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

Nebraska Application Information
Application for a License to Practice Medicine
☐ Medicine and Surgery
☐ Osteopathic Medicine and Surgery

LICENSE FEE WAIVER: Starting January 1, 2020, if you meet one of the following waiver options, your initial license and temporary license fee **is waived, (this does not waive** the fee for criminal background checks):

1. **Young Worker:** You are between the ages of 18 and 25 (under the age of 26).

2. **Low-Income Individual:** You are enrolled in a state or federal public assistance program **such as** the medical assistance program established pursuant to the Medical Assistance Act, the federal Supplemental Nutrition Assistance Program (SNAP), or the federal Temporary Assistance for Needy Families (TANF) program, **OR** your household adjusted gross income is below 130% of the federal income poverty guideline.
   - If you live in Nebraska and are enrolled in a state or federal public assistance program, no further documentation is required to be submitted.
   - If you live in a state other than Nebraska and are enrolled in a state or federal public assistance program, submit a copy of a document showing current enrollment.
   - If your household adjusted gross income is at 130% of the Federal Income Poverty Guideline or below, click this link to see the current income guidelines, https://dhhs.ne.gov/licensure/documents/LowIncomeFeeWaiverTable.pdf. To be eligible for this waiver, you must submit a copy of your most recent tax return.

3. **Military Family:** You are an active duty service member in the armed services of the United States, a military spouse, honorably discharged veteran of the armed services of the United States, spouse of such honorably discharged veteran, and un-remarried surviving spouses of deceased service members of the armed services of the United States. To be eligible for this waiver, you must submit a copy of your ID card, discharge paperwork, or similar document that shows you are a military family member as described above.

MILITARY: To view licensing services available to members of the military and their spouses, visit our website at https://dhhs.ne.gov/licensure/Pages/Professions-and-Occupations.aspx

APPLICATION PROCESS - To apply for a License:

STEP 1: Get copies of the following documents:

NON-ENGLISH DOCUMENTS. Any documents written in a language other than English must translated into the English language. You must submit a copy of the original document and the translated document. The translation must be an original document and contain the notarized or equivalent signature of the translator. An individual may not translate his/her own documents.

1) **US Citizenship/Lawful Presence** (must be at **least 19** years old):

U.S. Citizen, a PHOTOCOPY of one of the following:
- ☐ Birth Certificate (Hospital issued keepsake birth certificates cannot be accepted).
- ☐ U.S. Passport (unexpired or expired).
- ☐ Certificate of Naturalization.
- ☐ Other documents that show U.S. Citizenship.

A Driver's License is NOT acceptable.

NOT a U.S. Citizen, a PHOTOCOPY of one of the following:
- ☐ Green Card, otherwise known as a Permanent Resident Card (Form I-551), both front and back of the card;
- ☐ Form I-94 (Arrival-Departure Record) **AND** an unexpired foreign passport with a valid unexpired US visa; or
- ☐ Employment Authorization Card **AND**
  - ☐ 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; or
  - ☐ A pending application for adjustment of status to that of an alien lawfully admitted for permanent Residence in the United States or conditional permanent resident status in the United States.

NOTE: Documents (other than those for U.S. Citizenship) are verified by our office through the Department of Homeland Security. This process may take up to 30 days.

2) **Education and Transcript:** **US and Canadian Graduates** - You must have your medical school or electronic transcript service submit an official college or university transcript **directly to our office**. If sending by e-mail, send to dhhs.medicaloffice@nebraska.gov

Foreign Medical School Graduates: Must use the enclosed Verification of Foreign Medical College form to verify your medical school. Please have your medical school complete the form and send it directly to this office.

A completed profile from FCVS may be submitted. The profile will be reviewed to determine if its components meet the documentation requirements for licensure. It is not automatic acceptance of the documentation verified by FCVS.

Information Relating to Military Education, Training, or Service: If you have completed education, training, or service that you believe is substantially similar to the education or training required for this credential while you were a member of the armed forces of the United States, active or reserve, the National Guard of any state, the military reserves of any state, or the naval militia of any state, you may submit such evidence with your application for review.

3) **Examination:** Applications can be based on: United States Medical Licensing Examination (USMLE), National Boards of Medical Examiners (NBME), National Boards of Osteopathic Medical Examiners (NBOME), Federation Licensing Examination (FLEX), Licentiate of the Medical Council of Canada (LMCC), or a State Board Examination.

