## KENTUCKY BOARD OF LICENSED DIABETES EDUCATORS

P.O. Box 1360 Frankfort, KY 40602 (502) 782-8807 http://bde.ky.gov

## REINSTATEMENT APPLICATION

Name:		SSN:		
Address:				
City:	State	Zip:		
License #	Ex1	piration Date:_		
the date indicated about with the completion a annual requirement of permit was active. T	ove. In accordance with the submission of the fifteen (15) continue the fee should be pa	with KRS 309.335 a his form, a reinstate uing education hou- id by check or mon	nd 201 KAR 45:120, 1 ment fee of \$120.00 ar rs <b>for each year since</b> ey order made payable	etes Educator Permit expired on reinstatement may be requested and evidence of completion of the the last date the license or to the Kentucky State ained, including course name, and
PLEASE COMP	LETE THE FO	OLLOWING (P	lease print or type	e):
l. Present Mailing Name:				
Address:_				
				Date of Birth
2. Present Busines				
Address:_				
3. Home Phone (_	)		Business Phon	e ()
4. License Numbe	er		Social Security Nu	mber
				t renewal of your license?
If yes, what offens	se and give detai	ls:		
	other state been s	subject to discipl	inary action?	er professional credential in Yes No. If

List below the units of continuing education obtained, INCLUDING DATE AND HOURS COMPLETED. Incomplete forms will be returned. DO NOT ATTACH DOCUMENTATION UNLESS YOU ARE AUDITED. It is your responsibility to maintain all documentation.

Approved Provider

Date(s) M/D/Y

Hours

			Completed	
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Course Name