AMEND A NEBRASKA MAIL SERVICE PHARMACY PERMIT (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 FOLLOWING INFORMATION:

Nebraska Licensed Pharmacist: Your NE licensed RP MIGHT or MIGHT NOT be the same person as your PIC

Old: NE RP LICENSE #:

New: NE RP LICENSE #:

Effective Date of Amendment:

Pharmacist-in-Charge (PIC): RP you have reported to your home state of licensure as the PIC for your facility

NOTE -- YOU MUST ATTACH A COPY OF THE NEW PHARMACIST-IN-CHARGE LICENSE FROM THE STATE IN WHICH YOU ARE LOCATED

Old: New:

Effective Date of Amendment:

Location:

NOTE -- YOU MUST ATTACH A COPY OF THE PHARMACY PERMIT FROM THE STATE IN WHICH YOU ARE LOCATED SHOWING THE CHANGE HAS BEEN MADE ON YOUR HOME STATE LICENSE.

Old address (street/city/state/zip):

New address (street/city/state/zip):

Effective Date of Amendment:

Name of facility: This name must match the name listed on your home state license.

NOTE -- YOU MUST ATTACH A COPY OF THE PHARMACY PERMIT FROM THE STATE IN WHICH YOU ARE LOCATED SHOWING THE CHANGE HAS BEEN MADE ON YOUR HOME STATE LICENSE.

Old name:

New name:

Effective Date of Amendment:



If you have questions regarding this amendment, please email ATTN: PHARMACY DESK @ DHHS.MEDICALOFFICE@NEBRASKA.GOV.

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

Signature of Owner or Corporate Officer

Date Signed

Printed Name and Title