



State of Alaska
Department of Commerce, Community and Economic Development
Division of Corporations, Business and Professional Licensing
MORTUARY SCIENCES SECTION
State Office Building, 333 Willoughby Avenue, 9th Floor
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Phone: (907) 465-3811 ★ Fax: (907) 465-2974
E-mail: license@alaska.gov
Website: http://commerce.alaska.gov/cbpl/pl

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MORTUARY TRAINEE PERMIT RENEWAL APPLICATION

Renewal fee - \$80 (one permit); or \$160 (both permits)

Renewal application for: [ ] Embalmer Trainee [ ] Funeral Director Trainee

Instructions: Make check or money order payable to the State of Alaska. Applicant completes front of form; supervisor must complete reverse side. Please print or type requested information. Renewal period covered: one year from date of renewal.

Name Last First Middle Maiden/Other

Social Security Number Birth Date Sex

Mailing Address City State ZIP Code

Residence Address City State ZIP Code

Telephone - Business Home

Email Address (optional):

Please send correspondence via: [ ] Email [ ] US Mail

I certify that the above information is true and correct to the best of my knowledge. I understand that any false or misleading information may result in failure to renew my trainee permit.

SUBSCRIBED AND SWORN TO before me on

Date Signature of Applicant

Notary Public, State of
My commission expires:

(NOTARY SEAL)

SEE REVERSE

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Trainee Permit No. Date Issued Date Expires
Disapproved Comments

**Instructions:** If the applicant has checked the “embalmer” box on the front of this application, complete the upper certification. If the applicant is renewing the “funeral director” training permit, complete the lower certification. If this is a combined renewal of both trainee permits, both certifications must be completed.

**EMBALMER: TO BE COMPLETED BY SUPERVISOR**

CERTIFICATION OF SUPERVISION: I, \_\_\_\_\_, certify that I am a licensed embalmer in the State of Alaska holding license number \_\_\_\_\_ and will be supervising the training of \_\_\_\_\_, who has already completed \_\_\_\_\_ hours/months of training. The training will take place at:

Establishment \_\_\_\_\_

Address \_\_\_\_\_

City/State/ZIP Code \_\_\_\_\_

Funeral Establishment Permit No. \_\_\_\_\_

I certify that the above information is true and correct to the best of my knowledge and I accept full responsibility for the supervision of the above-named trainee. I understand that any false or misleading information may result in failure to renew a trainee permit, or subsequent revocation.

Signature of Supervisor \_\_\_\_\_ Date \_\_\_\_\_

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**FUNERAL DIRECTOR: TO BE COMPLETED BY SUPERVISOR**

CERTIFICATION OF SUPERVISION: I, \_\_\_\_\_, certify that I am a licensed funeral director in the State of Alaska holding license number \_\_\_\_\_ and will be supervising the training of \_\_\_\_\_, who has already completed \_\_\_\_\_ hours/months of training. The training will take place at:

Establishment \_\_\_\_\_

Address \_\_\_\_\_

City/State/ZIP Code \_\_\_\_\_

Funeral Establishment Permit No. \_\_\_\_\_

I certify that the above information is true and correct to the best of my knowledge and I accept full responsibility for the supervision of the above-named trainee. I understand that any false or misleading information may result in failure to renew a trainee permit, or subsequent revocation.

Signature of Supervisor \_\_\_\_\_ Date \_\_\_\_\_



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AUTHORIZATION FOR RELEASE OF RECORDS

To Whom It May Concern:

I, \_\_\_\_\_

residing at \_\_\_\_\_

authorize the Alaska Division of Corporations, Business and Professional Licensing and its investigators to examine my medical, dental, employment, and education records, and any records pertaining to litigation, suits, judgments and/or settlements, and any law enforcement records pertaining to me and discuss them with persons having possession of them. I also expressly permit and authorize the release of any and all such records pertaining to me to the Alaska Division of Corporations, Business and Professional Licensing and its investigators.

I authorize the Division to discuss my records with persons or organizations which are considered appropriate by the Division in connection with an official investigation, and to provide copies of my records to those persons or organizations considered appropriate by the Division.

This release also applies to any documents or records which contain information pertaining to psychiatric, drug or alcohol evaluation, diagnosis, or treatment received by me and which were prepared or made in conjunction with, or under the authority or guidance of any local, state, or federal law which relates to psychiatric, drug or alcohol evaluation, diagnosis or treatment.

I request that upon presentation of this release, or a certified true copy of it, that you provide copies of those records to the Division and/or its investigators, and/or representatives of the Office of the Attorney General of the State of Alaska.

This authorization is given expressly in connection with my application for initial issuance of a license as an embalmer. This authorization expires one year from the date of my signature below.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Home Telephone: \_\_\_\_\_

Work Telephone: \_\_\_\_\_