KANSAS DEPARTMENT FOR AGING AND DISABILITY SERVICES
SURVEY, CERTIFICATION AND CREDENTIALING COMMISSION
HEALTH OCCUPATIONS CREDENTIALING
AUTHORIZATION FOR REPLACEMENT WALL CERTIFICATE OR POCKET CARD

CONTACT INFORMATION:

Name : ____

Address: ____

Email: ____

Phone: ____

CREDENTIAL: Include your KANSAS license or Registration number next to the profession.

Adult Care Home Administrator: __________ Operator: __________ Dietitian: ___________

Speech Language Pathologist: ____________ Audiologist: ________

REPLACEMENT REQUEST: Each document requested has a $10 fee.

Wall Certificate: ______ X $10 = ______ Pocket Card: ______ X $10 = ______ TOTAL: _________

CREDIT CARD INFORMATION: ***Credit Card company service of 3.04% will be added to the total***

VISA Card Number (required): ____

Expiration Date (required): _____________________

OR

MASTERCARD Number (required): ____

Expiration Date (required): ______________________

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FOR OFFICE USE ONLY:

AMOUNT: _________ SERVICE FEE: __________ TOTAL CHARGED: _________

WJ 10.1.21
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