

Physician Reinstatement Information Medicine and Surgery Osteopathic Medicine and Surgery

If your license was revoked or suspended for disciplinary reasons, contact the Licensure Unit for the appropriate application

To reinstate your license, you must:

1. Complete the attached application for reinstatement.
2. Have a valid Social Security #.
3. Be lawfully present in the U.S.
4. **Have already completed at least 50 Category 1 hours** of continuing education within the previous 24 months before submitting this application.
5. Pay the renewal, reinstatement and Patient Safety Fund fees. (see page 1 of the application)
We do not accept credit/debit card payment.

If you reinstate your license at this time, the expiration date will be October 1st of the even-numbered year.

1. Reinstatement Application: Neb. Rev. Stat. 38-2026(4) states that an applicant for a license in medicine and surgery must present proof satisfactory to the Department that he or she, within the three years immediately preceding the application for licensure, (a) has been in the active practice of the profession of medicine and surgery in some other state, a territory, the District of Columbia, or Canada for a period of one year, (b) has had at least one year of graduate medical education as described in subdivision (2) of this section, (c) has completed continuing education in medicine and surgery approved by the board, (d) has completed a refresher course in medicine and surgery approved by the board, or (e) has completed the special purposes examination approved by the board.

Be advised that the Board of Medicine and Surgery **does not routinely accept continuing education or the special purposes examination alone as acceptable to meet the experience requirement in the absence of recent practice or other evidence of continued competency.**

Neb. Rev. Stat. 38-2026.01 gives the Department, with the recommendation of the Board, authority to issue a reentry license to a physician who has not actively practiced medicine for the two-year period immediately preceding the filing of an application for a license or who has not otherwise maintained continued competency during such period as determined by the Board.

Following is the website to the Statutes Relating to Medicine and Surgery where you can read the complete language regarding the reentry license. <https://dhhs.ne.gov/licensure/Documents/MedSurgPerfusionGenCouns.pdf>

The Board of Medicine and Surgery will review applications for a license, either initial application or reinstatement of license, which do not clearly meet the requirements for experience (continued competency) as outlined in the statutes listed above. The Board will make a recommendation to the Department to either issue the license, deny the application or offer a reentry license to the applicant. (This assumes there are no matters whereby discipline would be appropriate.) **Please be aware, that if a reentry license is decided upon by the Board and Department, the process would be that the application be denied if the applicant does not accept the reentry license.**

2. A copy of your Federal Controlled Substance Registration Card (if applicable);
3. Proof of Liability (Malpractice) Information:

If You Answered YES To Section IV Question #1: Indicate the total number of claims you have had which resulted in:

- a. an adverse judgment against you;
- b. a settlement made on your behalf, including those made prior to suit in which the patient released any professional liability claim against you;
- c. an award was required or made by you or on your behalf.

Submit a **detailed explanation of each claim to include the following:**

1. Name, sex and age of patient
2. Date of occurrence
3. Initial event (procedure/diagnosis)
4. Subsequent event that precipitated the claim – include the time sequence in relation to the initial event
5. Damages – a description of damages or alleged damages resulting from the initial and subsequent events
6. Date of filing of malpractice claim in court (if applicable)

7. Outcome of claim – include the court disposition, whether or not the case was settled, and the amount of any monetary settlement or judgment made on your behalf.
8. Date of final outcome of claim.

If You Answered YES To Section IV Question #2: **Indicate the total number of malpractice claims that are currently pending against you.** Submit the following for each pending claim:

- a. A **detailed explanation** of the claim to include the information as outlined above, numbers 1-6;
- b. Copies of the court documents that outline the **statement of charges** (often called the “Complaint”);
- c. **Letter from the attorney** stating the current status of the claim.

If you are NOT a U.S. Citizen, you must submit:

1. Green Card, otherwise known as a Permanent Resident Card (Form I-551), both front and back of the card.
2. Form I-94 (Arrival-Departure Record) **AND** an unexpired foreign passport with a valid unexpired US visa.
3. Employment Authorization Document (EAD) (unexpired) **AND** at one of the following documents under the Federal REAL ID Act:
 - 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;
 - A pending application for adjustment of status to that of an alien lawfully admitted for permanent residence; or in the United States or conditional permanent resident status in the United States; or
4. Other document that shows current immigration status.

NOTE: Documents are verified by our office through the Department of Homeland Security. This process may take 4-6 weeks.

