NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Department of Health and Human Services
Division of Public Health - Licensure Unit
P.O. Box 94986 - Lincoln, Nebraska 68509-4986
E-mail: dhhs.medicaloffice@nebraska.gov
Telephone #: 402-471-2118

Reinstated on: _____

Office Use Only
Revised 10/2018

APPLICATION FOR REINSTATEMENT

Surgical First Assistant

FEE: $145.00

Original Application/Signature Required

License # _____

SECTION A – PERSONAL INFORMATION: All applicants must complete this section) Items 1 and 2 are public information. Name and Licensure information will be displayed on the INTERNET at http://www.nebraska.gov/LISSearch/search.cgi

NOTE: All mailings will be sent to the address you indicate below– if you change your address, you must advise this office.

1	Legal Name (Last, First, Middle)			
2	Mailing Address	Street/PO/Route:		
		City:	State or Country:	Zip:
3	Date of Birth:	Month/Day/Year:	Place of Birth (city/state/country):	
4	Check the Appropriate Box(es)	☐ Social Security Number (SSN); ☐ Alien Registration Number ("A#"); ☐ Form I-94 (Arrival-Departure Record) number	SSN# A# I-94 #	
	If you have both a SSN and an A# or I-94 number, you must report both. Neb. Rev. Stat. §38-123 mandates disclosure of your social security number to DHHS. Although your number is not public information, DHHS may disclose it for child support enforcement purposes and to the Nebraska Department of Revenue.			
	Phone		Fax (optional)	
	Licensee E-mail Address		Credentialing contact e-mail Address (optional)	

Office Use ONLY			Federation	Yes__	No__
BOARD	Yes__	No__	NPDB	Yes__	No__
			NDEN	Yes__	No__

SECTION B – CONVICTION (All applicants must complete this section) Failure to disclose any such conviction or disciplinary action, regardless of when the action occurred, could result in disciplinary action, including, but not limited to, payment of a civil penalty.

NOTE: If you have any criminal charges or license disciplinary actions pending that results in conviction or license discipline, you are required to report such actions to the Investigative Unit within 30 days (Neb. Rev. Stat. §38-1, 125) at https://dhhs.ne.gov/pages/investigations.aspx or by requesting a reporting form by telephone at 402-471-0175.

Answer each of the following questions by placing a (✓) in the appropriate box (yes or no) and completing the information requested. All 'yes' responses MUST be explained in detail and you must submit the requested documentation.

Conviction Information:

			Type of Crime or Licensure Action	Date of Action	Name of Court/Entity Taking action
Have you been convicted of a misdemeanor or felony since your license was active?	☐ Yes	☐ No			

If you **answered YES**, you must submit the following documents:

a) The court record, which includes charges and disposition;
b) A letter from the applicant of the events leading to the conviction (what, when, where, why) and a summary of actions the applicant has taken to address the behaviors/actions related to the convictions;
c) All addiction/mental health evaluations and proof of any treatment obtained; and
d) A letter from the probation officer addressing probationary conditions and current status if the applicant is currently on probation;

Section C: LICENSURE INFORMATION: The following questions relate to a credential that you hold or have held in health services, health related services or environmental services in another jurisdiction.

			If yes, what State(s) are you licensed in? State	License #	What type of license do you hold?		
Are you licensed in any state?	☐ Yes	☐ No					
If yes, has your license ever been denied, refused renewal, limited, suspended, revoked or had other disciplinary measures taken against it?	☐ Yes	☐ No	Type of Licensure Action		Date of Action	Name of Entity taking Action	

If you have had any disciplinary actions taken against your credential you will need to request verification of the license be submitted, along with a copy of any public documents regarding any and all actions. This documentation needs to be provided to the office directly from the State Board.

SECTION D - CONTINUING COMPETENCY:

I have met the continuing competency requirements within the 24 months immediately preceding that date of application for reinstatement:

- The Accreditation Council for Continuing Medical Education (ACCME) Category 1 continuing education; or
- The National Board of Surgical Technology and Surgical Assisting (NBSTSA); or
- The National Surgical Assistant Association (NSAA); or
- The American Board of Surgical Assistants (ABSA); or
  A nationally recognized continuing education provider approved by the board

All applicants for reinstatement must answer the following question by placing a (✓) in the appropriate box (yes or no):	**Yes**	**No**
Have you met the continuing competency requirements as outlined above?	☐	☐

WAIVER OF CONTINUING COMPETENCY: If you **have not** completed the continuing competency requirement, and wish to apply for a waiver of the continuing competency requirement, check the appropriate reason below:

☐	**Military:** I have served in the regular armed forces of the United States during part of the 24 months immediately preceding the biennial licensure renewal date. (Attach official documentation stating dates of service) If you meet this exemption, you are not required to pay the renewal fee.
☐	**Initial License:** I was first licensed within the 24 months immediately preceding my date of application for active status.

SECTION E - QUESTIONS:

(All applicants must complete this section) **Failure to disclose any such conviction or disciplinary action, regardless of when the action occurred, could result in disciplinary action, include, but not limited to, payment of a civil penalty.** The questions pertain to the time period since the license was last active, unless otherwise specified.