All parts of the examination must be passed within ten years of passing the first examination.
An applicant who fails to pass any part of the examination within four attempts must have completed one additional year of postgraduate medical education at an accredited school of medicine.

You must request that official documentation of passing scores obtained on all parts of each national examination you took be sent directly from the official repository of scores to this office (See below):

USMLE and FLEX contact FSMB at (817) 868-4041 website at www.fsmb.org
NBME (215) 590-9592 website at www.nbme.org
NBOME (773) 714-0622 website at www.nbome.org
LMCC (613) 521-6012

If you took a **State Board Examination** the Board of Medicine and Surgery will review the requirements under which you were licensed in the other state for comparability with Nebraska requirements. Please have the state in which you took the Board examination forward your scores to this office.

4) **Post-Graduate Medical Education:** **US and Canadian Graduates**: Must have completed one year of ACGME accredited postgraduate education, or postgraduate education as approved by the Nebraska Board. You must use the enclosed Certificate of Post- Graduate Medical Education Form. These forms must come directly from the Program to the Board. Do not submit them with the application. Forms completed, mailed or signed in advance of your completion of one year of post-graduate medical education will not be accepted for licensure.

Foreign Medical School Graduates: Must have completed two years of ACGME postgraduate education, or postgraduate education as approved by the Nebraska Board. You must use the enclosed Certificate of Post-Graduate Medical Education Form. These forms must come directly from the Program to the Board. Do not submit them with the application. Forms completed, mailed or signed in advance of your completion of two years of post-graduate medical education will not be accepted for licensure.

5) **Educational Equivalency:** Foreign graduates must possess a permanent Educational Commission on Foreign Medical Graduates (ECFMG) Certification that is Valid Indefinitely. You must request that an official ECFMG Certification Status Report be sent directly to this office from ECFMG (215) 386-5900 and the website is www.ECFMG.org.

6) **Professional Activities**: These must be listed for the last ten years or since graduated from medical college if less than ten years ago. Also, please list all periods of non-professional activity. **This information is to be completed on the application form.** **PLEASE DO NOT PROVIDE CURRICULUM VITAE.**

7) **Medical Malpractice Information:** If you answered YES to Section VI 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 suite 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:
   - Name, sex and age of patient;
   - Date of occurrence;
   - Initial event (procedure/diagnosis);
   - Subsequent event that precipitated the claims – include the time sequence in relation to the initial event;
   - Damages – a description of damages or alleged damages resulting from the initial and subsequent events;
   - Date of filing of malpractice claim in court (if applicable);
   - 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;
   - Date of final outcome of claim.

   If You Answered YES To Section VI 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.

8) **Other State License Information:** If you hold or have held a health related license in any state (**other than Nebraska)** our office may contact you and request that you contact that state and request a certification/verification of your license **(do not send a copy of your license)**.

9) **Criminal Background Check:** A criminal background check is required for all applicants for an individual license in medicine and surgery or osteopathic medicine and surgery. Standard processing time for background checks can take up to 8-10 weeks. **Background checks will NOT be expedited for any reason.**

10) **Conviction Information:** If you have **EVER** received a ticket from law enforcement or animal control, check the court system to see if the ticket is on your record as a misdemeanor or felony conviction. Speeding tickets are not misdemeanors or felonies. You are required to list ALL convictions (regardless of when they occurred) on the application; 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/felony convictions.

    If you have convictions, you must submit:
    (i) A copy of the court record related to all misdemeanor and felony convictions, that includes the statement of charges and final disposition, if the conviction(s) occurred in a state other than Nebraska;
    (ii) An explanation of the events leading to the conviction (what, when, where, why) and a summary of actions that the applicant has taken to address the behaviors or actions related to the conviction; and
    (iii) A letter from the applicant's probation officer addressing the terms and current status of the probation, if the applicant is currently on probation.

    If you had an alcohol and drug evaluation and/or completed treatment, to assist the Board and Department in review of any drug and/or alcohol conviction(s), we encourage you to request that the treatment provider submit all evaluations and discharge summaries directly to the Department.

