

STATE OF NEBRASKA
DEPARTMENT OF HEALTH & HUMAN SERVICES
DIVISION OF PUBLIC HEALTH
Licensure Unit
P. O. Box 94986
Lincoln, NE 68509-4986

APPLICATION TO AMEND A DELEGATED DISPENSING PERMIT FOR A PUBLIC HEALTH CLINIC

Please be sure to send your original Delegated Dispensing Permit with this completed form to the address above. There is not a fee to amend the permit.

Section A--Identifying Information

Name of Clinic _____

Address _____
(Street/P.O. Box/Route) (City) (State) (Zip)

Phone Number _____ Permit # _____

Name of Owner _____

Section B - Reason for Amending Permit

_____ 1. **Change of Delegating Pharmacist** Effective Date of Change: _____

This change requires the new delegating pharmacist to submit a delegating dispensing agreement.

Previous delegating pharmacist _____ Lic # _____

Delegating pharmacist _____ Lic # _____

_____ 2. **Name Change** Effective Date of Change: _____

Current Name of Clinic: _____

New Name of Clinic: _____

Section C--Affidavit (This form must be notarized.)

STATE OF _____)

COUNTY OF _____)

I do solemnly swear and affirm that I am the person authorized to sign this application to amend a Delegated Dispensing Permit for a Public Health Clinic and that all the statements made are true and correct in all respects.

Legal Signature of Authorized Person

Printed Name and Title:

Sworn to and signed before me this _____ day of _____, _____.

(Seal) _____

NOTARY PUBLIC

My Commission Expires: _____