Practice After Expiration Date:

If you practiced after the expiration date of your license and prior to reinstatement, you are subject to an Administrative Penalty of \$10 per day up to \$1,000, or other action as provided in the statutes and regulations governing your profession (such as probation, limitation, censure, etc.).

Additionally, if you committed any other violation of the statutes or regulations governing your practice, the Department may deny the application for reinstatement or reinstate your license to active status and impose limitation(s) or other disciplinary actions on your license.

Questions:

If you have any questions regarding the procedure for reinstatement, please contact the Licensure Unit, at (402) 471-2118 or DHHS.medicaloffice@nebraska.gov

If your license is reinstated, you will receive an e-mail or mail notice so you can print your wallet card from our website: TO PRINT YOUR WALLET CARD GO TO: https://www.nebraska.gov/LISSearch/search.cgi



Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Division of Public Health - Licensure Unit
P.O. Box 94986 - Lincoln, Nebraska 68509-4986
Telephone #: 402-471-2118
DHHS.medicaloffice@nebraska.gov

Medicine and Surgery
Osteopathic Medicine and Surgery
REINSTATEMENT APPLICATION

This section for Office Use Only
Expiration Date:
Date of License:
Revised 9/2022

FEE: The fee due is listed by month and year.

Make payable by check or money order to "Licensure Unit"
We do not accept credit/debit card payment

Table with 13 columns (YEAR, Jan, Feb, Mar, Apr, May, June, July, Aug, Sep, Oct, Nov, Dec) and 3 rows (Even Numbered Year, Odd Numbered Year, and a row with highlighted values).

EFFECTIVE JANUARY 1, 2020 ADDITIONAL FEES FOR APPLICANTS FOR THE RENEWAL AS A PHYSICIAN UNDER THE MEDICINE AND SURGERY PRACTICE ACT SHALL PAY A PATIENT SAFETY FEE OF FIFTY DOLLARS (\$50.00).

PLEASE ADD THE \$50.00 FEE TO THE AMOUNT LISTED IN THE CHART ABOVE - THIS FEE CANNOT BE WAIVED.

You must complete ALL sections of this application

SECTION A: PERSONAL INFORMATION

1 Legal Name: First: Middle/MI: Last:

For name changes, you must submit a copy of marriage certificate, divorce decree, court order, etc. If not submitted, the license will be issued in the name as printed above.

2 Mailing Address: Street/PO/Route: City: State or Country: Zip:
Check this box if NEW address

3 Date of Birth (Month/Day/Year): Place of Birth (City/State or COUNTRY):

4 Phone #: E-Mail Address:

5 License Number:

To reinstate your license, you must have a valid Social Security Number

6 Social Security Number (SSN):
If you also have an A# or I-94#, check the correct box and provide your number:
Alien Registration Number ("A#"):
I-94 #:

Neb. Rev. Stat. §§38-123 and 38-130 requires that you provide your social security number to DHHS. Although your number is not public information, DHHS may disclose it for child support enforcement purposes as well as to the Nebraska Department of Revenue, Department of Labor and for other Administrative purposes.

MILITARY SERVICE:

If you meet the following definition of 'military', you are NOT required to pay the renewal fee or meet the continuing education requirements. (The Reinstatement fee of \$35.00 and the Patient Safety Fund fee of \$50.00 are required fees)
(You must check the box and submit the requested document)

Military: I have served in the regular armed forces of the United States or am actively engaged in military service (active duty for at least 30 days) during part of the 24 months immediately preceding the biennial renewal date. (You must attach your military orders)

SECTION B: CONVICTION AND LICENSE INFORMATION

Failure to list any conviction(s) or disciplinary action(s), could result in disciplinary action against your license.

Conviction Information:

You are NOT required to list infractions, diversions or dismissals. Misdemeanor and felony convictions can either be processed through traffic or criminal court, so when you check with the county court/district court, you should ask for both traffic and criminal court misdemeanor and felony convictions

1	<p>Were you convicted of a misdemeanor or felony in any state/jurisdiction since your license was last renewed (or since you received your initial license if such was within the past 24 months). If you answer YES to this question, you must submit the following documents to the Licensure Unit:</p> <ul style="list-style-type: none"> A copy of the entire/complete court record, which includes charges and disposition; 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 convictions; If you have a drug and/or alcohol offense, to assist in the 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 DHHS; and If you are currently on probation, a letter from the probation officer addressing the terms and current status of your probation. <p>List below misdemeanor or felony convictions</p> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <thead> <tr> <th style="width: 50%;">Name of Conviction</th> <th style="width: 20%;">Date of Conviction</th> <th style="width: 30%;">Name of Court</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table>	Name of Conviction	Date of Conviction	Name of Court							<input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Conviction	Date of Conviction	Name of Court									