Answer the following questions either yes or no by placing a (✓) in the appropriate box. **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. Have you had any disciplinary or adverse action imposed against a professional license or permit in any state or jurisdiction?	☐	☐
2. Have you voluntarily surrendered or voluntarily limited in any way a license or permit issued to you by a licensing or disciplinary authority?	☐	☐
3. Have you been requested to appear before any licensing agency?	☐	☐
4. Have you been notified of any charges, complaints or other actions filed against you by any licensing or disciplinary authority?	☐	☐
5. Are you aware of any pending disciplinary actions or of any on-going investigations of a complaint against your license or permit in any jurisdiction?	☐	☐
6. Have you been asked to and/or permitted to withdraw an application for licensure or permit with any Board or jurisdiction?	☐	☐
7. Has any state or jurisdiction refused to issue, refused to renew or denied you a license or permit to practice?	☐	☐
SECTION II	**Yes**	**No**
1. Are you currently, or have you been, addicted to, dependent upon or chronically impaired by alcohol, narcotics, barbiturates, or other drugs which may cause physical and/or psychological dependence?	☐	☐
2. Within the past 5 years, have you received any therapy/treatment or been admitted to any hospital or other in-patient care facility for reasons relating to your use/abuse of alcohol, narcotics, barbiturates, or other drugs?	☐	☐
3. Do you currently, or have you had, any physical, mental, or emotional condition which impaired, or does impair your ability to practice your health care profession safely and competently?	☐	☐

4. Within the past 5 years, has any licensing agency or credentialing organization initiated any inquiry into your physical, mental or emotional health?	☐	☐
SECTION III	**Yes**	**No**
1. Have you been restricted, suspended, terminated, requested to voluntarily resign, placed on probation, counseled, received a warning or been subject to any remedial or disciplinary action during medical school or postgraduate training?	☐	☐
2. Have you had hospital or institutional privileges denied, reduced, restricted, suspended, revoked, terminated or placed on probation?	☐	☐
3. 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?	☐	☐
4. Have you been notified that any action against your hospital or institutional privileges is pending or proposed?	☐	☐
5. Have you been allowed to withdraw your staff privileges from a hospital or institution?	☐	☐
6. Have you been subject to staff disciplinary action or non-renewal of an employment contract?	☐	☐
SECTION IV	**Yes**	**No**
1. Have you been convicted of a felony?	☐	☐
2. Have you been convicted of a misdemeanor?	☐	☐
3. Have you been notified of any charges, complaints or other actions filed against you by any criminal prosecution authority?	☐	☐
SECTION V	**Yes**	**No**
1. Have you been denied a Federal Drug Enforcement Administration (DEA) Registration or state controlled substances registration?	☐	☐
2. Have you been called before any licensing agency or lawful authority concerned with DEA controlled substances?	☐	☐
3. Have you surrendered your state or federal controlled substances registration?	☐	☐
4. Have you had your state or federal controlled substances registration restricted or disciplined in any way?	☐	☐
SECTION VI	**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?	☐	☐
2. Are you aware of any professional liability claims currently pending against you?	☐	☐

SECTION F – PRACTICE PRIOR TO CREDENTIAL

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 credential.

1	I have practiced (profession) in Nebraska since I last held an active credential?	☐ Yes ☐ 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: _____
		Name of Business:
		City:

SECTION G - ATTESTATION

Lawful Presence in the United States Attestation: For the purpose of complying with Neb. Rev. Stat. §38-129, I attest as follows:

Please check only one of the boxes below:

☐ I am a citizen of the United States; or
☐ I am an alien lawfully admitted into the United States who is eligible for a credential under the Uniform Credentialing Act; or
☐ I am a non-immigrant lawfully present in the United States who is eligible for a credential under the Uniform Credentialing Act.

Alien or Non-Immigrant Status: If you are a qualified alien lawfully admitted into the United States OR a non-immigrant lawfully present in the United States, you must submit evidence of lawful presence which may include a copy of:

1. A "Green Card" otherwise known as a Permanent Resident Card (Form I-551), both front and back of the card; or
2. An unexpired foreign passport with an unexpired Temporary I-551 stamp bearing the same name as the passport; or
3. A document showing an Alien Registration Number ("A#"), an Employment Authorization Card/Document is **NOT** acceptable; or
4. A Form I-94 (Arrival-Departure Record).

If you are an Alien or Non-Immigrant, your credential will **NOT** be issued until such proof is received by our office and your documents are verified by our office through the Department of Homeland Security. This process may take four to six weeks.

Criminal Background Check Notification: Pursuant to Neb. Rev. Stat. §38-131, an applicant for an initial license to practice a profession which is authorized to prescribe controlled substances shall be subject to a criminal background check. I understand that I am able to receive any national criminal history record that may pertain to me directly from the FBI, pursuant to 28 CFR Sections 16.30-16.34, and that I could then freely disclose any such information to whomever I choose. By signing this application, it is my intent to authorize the dissemination of any national criminal history record that may pertain to me to the Department of Health and Human Services (DHHS) with whom I am applying for licensure. I understand that I am entitled to challenge the accuracy and completeness of any information contained in any such report, and that you will provide me a copy of the criminal history background report, if any, you receive on me if I appear at the DHHS in person and present proper identification. Information on how to challenge your federal report can be found at FBI.gov. To challenge your Nebraska state record, contact the Nebraska State Patrol-Criminal Identification Division. I may obtain a prompt determination as to the validity of my challenge before you make a final decision about my application for licensure.

Application Attestation: I further attest that:

1. I have read the application or have had the application read to me;
2. All statements on the application are true and complete; and
3. I am of good character.

Print Name: _____

Signature: _____ Date: _____