# APPLICATION FOR APPOINTMENT TO THE BOARD OF ADVANCED PRACTICE REGISTERED NURSES
## (*PHYSICIAN MEMBER*)

**PLEASE PRINT OR TYPE**
**Name:**

_____
First Middle Last Credentials (ie, MD, etc., if applicable)

**Mailing Address:**

_____
Street/Box/RR

_____
City State Zip

Business Telephone _____ Cell_____ Home Telephone _____

Email Address _____ FAX Number _____

Are you available to meet, usually in Lincoln, on a monthly basis, if necessary or required for Board Meetings? Yes ☐ No ☐

Please indicate how you became aware of this vacancy on this Board.
Professional Association ☐ DHHS Web Page ☐ Newspaper ☐ Other ☐ (please explain) _____

### ELIGIBILITY REQUIREMENTS

Do you hold a current Nebraska license to practice as a Physician? Yes ☐ No ☐ (Statutes require the physician members of the board shall have held and maintained an active physician license for a period of five years just preceding appointment and shall maintain such license while serving as a board member.)

Have you been actively engaged in practice as a physician for the five (5) years just preceding this application? Yes ☐ No ☐ (Statutes require the physician members of the board shall have been actively engaged in practice as a physician for a period of five years just preceding appointment and shall maintain such practice while serving as a board member. Active practice means devoting a substantial portion of time to rendering professional services.)

How many years you have been engaged in the practice of medicine and surgery? _____

Have you been a Nebraska resident for at least one (1) year? Yes ☐ No ☐ (Statutes require every board member shall have been a resident of Nebraska for one year and shall remain a resident of Nebraska while serving as a board member.)

Who do you have a professional relationship with: Nurse Practitioner ☐ Certified Nurse Midwife ☐ or a Certified Registered Nurse Anesthetist ☐ List the name(s) of any NP, CNM, or CRNA with whom you work.

_____

_____
(Statutes require that of the 3 physicians on this board, one shall have a professional relationship with an NP, one shall have a professional relationship with a CNM, and one shall have a professional relationship with a CRNA.)

### EDUCATION

| Degree/Specialty | School Name & Location | From | To |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

**PLEASE COMPLETE REVERSE SIDE**

## DETAILED DESCRIPTION OF WORK EXPERIENCE AS A PHYSICIAN WITHIN THE LAST FIVE YEARS IN NEBRASKA

| Position Title | Name & Location | From | To | Average # of Hours/Week |
|---|---|---|---|---|
| | | | | |
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## ADDITIONAL INFORMATION

Describe your interest in advanced practice registered nursing and why you wish to serve on this Board.

Are you aware of any reason why your appointment might be considered a conflict of interest as defined in Title 172 NAC 3, Regulations Establishing Definitions of Conflicts of Interest for Members of the Boards of Examiners in the Health Professions? Yes☐ No☐ If yes, explain.

Have you ever had your statutory ability to practice or clinical privileges suspended or revoked? Yes☐ No☐

Are you currently under investigation? Yes☐ No☐

Are you a veteran of the U.S. Armed Forces, or National Guard? Yes☐ No☐

If yes, is your military experience related to your current practice? Yes☐ No☐

Have you interviewed previously with the Board of Health Professional Boards Committee? Yes☐ No☐ If so, when_____

I swear and affirm that all information I have provided on this application is true and complete to the best of my knowledge.

_____ _____

Signature Date

**Return completed Application to: Monica Gissler, State Board of Health**
**DHHS, Division of Public Health, LU/RPQI, P.O. Box 95026, Lincoln, NE 68509-5026**
**402/471-6515; FAX 402/471-0383; Monica.gissler@nebraska.gov**