NOTE: If you have any criminal charges or credential disciplinary actions pending that result in misdemeanor or felony conviction or license discipline, you must report such actions to of Division of Public Health Office of Investigation within 30 days of the conviction or disciplinary action (Neb. Rev. Stat. 38-1,125). Reporting forms are available at: <https://dhhs.ne.gov/Pages/Investigations.aspx> or by calling 402-471-0175

Licensure Information:

The following questions relate to a license/certificate/registration that you currently **hold or have held** to provide health related services in a state/jurisdiction **other** than Nebraska.

		Yes	No		
2	<p>Do you hold or have you held a license in any state?</p> <p style="color: red; font-size: small;">If you answer 'yes' to this question, you must respond to question 2a</p>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, what State(s) are you licensed in?	What type of license do you hold?
2a	<p>If YES, has your license ever been denied, refused renewal, limited, suspended, revoked or had other disciplinary measures taken against it, or voluntarily surrendered or voluntarily limited?</p> <p style="color: red; font-size: small;">If you answered YES to this question, you must submit Official Documents from the State Board in which the disciplinary action was taken.</p>	<input type="checkbox"/>	<input type="checkbox"/>	Type of License Action	Date of Action
3	<p>Have you ever been denied the right to take a licensing examination in any state?</p>	<input type="checkbox"/>	<input type="checkbox"/>	Please Explain:	

Licensure Information Continued:

The following questions pertain to the time period since the license was last active, unless otherwise specified. **All 'yes' responses MUST be explained in detail.** Additional documentation may be requested by the Board/Department after submission of initial information.

SECTION I	Yes	No
1. Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical and professional manner?	<input type="checkbox"/>	<input type="checkbox"/>

SECTION II	Yes	No
1. Have you had hospital or institutional privileges denied, reduced, restricted, suspended, revoked, terminated or placed on probation?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you been requested to voluntarily resign or suspend hospital or institutional privileges while under investigation from a hospital, clinic, institution, or other medically related employment?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you been notified that any action against your hospital or institutional privileges is pending or proposed?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you been allowed to withdraw your staff privileges from a hospital or institution?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you been subject to staff disciplinary action or non-renewal of an employment contract?	<input type="checkbox"/>	<input type="checkbox"/>

SECTION III	Yes	No
1. Have you been denied a Federal Drug Enforcement Administration (DEA) Registration or state controlled substances registration?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you been called before any licensing agency or lawful authority concerned with DEA controlled substances?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you surrendered your state or federal controlled substances registration?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you had your state or federal controlled substances registration restricted or disciplined in any way?	<input type="checkbox"/>	<input type="checkbox"/>

SECTION IV	Yes	No
1. Have you been notified of any professional liability claim that resulted in an adverse judgment, settlement, or award, including settlements made prior to suit in which the patient releases any professional liability claim against the applicant?	<input type="checkbox"/>	<input type="checkbox"/>
2. Are you aware of any professional liability claims currently pending against you?	<input type="checkbox"/>	<input type="checkbox"/>

SECTION C – EXPERIENCE REQUIREMENT:

Indicate that within the three years immediately preceding the application for reinstatement, you meet ONE of the following:

- I have been in the active practice of the profession of medicine and surgery in Nebraska, another state or a territory, the District of Columbia, or Canada for a period of one year. List this information in the section below.
- I have had at least one year of approved graduate medical education. List this information in the section below.
- I have completed continuing medical education approved by the Board. Submit proof of attendance at continuing education, as well as information about the content for Board approval. *See below*
- I have completed a refresher course in medicine and surgery approved by the Board. Submit proof of attendance at a refresher course as well as information about the content for Board approval. *See below
- I have completed the special purposes examination approved by the Board. Have scores sent directly to this office. *See below*

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The Board of Medicine and Surgery will review applications for a license, either initial application or reinstatement of license, which do not clearly meet the requirements for experience (continued competency) as outlined in the statutes listed above. The Board will make a recommendation to the Department to either issue the license, deny the application or offer a reentry license to the applicant. (This assumes there are no matters whereby discipline would be appropriate.) **Please be aware, that if a reentry license is decided upon by the Board and Department, the process would be that the application be denied if the applicant does not accept the reentry license.**

List your professional activities for the three years preceding date of application, or since your license was last active, whichever time period is longer.