The following provides SOME examples of convictions; this is NOT a complete list	
• MIP/ Tobacco Use by Minor	• Driving under Suspension / Revocation
• DUI / DWI / Open Container	• License Vehicle without Liability Insurance
• Controlled Substance	• False Information or Reporting
• Shoplifting / Theft / Burglary	• Reckless Driving / Leave the Scene of an Accident
• Unauthorized use of a Financial Transaction	• Operator not Carrying License
• Disturbing the Peace	• Unlawful Display of Plates/Renewal tabs
• Assault / Prostitution	• Park Rule Violation / Curfew Violation
• Disorderly Conduct / Disorderly House	• Dog at Large / Fail to Vaccinate Animal
• Fail to Appear in Court	• Littering / Fireworks / Bad Check

    NOTE: If you have **any criminal charges or license disciplinary actions pending that result in a conviction** or license discipline, you are required to report such action to the Investigative Unit **within 30 days of the conviction or disciplinary action.** Reporting forms can be obtained at the following website: **https://dhhs.ne.gov/Pages/Investigations.aspx** or by phone 402-471-0175.

11) **Active Federal DEA Certificate:** A photocopy of your DEA Registration Card needs to be submitted if controlled substances will be prescribed, administered or dispenses by the licensee. This is not required for licensure. https://www.deadiversion.usdoj.gov/

STEP 2: Complete all pages and questions on the Application

STEP 3: Submit your application to the Licensure Unit

☐ Completed Application ☐ Citizenship or Lawful Presence Document ☐ Education Documents ☐ Conviction Records (if you have convictions)	☐ License Certifications (if licensed in another state) **(if requested)** ☐ The License Fee (unless you qualified for a fee waiver). See the license application for a listing of fees for Medicine. **Pay by check/money order; debit or credit card is not accepted.**

Application Review: All applications are reviewed in date order received.

- If your application **is missing information**, you will be contacted **by e-mail**. The e-mail will list the information that is required to compete your application. You have 90 days to complete your application; if not completed within this 90 days, your application will be closed and all documents destroyed. A new application will then be required.
- If your application **is complete**, you will receive a wall credential in the mail.

Records Retention Schedule: When your license is issued, your application and documents will be kept by the Department for 5 years; then all documents will be destroyed. We encourage you to keep a copy of your application for your records.

Contact Information: Licensure Unit, Phone: 402-471-2118 / FAX: 402-742-8355 / E-Mail: dhhs.medicaloffice@nebraska.gov

INSTRUCTIONS FOR CRIMINAL BACKGROUND CHECKS

Criminal background checks are NOT expedited for any reason.

Fingerprints are required to be eligible for a Physician/Osteopathic Physician license in Nebraska. The Nebraska State Patrol will not process your request for a criminal background check until you have paid the required fee to the State Patrol and the Licensure Unit has received your Physician/Osteopathic application.

Please read and follow these instructions carefully to avoid delays in processing.

Even if you have recently obtained a criminal background check for another state or another license, you MUST obtain a new criminal background check for the license you are currently applying for in Nebraska.

Completing the Fingerprint Card:

1. **Fingerprint Cards:** Fingerprint cards are available at any State Patrol office or law enforcement agency in NEBRASKA. If you live in another state, contact your local law enforcement agency. You may also contact the Licensure Unit at 402/471-2118 and cards can be mailed to you.

2. **DO NOT FOLD THE FINGERPRINT CARDS.**

3. **Information to be completed on the Fingerprint Card:**

   a. Print your full name, address with zip code, *Social Security Number, date and place of birth, and other information as requested. **DO NOT sign the fingerprint cards until** the law enforcement officer has verified your signature with the form of identification that you provided. **DO NOT write in the field labeled ORI.**

   **Social Security Number: If you do not have a United States Social Security Number, you must provide in the "Miscellaneous No: MNU" section a Government issued identification number, a "consulate" number or a Passport Number. Please indicate the type of number provided.*

   b. In the box labeled "Reason Fingerprinted" PRINT 'Controlled Substance'.

Photo ID:

Take one form of photo ID with you when getting your fingerprints. Acceptable forms of ID include a driver's license, visa, passport or other document showing that you are legal in the U.S.

FEE: $45.25

There are 2 ways to pay for fingerprint processing:

1. **Credit Card/E-Check: Pay $45.25 by credit card at www.ne.gov/go/nsp.** Credit/debit card OR checking account and routing information will be required. A small transaction fee will be added to your payment. For some payments, selection of eCheck will give you a discount on your transaction fee.

