

State of Nebraska
Department of Health and Human Services
DIVISION OF PUBLIC HEALTH
LICENSURE UNIT
PO BOX 94986
Lincoln NE 68509-4986
(402) 471-2118

CERTIFICATE OF ADVANCED POSTDOCTORAL EDUCATION

Applicants must have the **current Program Director** of the institution where they completed their advanced postdoctoral education complete the following form and **affix the Official School Seal**. An **original signature** from the Program Director is required. Please mail the form directly to the address printed above.

This certifies that _____ has successfully completed
Name of Applicant

_____ at
Name of Residency

_____ located in _____
Name of Hospital/Teaching Institution City/State/Country

from _____ to _____
(MO/DAY/YR) (MO/DAY/YR)

Signature
(Signature Stamp NOT acceptable)

Date

Print or Type Official's Name

Title

Address

City/State/Zip

Phone number

OFFICIAL SEAL OF THE SCHOOL