



KANSAS DEPARTMENT FOR AGING AND DISABILITY SERVICES
FOR CERTIFICATE REPLACEMENT OR NAME CHANGE

For REPLACEMENT CERTIFICATE, NAME/ADDRESS CHANGE, fill out this form and submit copy of identification with your current name and social security number. For name change you must send documentation showing the change. (For example, a copy of your social security card with current name, Marriage License or Divorce Decree, whichever applies). Submit certificate/license you are replacing, and \$20.00 fee (check or money order).

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Birthdate: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Sex: M \_\_\_ F \_\_\_

Name: \_\_\_\_\_
(Last) (First) (MI)

Other Names Used: \_\_\_\_\_

Current Mailing Address: \_\_\_\_\_
(Street) (City/State) (Zip)

Phone Number (Home) ( ) \_\_\_\_\_ - \_\_\_\_\_ (Work) ( ) \_\_\_\_\_ - \_\_\_\_\_

NOTE: All applicants must sign this application below. All forms received without a signature will be returned. It may require up to 10 business days to provide the requested replacement certificate.

Indicate which certificate(s) you are requesting to be replaced. Include identification number. A nonrefundable fee of \$20.00 is required for EACH NEW CERTIFICATE requested.

\_\_\_\_ Nurse Aide (ID# IF AVAILABLE \_\_\_\_\_)
Home address at time of state test: \_\_\_\_\_
City and date test was taken: \_\_\_\_\_
Name of Vo-Tech/Community College: \_\_\_\_\_

\_\_\_\_ Home Health Aide (ID# IF AVAILABLE \_\_\_\_\_)

\_\_\_\_ Medication Aide (CURRENT ONLY) (ID# IF AVAILABLE \_\_\_\_\_)
We will not print expired certificate

I hereby attest that the information provided on this form and any attachments are accurate to the best of my knowledge.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Return completed form, attachments, and fee to:
Health Occupations Credentialing
612 South Kansas Avenue
Topeka, KS 66603-3404

Web site: www.kdads.ks.gov