   The website will ask you to select the type of payment you are making. Under 'transaction type' you need to choose "Controlled Substance". You will then need to enter the applicant's name, date of birth and the last 4 digits of social security number. If a company is paying for an applicant; the applicant's information needs to be entered on this page. The second page of the website will ask for information about the payer, which may or may not be the applicant.

2. **Check or Money Order:** Payment of **$45.25** must be mailed directly to: **Nebraska State Patrol, ATTN: CID, 4600 Innovation Drive, Lincoln NE 68521.**

The Nebraska State Patrol does not charge an additional fee for the service of taking your fingerprints. However, other law enforcement agencies in Nebraska or in other states may charge a fee.

Fingerprinting Process:

There are 2 ways to capture your fingerprints:

- Live Scan: Live Scan is available at all Nebraska State Patrol locations listed below and the fingerprints are captured electronically. The Nebraska State Patrol does not accept Live Scan prints from other states at this time. If you are out of state and have Live Scan prints, you will need to request that your fingerprints be printed out onto cards.

- Ink and Paper Finger Prints: Applicants outside of Nebraska or at an office other than the below listed State Patrol offices have traditional ink and paper fingerprinting.

Offices of the Nebraska State Patrol and the Days/Hours that Fingerprinting is Conducted	
Troop A 4411 S 108th ST **Omaha NE** 68137 Phone: 402-331-3333	Monday- Friday 8:00 a.m. to 4:00 p.m. (appointment required) **https://statepatrol.nebraska.gov/services/fingerprinting**
Troop B 1401 Eisenhower AVE **Norfolk NE** 68701 Phone: 402-370-3456	Monday – Friday, 8:00 a.m. to 4:00 p.m. (appointment required) **https://statepatrol.nebraska.gov/services/fingerprinting**
Troop C 3431 Old Potash Highway **Grand Island NE** 68801 Phone: 308-385-6000	Monday 8:30 a.m.-12:30 & 2:00-4:30 p.m. Tuesdays 9:00 a.m. to 4:00 p.m. Wednesdays 8:30 a.m. to 4:00 p.m. Thursdays 9:00 a.m. to 4:30 p.m. Fridays 8:30 a.m.-12:30 & 2:00 – 4:30 p.m. (appointment required) **https://statepatrol.nebraska.gov/services/fingerprinting**
Troop D 300 West South River Rd **North Platte NE** 69103 Phone: 308-535-6604	Monday - Thursday 8:00 a.m. to 4:00 p.m. (appointment required) **https://statepatrol.nebraska.gov/services/fingerprinting**
Troop E 4500 Avenue I **Scottsbluff NE** 69361 Phone: 308-632-1211	Monday – Thursday 8:00 a.m. to 4:00 p.m. (Mountain time) (appointment required) **https://statepatrol.nebraska.gov/services/fingerprinting**
Troop H Investigative Services Center 4600 Innovation Drive **Lincoln NE** 68521 Phone: 402-479-4971	Monday - Friday 8:00 a.m. to 4:00 p.m. (appointment required) **https://statepatrol.nebraska.gov/services/fingerprinting**

Where do you send the fingerprint cards?

You must send all fingerprint cards to the following address:

Criminal Identification Division (CID)
4600 Innovation Drive
Lincoln NE 68521

Criminal Background Check Notification: Pursuant to Neb. Rev. Stat. §38-131 (provided below), an applicant for an initial license to practice as a registered nurse or a licensed practical nurse or to practice a profession which is authorized to prescribe controlled substances shall be subject to a criminal background check. Applicants are able to receive any national criminal history record that may pertain to them directly from the FBI, pursuant to 28 CFR Sections 16.30-16.34, and may then freely disclose any such information to whomever they choose. Applicants must authorize the dissemination of any national criminal history record that may pertain to them to the Department of Health and Human Services (DHHS) when applying for licensure. Applicants are entitled to challenge the accuracy and completeness of any information contained in any such report and will be provided a copy of the criminal history background report, if any, received if they appear at the DHHS in person and present proper identification. Information on how to challenge an applicant's federal report can be found at FBI.gov. To challenge an applicant's Nebraska state record, contact the Nebraska State Patrol-Criminal Identification Division. Applicants may obtain a prompt determination as to the validity of their challenge before the DHHS makes a final decision about their application for licensure.

