NEBRASKA
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DEPT. OF HEALTH AND HUMAN SERVICES

Reinstatement Information For Nebraska Dialysis Patient Care Technician

LICENSE FEE WAIVER: Starting January 1, 2020, if you meet the following waiver option, your reinstatement application license fee **is waived, (this does not waive** the fee for criminal background checks):

Military Waiver: If you have served in the regular armed forces of the United State or have been actively engaged in military service (active duty for at least 30 days) during part of the previous 24 months you can waive the renewal and/or reinstatement fee. To waive the fee, you must submit a copy of your military orders with this application.

STEP 1: Get copies of the following documents:

Section A – Personal Information

1. ☐ **US Citizenship/Lawful Presence**

U.S. Citizens, a PHOTOCOPY of one of the following:

____ Birth certificate (Hospital issued keepsake birth certificates cannot be accepted).
____ U.S. Passport (unexpired or expired).
____ Certificate of Naturalization.
____ Other documents that show U.S. Citizenship.

A Driver's License is NOT acceptable.

NOT a U.S. Citizen (Current Immigration Status) a PHOTOCOPY of one of the following:

____ Green Card, otherwise known as a Permanent Resident Card (Form I-551), both front and back of the card;
____ Form I-94 (Arrival-Departure Record) **AND** an unexpired foreign passport with a valid unexpired US visa; or
____ Employment Authorization Card **AND one of the following**
- ____ An approved deferred action status (DACA);
- ____ A pending application for asylum in the United States;
- ____ A pending or approved application for temporary protected status in the United States; or
- ____ A pending application for adjustment of status to that of an alien lawfully admitted for permanent residence in the United States or conditional permanent resident status in the United States

____ Other document that shows current immigration status

***NOTE: Documents (other than those for U.S. Citizenship) are verified by our office through the Department of Homeland Security. This process may take 4-6 weeks.

2. ☐ According to the Uniform Credentialing Act of Nebraska §38-129(1) you must be at least 19 years old.

Section B – Conviction and Licensure/Registration/Certification Information

1. ☐ **Conviction Information:** Were you convicted of a misdemeanor or felony in any state or jurisdiction since your license was last renewed (or if you have not previously renewed, since you applied for an initial license)?

You must submit:

(a) A copy of the entire/complete court record related to all misdemeanor and felony convictions;
(b) Your explanation of the events leading to the conviction (what, when, where, why) and a summary of actions you have taken to address the behaviors/actions related to the conviction;
(c) If currently on probation, a letter from your probation officer addressing the terms and current status of your probation.

***NOTE: To aid the registry in evaluation of your drug and/or alcohol conviction(s), please submit all evaluation/discharge summaries where drug and/or alcohol treatment was obtained or required. All evaluations/discharge summaries must be submitted by the provider directly to the registry.**

The following provides SOME examples of convictions; this is NOT a complete list:

• MIP	• Driving under Suspension / Revocation
• DUI / DWI	• License Vehicle without Liability Insurance
• Controlled Substance	• Fail to Appear in Court
• Open Container	• False Information or Reporting
• Tobacco Use by Minor	• Leave the Scene of an Accident
• Shoplifting / Theft / Burglary	• Operator not Carrying License
• Unauthorized use of a Financial Transaction	• Unlawful Display of Plates/Renewal tabs
• Disturbing the Peace	• Parks Rule Violation / Curfew Violation
• Assault	• Dog at Large / Fail to Vaccinate Animal
• Disorderly Conduct / Disorderly House	• Littering / Fireworks
• Reckless Driving	• Bad Check

NOTE: If you have **any criminal charges or license disciplinary actions pending that result in a conviction** or license discipline, you are required to report such action to the Investigative Unit **within 30 days of the conviction or disciplinary action.** Reporting forms can be obtained at the following website: http://dhhs.ne.gov/Pages/Investigations.aspx or by phone 402-471-0175.

Section C - Education

1. ☐ **Education/Examination**:
   - Verification of Dialysis Patient Care Technician work setting training form.
   - Proof of successful completion of the National Certification examination. (A photocopy of Certificate).

   ***NOTE**: The verification of Dialysis Patient Care Technician work setting training and proof of successful completion of the National Certification examination are required when completed.

STEP 2: Application

☐ You must complete **ALL SECTIONS** of the application, pages 3-5.

