Nebraska Department of Health and Human Services

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Tobacco Cessation Program Application

Name of organization providing tobacco cessation: _____

Name of individual responsible for delivery of cessation program:_____

Address: _____ City:_____

State: _____ Zip: _____

Phone Number: _____ Cell Phone: _____

E-Mail Address: _____

Educational Attainment: ❑ High School ❑ Bachelors ❑ Masters ❑ Doctorate

Years of experience in tobacco cessation: _____

Total number of hours of cessation counseling program: _____

Number of sessions:_____ Ability to track attendance and progress ❑ Yes ❑ No

Type of program: Individual Counseling _____ Group Counseling _____

Additional information: _____

Cost per participant: _____

Please provide your website address: _____

Include a copy of the certificate issued to participants upon completion.

Send to: Clean Indoor Air Act Program Manager
Nebraska Department of Health and Human Services
Division of Public Health
PO Box 95026
Lincoln, NE 68509