RENEWAL NOTICE

DHHS – DIVISION OF PUBLIC HEALTH
LICENSURE UNIT
PO Box 94986
Lincoln NE 68509-4986
PH: (402) 471-2118

YOUR NEBRASKA MAIL-ORDER OPHTHALMIC PROVIDER REGISTRATION EXPIRES JULY 1, 2026. THE RENEWAL FEE OF $625.00 AND THIS DOCUMENT MUST BE POSTMARKED ON OR BEFORE JULY 1, 2026 TO RENEW THIS LICENSE.

Name:

Address:

City/State/Zip

Registration # :

SUBMIT CHECK PAYABLE TO DHHS LICENSURE UNIT AND THIS COMPLETED DOCUMENT IN THE ENCLOSED ENVELOPE.
YOU WILL NOT RECEIVE A RECEIPT. PLEASE ALLOW **THREE WEEKS** TO PROCESS YOUR RENEWAL.

CERTIFICATION FOR RENEWAL OF NEBRASKA MAIL-ORDER OPHTHALMIC PROVIDER REGISTRATION

I hereby attest that I will adhere to the following in compliance with my Nebraska Mail Order Ophthalmic Provider Registration:

1. **That I will comply with directions and appropriate requests for information from the regulating agency of each state where we are licensed or registered;**
2. **That I will respond directly and within a reasonable period of time to all communications from the department concerning emergency circumstances arising from the dispensing of contact lenses to Nebraska residents;**
3. **That I will maintain our records of contact lenses dispensed to Nebraska residents so that such records are readily retrievable;**
4. **That I will cooperate with the department in providing information to the regulatory agency of any state where we are licensed or registered concerning matters related to the dispensing of contact lenses to Nebraska residents;**
5. **That I will conduct business in a manner that conforms to the requirements in section 69-303;**
6. **That I will provide a toll-free telephone service for responding to patient questions and complaints during our regular business hours of operation and will include the toll-free number in literature provided with mailed contact lenses and will refer all questions relating to eye care for the lenses prescribed back to the contact lens prescriber; and**
7. **That I will provide the following, or substantially equivalent, written notification to the patient whenever contact lenses are supplied: "WARNING: IF YOU ARE HAVING ANY OF THE FOLLOWING SYMPTOMS, REMOVE YOUR LENSES IMMEDIATELY AND CONSULT YOUR EYE CARE PRACTITIONER BEFORE WEARING YOUR LENSES AGAIN: UNEXPLAINED EYE DISCOMFORT, WATERING, VISION CHANGE, OR REDNESS."**

I further attest that I am the person making application for renewal. I am of good character. My responses and the information provided on this form and any related application for public benefits are true, complete and accurate. I understand that the information provided may be used to verify my lawful presence in the United States.

(Signature of One of the Owners)	**(Date)**
(Printed Name)	**(Title)**