

APPLICATION FOR REINSTATEMENT OF A LICENSE TO PRACTICE (Revoked, Expired, Placed on Inactive Status, or Lapsed)

I hereby apply for reinstatement of my license to practice as a Public Health Authorization, License # _____ in the State of Nebraska and the required reinstatement fee of **\$35.00**.

Name:
 Address:

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| DOB: Place of Birth: |
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SECTION A PERSONAL INFORMATION (All applicants must complete this section) (*This information is not displayed on the internet*)

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|--|-------------------------------|--|----------------------------------|
| 1 | Phone #: | Fax #: (optional) | E-Mail Address: |
| 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# <hr/> A# <hr/> I-94 # |
| If you have both a SSN and an A# or I-94 number, you must report both. Social Security Numbers obtained are not public information but may be shared by the Department for administrative purposes if necessary and only under appropriate circumstances to ensure against any unauthorized access to this information. | | | |
| 3 | Check the Appropriate Box: | <input type="checkbox"/> I am a citizen of the United States <input type="checkbox"/> I am an alien lawfully admitted into the United States for permanent residence under the Immigration and Naturalization Act (INA and who is eligible for a credential under the Uniform Credentialing Act) <input type="checkbox"/> I am a non immigrant whose visa for entry, or application for visa for entry, is related to such employment in the United States | |

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.

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 <http://dhhs.ne.gov/Pages/investigations.aspx> or 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:

| # | 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"/> | | | |
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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. You must request a certificate of licensure from each state be sent to the department no matter the status of your license in the states in which you have held or hold a license.

| | | Yes | No | | | |
|---|--|--------------------------|--------------------------|--|-----------------------------------|------------------------------|
| 2 | Are you licensed in any state? | <input type="checkbox"/> | <input type="checkbox"/> | If yes, what State(s) are you licensed in? | What type of license do you hold? | |
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| | 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 |
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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. **If you are applying for reinstatement after discipline you will need to provide a statement of the reason the applicant believes his/her credential should be reinstated.**

SECTION C PROOF OF PROFESSIONAL LIABILITY INSURANCE COVERAGE:

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| <p>You must provide proof of current professional liability insurance coverage. If you are using the liability insurance coverage offered through your employer as proof, you must also provide a letter from the insurance company that indicates the insurance policy covers services you provide under the Public Health Authorization, as described in Neb. Rev. Stat. §38-1130(3), without the supervision of a licensed dentist.</p> | | |
| <p>All applicants for reinstatement must answer the following question by placing a (✓) in the appropriate box (yes or no):</p> <p>Have you provided proof of professional liability insurance coverage?</p> | Yes | No |
| | <input type="checkbox"/> | <input type="checkbox"/> |

SECTION E QUESTIONS:

| QUESTIONS | | |
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| <p>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:</p> | | |
| SECTION I | Yes | No |
| 1. Has any credential you hold in the other jurisdiction(s) been denied, refused renewal, or disciplined by another jurisdiction(s) since the license was last active that has not been previously reported? (If NOT credentialed in another jurisdiction answer "NO".) If "YES", please provide a list of any disciplinary actions taken against your credential and a copy of the disciplinary action(s), including charges and dispositions. | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever 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 ever been requested to appear before any licensing agency? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever been notified of any charges, complaints or other actions filed against you by any licensing or disciplinary authority? | <input type="checkbox"/> | <input type="checkbox"/> |

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| 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 ever 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. Have you abused or become dependent on or actively addicted to alcohol, any controlled substance, or any mind-altering substance? | <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 ever 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"/> |
| 5. Do you have the mental and physical capacity to practice your profession? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you practiced your profession while your ability to do so was impaired by alcohol, controlled substance, drugs, mind-altering substance, physical disability, mental disability, or emotional disability? | | |
| SECTION III | Yes | No |
| 1. Have you ever been convicted of a felony? Failure to disclose any such convictions regardless of when the conviction occurred could result in disciplinary action, including but not limited to a minimum of \$500 civil fine. | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been convicted of a misdemeanor? Failure to disclose any such convictions regardless of when the conviction occurred could result in disciplinary action, including but not limited to a minimum of \$500 civil fine. | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever been notified of any charges, complaints or other actions filed against you by any criminal prosecution authority? | <input type="checkbox"/> | <input type="checkbox"/> |
| SECTION IV | Yes | No |
| 1. Have you committed any immoral or dishonorable acts that would evidence unfitness to practice your profession? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you practiced your profession: <ul style="list-style-type: none"> • Fraudulently? • Beyond your authorized scope? • With gross incompetence or gross negligence? • In a pattern of incompetent or negligent conduct? | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| 3. Have you permitted, aided, or abetted the practice of any profession by a person not credentialed to do so? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you used untruthful, deceptive, or misleading advertising? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you been convicted of fraudulent or misleading advertising, or of violating the Uniform Deceptive Trade Practices Act? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you unlawfully distributed intoxication liquors, controlled substances, or drugs? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you violated: <ul style="list-style-type: none"> • The Uniform Credentialing Act? • Mandatory Reporting Regulations? • The Uniform Controlled Substances Act? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you invaded a field of practice for which you are not credentialed? | <input type="checkbox"/> | <input type="checkbox"/> |

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| 9. Have you committed any acts of unprofessional conduct relating to your profession? (Refer to the Practice Act and Regulations for Dentistry.) | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you been denied the right to take a Credentialing Examination? | <input type="checkbox"/> | <input type="checkbox"/> |
| SECTION F ATTESTATION | | |
| 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 your under you Public Health Authorization in Nebraska since I 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: _____ |
| <u>Lawful Presence in the United States Attestation:</u> | | |
| For the purpose of complying with Neb. Rev. Stat. §38-129, I attest as follows: Please check ONLY ONE of the boxes below: | | |
| <input type="checkbox"/> I am a citizen of the United States; or <input type="checkbox"/> I am an alien lawfully admitted into the United States who is eligible for a credential under the Uniform Credentialing Act; or <input type="checkbox"/> I am a non-immigrant lawfully present in the United States who is eligible for a credential under the Uniform Credentialing Act. | | |
| <u>Alien or Non-immigrant Status:</u> If you are a qualified alien lawfully admitted into the United States <u>OR</u> 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). | | |
| 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. | | |
| <u>Application Attestation:</u> 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: _____ |