Neb. Rev. Stat. §38-131 - **Criminal background check; when required.** (1) An applicant for an initial license to practice as a registered nurse, a licensed practical nurse, a physical therapist, a physical therapy assistant, a psychologist, an advanced emergency medical technician, an emergency medical technician, or a paramedic or to practice a profession which is authorized to prescribe controlled substances shall be subject to a criminal background check. A criminal background check may also be required for initial licensure or reinstatement of a license governed by the Uniform Credentialing Act if a criminal background check is required by an interstate licensure compact. Except as provided in subsection (3) of this section, the applicant shall submit with the application a full set of fingerprints which shall be forwarded to the Nebraska State Patrol to be submitted to the Federal Bureau of Investigation for a national criminal history record information check. The applicant shall authorize release of the results of the national criminal history record information check to the department. The applicant shall pay the actual cost of the fingerprinting and criminal background check.). (2) This section shall not apply to a dentist who is an applicant for a dental locum tenens under section 38-1122, to a physician or osteopathic physician who is an applicant for a physician locum tenens under section 38-2036, or to a veterinarian who is an applicant for a veterinarian locum tenens under section 38-3335. (3) An applicant for a temporary educational permit as defined in section 38-2019 shall have ninety days from the issuance of the permit to comply with subsection (1) of this section and shall have his or her permit suspended after such ninety-day period if the criminal background check is not complete or revoked if the criminal background check reveals that the applicant was not qualified for the permit. **Source:** Laws 2005, LB 306, § 2; Laws 2005, LB 382, § 15; Laws 2006, LB 833, § 1; R.S.Supp.2006, § 71-104.01; Laws 2007, LB247, § 60; Laws 2007, LB463, § 31; Laws 2007, LB481, § 2; Laws 2011, LB687, § 1; Laws 2015, LB129, § 1; Laws 2018, LB731, § 1; Laws 2018, LB1034, § 5.

PRIVACY ACT STATEMENT

Authority: The FBI's acquisition, preservation, and exchange of fingerprints and associated information is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include Federal statutes, State statutes pursuant to Pub. L. 92-544, Presidential Executive Orders, and federal regulations. Providing your fingerprints and associated information is voluntary; however, failure to do so may affect completion or approval of your application.

Principal Purpose: Certain determinations, such as employment, licensing, and security clearances, may be predicated on fingerprint-based background checks. Your fingerprints and associated information/biometrics may be provided to the employing, investigating, or otherwise responsible agency, and/or the FBI for the purpose of comparing your fingerprints to other fingerprints in the FBI's Next Generation Identification (NGI) system or its successor systems (including civil, criminal, and latent fingerprint repositories) or other available records of the employing, investigating, or otherwise responsible agency. The FBI may retain your fingerprints and associated information/biometrics in NGI after the completion of this application and, while retained, your fingerprints may continue to be compared against other fingerprints submitted to or retained by NGI.

Routine Uses: During the processing of this application and for as long thereafter as your fingerprints and associated information/biometrics are retained in NGI, your information may be disclosed pursuant to your consent, and may be disclosed without your consent as permitted by the Privacy Act of 1974 and all applicable Routine Uses as may be published at any time in the Federal Register, including the Routine Uses for the NGI system and the FBI's Blanket Routine Uses. Routine uses include, but are not limited to, disclosures to: employing, governmental or authorized non-governmental agencies responsible for employment, contracting, licensing, security clearances, and other suitability determinations; local, state, tribal, or federal law enforcement agencies; criminal justice agencies; and agencies responsible for national security or public safety.

Applicant Notification and Record Challenge

Your fingerprints will be used to check the criminal history records of the FBI. You have the opportunity to complete or challenge the accuracy of the information contained in the FBI identification record. The procedure for obtaining a change, correction, or updating an FBI identification record are set forth in Title 28, CFR, 16.34. You can find additional information on the FBI website at https://www.fbi.gov/services/cjis/identity-history-summary-checks

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

License to Practice Medicine

☐ Medicine and Surgery
☐ Osteopathic Medicine and Surgery

Application

12/2024

Licensure Unit
P.O. Box 94986, Lincoln, Nebraska 68509-4986
Phone: 402-471-2118 / FAX: 402-742-8355 / E-Mail: dhhs.medicaloffice@nebraska.gov

FCVS Profile Submitted: Yes ☐ No ☐

Mail this application to the address listed above.