STEP 3: Submit your application and fee to the Licensure Unit

You must submit:

1. ☐ Completed application
2. ☐ Copies of all documents requested
3. ☐ Applicant non-refundable fee. In order to prevent a delay in processing, submit an individual check/money order for each application.

Pay by check/money order – Payable to DHHS Licensure Unit
You must submit the exact amount needed or your application and payment will be returned

(Your cancelled check is your proof of receipt)

Debit or credit cards are not accepted at this time

Application Review: All applications are reviewed in order of date received.

- If your application **is missing information** your application and fee will be returned to you with a cover memo identifying what is needed. This will delay your application process and may affect your ability to practice as a dialysis patient care technician.

Contact Information
Telephone: 402-471-4322
Fax: 402-472-1151
E-Mail: DHHS.Nursingsupport@nebraska.gov

Physical Address:
DHHS, Division of Public Health
Licensure Unit- 3st Floor
301 Centennial Mall South,
Lincoln, Nebraska 68508

Mailing Address:
DHHS, Division of Public Health
Licensure Unit
P.O. Box 94986
Lincoln, Nebraska 68509-4986

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DEPT. OF HEALTH AND HUMAN SERVICES
Division of Public Health /Licensure Unit
P.O. Box 94986, Lincoln, Nebraska
68509-4986

Reinstatement Application
Nebraska Dialysis Patient Care Technician

LICENSE FEES:

Military Waiver

- ☐ Check here if you are an active duty member of the U.S. Armed Forces.
- ☐ Check here if you are the spouse of an active duty member of the U.S. Armed Forces stationed in Nebraska

Fee Required if YOU DO NOT qualify for the above fee waiver

YEAR	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Odd Number Year	$130	$130	$130	$130	$130	$130	$130	$130	$130	$130	$60	$60
Even Numbered Year	$60	$60	$60	$60	$130	$130	$130	$130	$130	$130	$130	$130

Dialysis Patient Care Technician registration expires 5/1 of even-numbered years. Fee is based on month and year your license will be issued.

Pay by check or money order to: **DHHS Licensure Unit**
Your cancelled check is your proof of payment. Payment is processed upon receipt. Debit or credit card are not accepted.

You must complete all sections of this application.

DPCT Lic. #_____

A. PERSONAL INFORMATION				
Legal Name	First	Middle	Last	
	Maiden	List any other names you have used or have been known as:		
Mailing Address	Street Address		PO Box	
	City	State or Country	Zip	
Date of Birth (Month/Day/Year)		**Place of Birth**	(City/State or Country)	
Phone # (optional)		Additional Phone # (Optional)		
A valid email address speeds the processing of your application.	**Email Address** (optional)			
Providing your SSN is mandatory	**Social Security Number**			
Neb. Rev. Stat. 38-123 mandates the disclosure of your Social Security Number to DHHS. Your SSN is not public information, but DHHS may disclose it for child support enforcement purposes and to the Department of Revenue, the Department of Labor, and for other administrative purposes if necessary and only under appropriate circumstances to ensure against any unauthorized access to the information. Other information supplied is part of the public record				
If you are not a U.S. Citizen provide your:	Alien Number (A#)			
	I-94 #			

B. CONVICTION INFORMATION. Failure to disclose misdemeanor and/or felony convictions can lead to disciplinary action.

1. Have you been convicted of any misdemeanor or felony in any state or jurisdiction since the date you last renewed your license? ☐ **Yes** ☐ **No**

If yes, list convictions below. If you need more space, list additional convictions on a separate sheet. For each conviction, you must submit the following:

- Explanation of the events leading to the conviction (what, when, where, why) and a summary of actions you have taken to address the behaviors or actions related to the convictions.
- If the conviction occurred in a state other than Nebraska, a copy of the court record that includes the statement of charges and final disposition.
- If you are currently on probation, a letter from your probation officer addressing the terms and current status of the probation.

To aid in the evaluation of drug or alcohol related convictions, you may submit evaluation and discharge summaries of any drug or alcohol treatment obtained. Evaluations and discharge summaries may be submitted by the provider directly to the department.

	Type of Crime	Conviction Date	Name of Court or Jurisdiction
1			
2			
3			
4			

Pending Charges: If you have any pending criminal charges that result in a misdemeanor or felony conviction, you are required to report the conviction to the Investigations Unit within 30 days of the conviction. Reporting forms can be obtained from https://dhhs.ne.gov/Pages/Investigations or by calling (402) 471-0175.

