



Department of Health and Human Services
Division of Public Health, Licensure Unit
Nursing Support
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**Nurse Aide
Medication Aide
Paid Dining Assistant**

Address Change Form

Name (please print): _____

Social Security Number: _____

Address: _____

City: _____

State: _____

Zip: _____

Phone (including area code): _____

E-mail Address: _____

Signature: _____

Please return the completed form to the address above.