From: Month/Year		To: Month/Year	
Name of Facility:			
City/State/Country:			
Activity:			
From: Month/Year		To: Month/Year	
Name of Facility:			
City/State/Country:			
Activity:			
From: Month/Year		To: Month/Year	
Name of Facility:			
City/State/Country:			
Activity:			
From: Month/Year		To: Month/Year	
Name of Facility:			
City/State/Country:			
Activity:			

SECTION D: CONTINUING EDUCATION

You must have already completed **50** hours of continuing education within the previous 24 months before submitting this application for reinstatement.

CONTINUING EDUCATION HOURS:

<input type="checkbox"/> Yes	Have you met the continuing education requirements for your profession? If no, you may qualify for a waiver under the 'waiver' section below.
<input type="checkbox"/> No	

Continuing Education requirements are listed below:

You must have earned ONE of the following within the 24 months immediately preceding that date of application for reinstatement:

- 50 hours of Category 1 continuing education approved by the Accreditation Council for Continuing Medical Education (ACCME) or the American Osteopathic Association (AOA); OR
- One year of participation in an approved graduate medical education program; OR
- The AMA Physician's Recognition Award or the AOA CME certification (awarded within the 24 months immediately preceding the date of application for reinstatement).

Hours are to be earned within 24 months of the date of expiration, except that a licensee who has earned more than 50 hours required for renewal for one 24 month renewal period, is allowed to carry over up to 25 hours to the next 24 month renewal period.

WAIVER OF CONTINUING EDUCATION HOURS:

If you **have not** completed the continuing education and you qualify for a waiver, check the appropriate reason below:

<input type="checkbox"/>	Initial License: I was first licensed within the previous 24 months before submitting this application for reinstatement.
<input type="checkbox"/>	Circumstances Beyond My Control: I was not able to complete my continuing education requirement due to circumstances beyond my control. <u>Waivers</u> of continuing education may be considered for circumstances lasting longer than 30 consecutive days that DHHS determines are beyond your control. Such circumstances can include, but are not limited to, a shortage of available continuing competency courses resulting from an officially declared state of emergency. Submit the following information: 1. List the reason(s) you were not able to complete the required continuing education. 2. Did this last longer than 30 consecutive days? 3. Are you requesting a waiver of the total hours of continuing education, or a partial waiver? If partial waiver, how many hours are your requesting be waived?

Documents (if requested above) must be provided to support your request for waiver of continuing education.

If the requested documents are not submitted, review and processing of your reinstatement application will not occur.

On March 15, 2022, Governor Pete Ricketts extended Executive Order 21-18 which suspends the Continuing Competency/Continuing Education requirements as a requirement for renewal for the following professions: medicine and surgery (MD), advanced practice nursing, emergency medical services, mental health, drug and alcohol counselors, nursing, osteopathic medicine and surgery (DO), pharmacy, perfusion, psychology, respiratory care, surgical assistants, occupational therapy, physical therapy, nursing home administration, audiology and speech language pathology, medical radiography, and medical nutrition therapy. The Continuing Competency/Education questions remain on the reinstatement application and will be processed regardless of how you answer the questions.

SECTION E: PRACTICE AFTER EXPIRATION OR INACTIVE STATUS

If you practice after the expiration date and prior to reinstatement of your license, you are 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 your profession.

1	Have you practiced medicine and surgery as a physician in Nebraska since your license expired or was placed on inactive status?	<input type="checkbox"/> Yes <input type="checkbox"/> No						
2	If yes, what are the actual number of days you practiced in Nebraska and what is the business name, location and telephone number of the practice: # of days: _____	<table style="width: 100%; border: none;"> <tr> <td style="border: none;">Name of Business:</td> <td style="border: none;">_____</td> </tr> <tr> <td style="border: none;">City:</td> <td style="border: none;">Telephone #:</td> </tr> <tr> <td style="border: none;">_____</td> <td style="border: none;">_____</td> </tr> </table>	Name of Business:	_____	City:	Telephone #:	_____	_____
Name of Business:	_____							
City:	Telephone #:							
_____	_____							

SECTION F: ATTESTATION

For the purpose of meeting Neb. Rev. Stat. §4-108 through §4-114 and §38-129, **I attest that:**

*(check only **ONE** of the boxes below)*

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.

I further 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: _____

TO PRINT YOUR WALLET CARD GO TO: <https://www.nebraska.gov/LISSearch/search.cgi>