NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

DHHS Division of Public Health
Licensure Unit
PO Box 94986, Lincoln NE 68509-4986

APPLICATION TO AMEND A NEBRASKA MAIL SERVICE PHARMACY PERMIT (No Fee Required)

Name of Pharmacy: _____ Nebraska Permit#: _____

Current Physical Address (street/city/state/zip):_____

Contact Person's Name & Title: _____

Contact Person's Telephone #: _____ Contact Person's email: _____

REQUEST TO AMEND THE FOLLOWING INFORMATION:

☐ **Nebraska Licensed Pharmacist:** Your NE licensed RP MIGHT or MIGHT NOT be the same person as your PIC

- Old: _____ NE RP LICENSE #: _____
- New: _____ NE RP LICENSE #: _____

Effective Date of Amendment: _____

☐ **Pharmacist-in-Charge (PIC):** *RP you have reported to your home state of licensure as the PIC for your facility*
NOTE -- YOU MUST ATTACH A COPY OF THE NEW PHARMACIST-IN-CHARGE LICENSE FROM THE STATE IN WHICH YOU ARE LOCATED

- Old: _____ New: _____

Effective Date of Amendment: _____

☐ **Name of facility:** *This name must match the name listed on your home state license.*
NOTE – YOU MUST ATTACH A COPY OF THE PHARMACY PERMIT FROM THE STATE IN WHICH YOUARE LOCATED SHOWING THE CHANGE HAS BEEN MADE ON YOUR HOME STATE LICENSE.

- Old name: _____
- New name: _____

Effective Date of Amendment: _____

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If you have questions regarding this amendment, please email ATTN: PHARMACY DESK @ DHHS.MEDICALOFFICE@NEBRASKA.GOV.

I DO SOLEMNLY SWEAR AND AFFIRM THAT IAM THE PERSON AUTHORIZED TO SIGN THIS APPLICATION TO AMEND A MAIL SERVICE PHARMACY PERMIT AND THAT ALL STATEMENTS MADE ARE TRUE AND CORRECT IN ALL RESPECTS.

_____ _____
Signature of Owner or Corporate Officer Date Signed

_____
Printed Name and Title