

Please Reply To: Licensure Unit
P.O. Box 94986, Lincoln, NE 68509-4986
Phone (402) 471-2118
FAX (402) 742-8355

Dear Applicant:

Our office is in receipt of your request to reinstate your license to practice acupuncture. Our records indicate that your license expired.

In order to reinstate your license, you must submit the following documentation:

1. A complete application for reinstatement (form enclosed).
2. Documentation that you have fulfilled the continuing education requirement.
3. The renewal and reinstatement fees.

The breakdown of the specific renewal fees now due are as follows:

License Renewal Fee	\$ 121.00
<u>Reinstatement Fee</u>	<u>\$ 35.00</u>
Total fee due	\$ 156.00

Please be advised that should you reinstate your license at this time, the expiration date will be May 1, 2021. At least 30 days prior to that date you will be sent notification of the need to submit a completed renewal application, the renewal fee payment and evidence of the required continuing competency, on or before the expiration date.

If you have any questions regarding the procedure for reinstatement, please contact me at (402) 471-2118.

Sincerely,

Jan Gadeken-Harris
Health Licensing Coordinator

Attachments

ACUPUNCTURE LICENSE REINSTATEMENT APPLICATION

I hereby apply for reinstatement of my license to practice as an Acupuncturist, **License #** _____ in the State of Nebraska and submit the required fee of \$ _____.

Name: _____

Address: _____

SECTION A PERSONAL INFORMATION (All applicants must complete this section) (*This information is not displayed on the internet*)

1	Phone #: (optional)		Fax #: (optional)		E-Mail Address: (optional)	
2	Check the Appropriate Box(s):	<input type="checkbox"/> Social Security Number (SSN); <input type="checkbox"/> Alien Registration Number ("A#"); or <input type="checkbox"/> Form I-94 (Arrival-Departure Record) number:			SSN#	
					A#	
					I-94 #	
<p>NOTE: 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.</p>						

SECTION B CONVICTION AND LICENSURE INFORMATION (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.

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:

#	Question	Yes	No	Type of Crime or Licensure Action	Date of Action	Name of Court/Entity Taking action
1	Have you been convicted of a misdemeanor or felony since your license was active?	<input type="checkbox"/>	<input type="checkbox"/>			

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

- a) The court record, which includes charges and disposition;
- b) Arrest records;
- c) 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;
- d) All addiction/mental health evaluations and proof of any treatment obtained; and
- e) A letter from the probation officer addressing probationary conditions and current status if the applicant is currently on probation;

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.

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

If you have had any disciplinary actions taken against your credential, you must submit a copy of the disciplinary action(s), including charges and disposition.

SECTION C CONTINUING COMPETENCY:

CONTINUING COMPETENCY REQUIREMENTS

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
- 50 hours of continuing education approved by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM); OR
- Active certification or active recertification of diplomate status with the NCCAOM earned within the 24 months immediately preceding the date of expiration.

All applicants for reinstatement must answer the following question by placing a (✓) in the appropriate box (yes or no):	Yes	No
	<input type="checkbox"/>	<input type="checkbox"/>

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:

<input type="checkbox"/>	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.
<input type="checkbox"/>	Initial License: I was first licensed within the 24 months immediately preceding my date of application for active status.

SECTION D EXPERIENCE:

EXPERIENCE REQUIREMENTS

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 acupuncture in some other state, a territory, the District of Columbia, or Canada for a period of one year. List this information in the section below.
- I have demonstrated other proof of professional competency as approved by the Board. Submit proof of completion as well as information about the content for Board approval.
- I have passed the approved acupuncture examination. Have your scores sent directly to this office.

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

SECTION E QUESTIONS:**QUESTIONS**

All applicants for reinstatement must answer the following questions by placing a (✓) in the appropriate box (yes or no). The questions pertain to the time period since the license was last active, unless otherwise specified. For any yes answers, explain the circumstances and outcome. The applicant will be notified of any additional documentation which is required by the Board/Department:

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?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you voluntarily surrendered or voluntarily limited in any way a license or permit issued to you by a licensing or disciplinary authority?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you been requested to appear before any licensing agency?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you been notified of any charges, complaints or other actions filed against you by any licensing or disciplinary authority?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you been asked to and/or permitted to withdraw an application for licensure or permit with any Board or jurisdiction?	<input type="checkbox"/>	<input type="checkbox"/>
7. Has any state or jurisdiction refused to issue, refused to renew or denied you a license or permit to practice?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
4. Within the past 5 years, has any licensing agency or credentialing organization initiated any inquiry into your physical, mental or emotional health?	<input type="checkbox"/>	<input type="checkbox"/>
SECTION III	Yes	No
1. Have you been convicted of a felony?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you been convicted of a misdemeanor?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you been notified of any charges, complaints or other actions filed against you by any criminal prosecution authority?	<input type="checkbox"/>	<input type="checkbox"/>
SECTION V	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"/>

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	Have you practiced Acupuncture in Nebraska since you last held an active credential?	<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: _____
		Name of Business: _____
		City: _____

SECTION F ATTESTATION

Attestation: For the purpose of complying with 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; **OR**
- I am a nonimmigrant lawfully present in the United States; **OR**
- 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.

NOTE: You may still be eligible for a certificate if you provide a photocopy of your unexpired Employment Authorization Document (EAD) and evidence of meeting section 202(c)(2)(B)(i) through (ix) of the Federal REAL ID Act of 2005.

If you are **NOT a citizen of the United States**, you must submit proof of lawful presence in the U.S. Your certificate will NOT be renewed until such proof is received by our office and verified through the Department of Homeland Security (may take 4-6 weeks).

Signature and Application Attestation: I attest that:

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

Print Name: _____

Signature: _____

Date: _____