C. LICENSE INFORMATION

1. Do you hold or have you held a license or credential to provide health services, health-related services, or environmental services in any state or jurisdiction other than Nebraska? ☐ **Yes** ☐ **No**

If yes, complete the following. If you need more space, list additional licenses on a separate sheet.

Type of License/Credential	State or Jurisdiction	License Number	Date Issued	Expiration Date

2. Has any health care profession credential you hold or have held in another state or jurisdiction ever been denied, refused renewal, limited, suspended, revoked, or had other disciplinary measures taken against it? ☐ **Yes** ☐ **No**

If yes, list all actions below. If you need more room, list additional actions on a separate sheet. You must also submit a copy of the charges and disposition issued by the state that took the action.

License Type	State/Jurisdiction	Type of Action	Date of Action

NOTE: If you have any disciplinary charges pending that result in disciplinary action being taken against your license, you are required to report such actions to the Investigative Unit within 30 days of occurrence. Reporting forms can be obtained from https://dhhs.ne.gov/pages/Investigations.aspx or by calling (402) 471-0175.

D. EDUCATION	
1. Have you completed Dialysis Patient Care Technician training which follows national recommendations and is conducted in the work setting?	Yes ☐ ***Please include Verification Form with Application. (Page 6)***
2. Have you successfully passed a National Certification Examination?	Yes ☐ ***Please include a photocopy of your most recent Exam Completion Certificate with Application.***

E. PRACTICE PRIOR TO LICENSURE	
An individual who practices prior to issuance of a credential is subject to assessment of an Administrative Penalty of $10 per day up to $1,000, or such other action as provided in the statutes and regulations governing the license.	
Have you practiced as practiced as a Dialysis Patient Care Technician in Nebraska without being active on the registry?	☐ **Yes** ☐ **No**
If yes, what are the actual number of days you practiced in Nebraska without a license and what is the business name, location, and telephone number of the practice?	Number of Days:
	Name of Business:
	City:
	Telephone:

F. ATTESTATION

For the purpose of meeting Neb. Rev. Stat. §4-108 through §4-114 and §38-129 *check **ONE** of the boxes below:*

I attest that:
☐ I am a citizen of the United States.
OR
☐ I am a qualified alien under the Federal Immigration and Nationality Act.
☐ I am a nonimmigrant lawfully present in the United States.
☐ Check this box if you are **NOT** a citizen of the United States, a nonimmigrant, nor a qualified alien under the Federal Immigration and Nationality Act.

Application Attestation

I attest that:

1. I have read the application or have had the application read to me, and
2. All statements on this application are true and complete.

Print Name: _____

Signature*: _____ Date: _____

*Sign your name after printing application. Electronic signatures are not accepted.

Contact Information
Telephone: 402-471-4322
Fax: 402-472-1151
E-Mail: DHHS.Nursingsupport@nebraska.gov

Physical Address:
DHHS Division of Public Health
Licensure Unit - 3st Floor
301 Centennial Mall South
Lincoln Nebraska 68508

Mailing Address:
DHHS Division of Public Health
Licensure Unit
P.O. Box 94986
Lincoln NE 68509-4986

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Jim Pillen, Governor

Verification of Dialysis Patient Care Technician Worksite Training Program Completion

Part 1-General Information-Please Print *Applicant must complete this section*

Full LegalName_____
Last **First** **Middle** **Maiden**

Date of Birth _____ **Telephone**_____
(Month / Day / Year)

.....

Part 2-Verification of Completion of Dialysis Patient Care Technician Worksite Training Program-Please Print

Dialysis training program administrator must complete this section

Name of Facility/Worksite _____

Address_____

City_____**State**_____

Zip_____ **Telephone Number of Program**_____

This is to verify that the applicant named above enrolled in and has successfully completed a dialysis patient care technician training program that is approved by the medical director, under the direction of a registered nurse. This training program follows national recommendations for dialysis patient care technicians and is conducted primarily in the work setting (Neb. Rev. Stat. §38-3705)

Employment Start Date_____
(Month/Day/Year)

Date of Enrollment in Training Program _____
(Month/Day/Year)

Date of Training Program Completion _____
(Month/Day/Year)

_____ _____
Name of Registered Nurse **State Licensed / License Number**

_____ _____
Phone Number of Registered Nurse **E-mail Address of Registered Nurse**

_____ _____
Signature of Registered Nurse **Date**