NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Jim Pillen, Governor

APPLICATION FOR MEMBERSHIP
NEBRASKA MEDICAID DUR BOARD

Name: _____

Address: _____

Phone Number: _____ E-mail: _____

☐ Physician ☐ Pharmacist ☐ Student

Employment Current Position/Title: _____

Brief description of your practice:

_____

_____

_____

Specialty:_____

Educational Background: _____

_____

Conflicts of interest disclosure: _____

_____

Describe your interest in serving as a member of the DUR Board:

_____

_____

Previous Committee experience: _____

_____

If appointed, do you believe you will be able to regularly participate in Board meetings?
___ Yes ___ No

Signature _____ Date _____

Preferred communication regarding this applicaiton: ___ email ___ phone ___text

Additional Information may be attached.
Return completed application form by email: DHHS.Medicaidpharmacyunit@nebraska.gov
Questions may also be directed to this box.

By Mail:
Medicaid and Long-Term Care
Pharmacy director
301 Centennial Mall
Lincoln, NE 68509