

DUPLICATE LICENSE REQUEST FORM

**\$35 FEE PER CARD
(NON-REFUNDABLE)**

Please type or print using CAPITAL LETTERS and black ink.

Section 1: Biographical Data

Last Name (print clearly)

First Name (print clearly)

Full Middle Name (print clearly)

Maiden Name (print clearly)

Street (print clearly)

City (print clearly)

State

Zip Code (print clearly)

County of Residence (print clearly)

Country, if not U.S.A. (print clearly)

International Postal Code (print clearly)

Home Phone (print clearly)

Daytime Phone (print clearly)

Social Security # (print clearly)

Date of Birth (print clearly)

KY License # (print clearly)

Section 2: License Type Requested

Please indicate the type of license or credential you are requesting by checking the appropriate box(es):

RN LPN APRN SANE

A \$35 fee is required for each type of card requested.

Section 3: Reason for Reissue

Please indicate the reason for this request by checking the appropriate box:

Original License Card Was: Lost Stolen Never Received (No Fee Required)

Section 4: Declaration of Permanent Residence and Areas of Practice

I declare my state of primary residence to be: Kentucky Other (Specify State) _____

Do not submit evidence of primary residence unless requested to do so.

Do you practice nursing ONLY in a military/federal facility? Yes No

Signature

Date

Return Completed Form To:

Credentials Department, Attn: Duplicate License Request
Kentucky Board of Nursing
312 Whittington Pky, Suite 300, Louisville, KY 40222-5172