NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Jim Pillen, Governor

Verification of Dialysis Patient Care Technician Worksite Training Program Completion

Part 1-General Information-Please Print *Applicant must complete this section*

Full LegalName_____
Last **First** **Middle** **Maiden**

Date of Birth _____ **Telephone**_____
(Month / Day / Year)

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Part 2-Verification of Completion of Dialysis Patient Care Technician Worksite Training Program-Please Print

Dialysis training program administrator must complete this section

Name of Facility/Worksite _____

Address_____

City_____**State**_____

Zip_____ **Telephone Number of Program**_____

This is to verify that the applicant named above enrolled in and has successfully completed a dialysis patient care technician training program that is approved by the medical director, under the direction of a registered nurse. This training program follows national recommendations for dialysis patient care technicians and is conducted primarily in the work setting (Neb. Rev. Stat. §38-3705)

Employment Start Date_____
(Month/Day/Year)

Date of Enrollment in Training Program _____
(Month/Day/Year)

Date of Training Program Completion _____
(Month/Day/Year)

_____ _____
Name of Registered Nurse **State Licensed / License Number**

_____ _____
Phone Number of Registered Nurse **E-mail Address of Registered Nurse**

_____ _____
Signature of Registered Nurse **Date**