You must complete all sections of this application

LICENSE FEES:

A. Fee Waiver:

If you meet one of the following fee waivers, your initial license fee **is waived**. **Check only ONE waiver**:

☐ **Young Worker:** I am under 26 years old.

☐ **Low-income Individual:**

☐ I am enrolled in a state or federal public assistance program, including, but not limited to, the medical assistance program established pursuant to the Medical Assistance Act, the federal Supplemental Nutrition Assistance Program, or the federal Temporary Assistance for Needy Families program; OR

☐ My household adjusted gross income is below 130% of the federal income poverty guideline.

☐ **Military Family:** I am an active duty service member in the armed services of the United States, a military spouse, honorably discharged veteran of the armed services of the United States, spouse of such honorably discharged veteran, and un-remarried surviving spouses of deceased service members of the armed services of the United States. PLEASE NOTE: The initial license fee can be waived, BUT the Patient Safety fee listed below CANNOT be waived.

B. Fee Required if YOU DO NOT qualify for one of the above fee waivers:

Review the following chart to determine the fee required based on the month and year in which your license **will be issued:**

Medicine and Surgery/ Osteopathic Medicine and Surgery:

YEAR	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec
Even Number Year	$300	$300	$300	$75	$75	$75	$75	$75	$300	$300	$300	$300
Odd Numbered Year	$300	$300	$300	$300	$300	$300	$300	$300	$300	$300	$300	$300

Medicine and Surgery, Osteopathic Medicine and Surgery licenses expire 10/01 of even-numbered years

EFFECTIVE JANUARY 1, 2020 ADDITIONAL FEES FOR APPLICANTS FOR THE INITIAL ISSUANCE AS A PHYSICIAN OR AN OSTEOPATHIC 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.

Pay by check or money order to: Licensure Unit
Your cancelled check is your proof of payment. Payment is processed upon receipt. Debit or credit card is not accepted.

SECTION A: APPLICANT INFORMATION

1 You must print your **Legal Name** below

First: | Middle: | Last Name:

List any other names, you are or have ever been known as (AKA), including maiden name and your last name on your birth certificate

2 Address: Street/PO/Route:

City: | State or Country: | Zip:

3 Social Security Number (SSN):

4 If you are not a U.S. Citizen, list your A# or I-94#:

Alien Registration Number ("A#"):

I-94 #

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

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

6 Phone #: | Additional Phone #: (optional - Authorized Credentialing Partner)

E-Mail Address:

E-Mail Address: (optional – Authorized Credentialing Partner)

7 Have you ever been denied the right to take a license examination in any State?

Yes ☐ No ☐ If yes, explain:

8 ☐ Check here if you are the spouse of an active duty member of the U.S. Armed Forces stationed in Nebraska.

SECTION B – EXAMINATION

☐ I have requested that an official copy of my score reports for any and all of the national examinations that I have taken (check ALL that apply) be sent to your office:

Application by Examination:

☐ USMLE ☐ NBME ☐ FLEX ☐ NBOME ☐ LMCC

☐ Combination of USMLE/FLEX ☐ Combination of USMLE/NBME

Application Based on License in Another State or Territory of the United States:

☐ State Exam (list state) _____ ☐ I have requested a copy of my state examination from that Board

Foreign medical graduates must indicate their ECFMG number: _____

SECTION C – EDUCATION: List in chronological order, beginning with high school and ending with medical school, the name and location of all institutions attended. List the diplomas or certificates earned and dates received for all preliminary (high school), pre-medical education and medical education. (Attach additional pages if necessary).

PRELIMINARY AND PRE-MEDICAL EDUCATION	
NAME OF HIGH SCHOOL	
City/State/Country	
Diploma/Certificate	
Date: (MO/YR)	
NAME OF PRE-MEDICAL COLLEGE	
City/State/Country	
Diploma/Certificate	
Date: (MO/YR)	
NAME OF PRE-MEDICAL COLLEGE	
City/State/Country	
Diploma/Certificate	
Date: (MO/YR)	

MEDICAL EDUCATION		
NAME OF MEDICAL SCHOOL		
City/State/Country		
Attended	From (M/D/Y):	To (M/D/Y):
Degree Conferred		Date Conferred (M/D/Y):
NAME OF MEDICAL SCHOOL		
City/State/Country		
Attended	From (M/D/Y):	To (M/D/Y):
Degree Conferred		Date Conferred (M/D/Y):

SECTION D- POST-GRADUATE MEDICAL EDUCATION: Indicate whether service was Internship, Residency or Fellowship.

