NURSE AIDE REGISTRY FORM

(Please type or print clearly)

DATE:_____

SOCIAL SECURITY NUMBER OR REGISTRY (LICENSE) NUMBER_____

NAME _____
(Last) (First) (Middle)

MAIDEN NAME _____ DATE OF BIRTH _____

MAILING ADDRESS _____

CITY_____ STATE _____ ZIP _____

Facility/Agency where employed_____
(Facility/Agency) (City)

Facility where aide is contracted to_____
(Facility Name) (City)

DATE HIRED _____

Facility Phone #:_____ or e-mail_____

Name of Facility Employee Completing This Form_____

Please return this form to:

Nebraska Nurse Aide Registry
PO Box 94986
Lincoln, NE 68509-4986

PH: 402-471-4322
FAX: 402- 742-1151
EMAIL: DHHS.NursingSupport@nebraska.gov

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