DT CREDENTIAL REISSUE FORM

Kentucky Board of Nursing
312 Whittington Pky Ste 300
Louisville KY 40222-5172
502-429-3300 or 800-305-2042

$10 FEE FOR EACH CREDENTIAL REQUESTED
(Fee is non-refundable)

Please type or print using capital letters and black ink.

Section 1: Biographical Data

Last Name

First Name M.I.

Maiden Name

Street

City State

Zip - County of Residence

Home Phone - - Day time Phone - -

Social Security #: - -

Credential #:

Section 2: Reason for Reissue

Please fill in the appropriate circle indicating the reason for this request. **Your credential card MUST BE RETURNED with this form if you are requesting a change of name, and you must submit a copy of a legal name change document with this application.**

Original Credential Was: ◯ **Name Change** ◯ **Lost** ◯ **Stolen** ◯ **Never Received**

Section 3: Notary

I certify that I am the person who is referred to in the foregoing application for reissue of a Kentucky dialysis technician credential; that the statements contained herein are true in every respect; that I have read and understand this application. I further understand that the falsification of any information contained herein will be cause for disciplinary action.

Applicant's Signature

Subscribed and sworn to before me by _____
(Applicant's Name)

this _____ day of _____, 20___.

State Of

Commission Expires

S E A L

Notary Public's Signature

For Office Use Only

Cred Status:_____ N/C Received: _____

6/2014