Name of Institution	
Name of Specialty	☐ Internship ☐ Residency ☐ Fellowship
City/State/Country	
Attended From:	(M/D/Y)
Attended To:	(M/D/Y)
Name of Institution	
Name of Specialty	☐ Internship ☐ Residency ☐ Fellowship
City/State/Country	
Attended From:	(M/D/Y)
Attended To:	(M/D/Y)
Name of Institution	
Name of Specialty	☐ Internship ☐ Residency ☐ Fellowship
City/State/Country	
Attended From:	(M/D/Y)
Attended To:	(M/D/Y)
Name of Institution	
Name of Specialty	☐ Internship ☐ Residency ☐ Fellowship
City/State/Country	
Attended From:	(M/D/Y)
Attended To:	(M/D/Y)

Information Relating to Military Education, Training, or Service:
If you have completed education, training, or service that you believe is substantially similar to the education or training required for this credential while you were a member of the armed forces of the United States, active or reserve, the National Guard of any state, the military reserves of any state, or the naval militia of any state, you may submit such evidence with your application for review.

SECTION E – COMPETENCY: Indicate that, within the three years immediately preceding the application for licensure, you have met **ONE** of the following:	
☐	**I have 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.**
☐	**I have had at least one year of approved graduate medical education.**
☐	**I have completed continuing medical education.** 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.** Submit proof of attendance at a refresher course, as well as information about the content for Board approval. *See below*
☐	**I have completed a special purposes examination.** Have your score sent directly to this office for Board approval. *See below*

*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, (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 document to the Statutes Relating to Medicine and Surgery where you can read the complete language regarding the reentry license. https://dhhs.ne.gov/licensure/Pages/Medicine-and-Surgery.aspx
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.**

SECTION F - PROFESSIONAL ACTIVITIES: List in chronological order all of your medical activities for the last ten years, or since graduation from medical college if less than ten years ago to present. Also list all periods of non-professional activity or employment for periods of non-medical activity of more than three months. Please account for all time and explain all gaps of more than three months. (Attach additional pages if necessary). This information must be completed below. **Do not attach CV or other work history forms. Do not put work/employment – be specific.**

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

SECTION G – CONTROLLED SUBSTANCES REGISTRATION: (Check one that applies)

1	☐	I have enclosed a photocopy of my current Federal Controlled Substances Registration.	
		Federal Controlled Substances Registration #:	Expiration Date:
2	☐	I am currently applying for a Federal Controlled Substances Registration, and will send a photocopy of such when I receive the registration.	
3	☐	I do not have nor am I applying for a Federal Controlled Substances Registration and I will not be prescribing, administering or dispensing controlled substances in Nebraska. I understand that at such time that I do intend to prescribe, administer or dispense controlled substances in Nebraska, I will first need to have a Federal Controlled Substances Registration issued to me. At that time, I am to supply a photocopy of the registration to the State of Nebraska.	

SECTION H: CONVICTION AND LICENSURE INFORMATION
Failure to list any conviction(s) or disciplinary action(s), regardless of when the action occurred, could result in disciplinary action. 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.

CONVICTION INFORMATION: **You must list ALL** misdemeanor or felony convictions (regardless of when they occurred).

1	Have you **EVER** been convicted of a misdemeanor or felony?	Name of Conviction	Date of Action	Name of Court Taking Action
	Yes ☐ No ☐			

The following provides SOME examples of convictions; this is NOT a complete list	
• MIP/ Tobacco Use by Minor • DUI / DWI • Controlled Substance • Open Container • Shoplifting / Theft / Burglary • Unauthorized use of a Financial Transaction • Disturbing the Peace • Assault / Prostitution • Disorderly Conduct / Disorderly House • Reckless Driving	• Driving under Suspension / Revocation • License Vehicle without Liability Insurance • Fail to Appear in Court • False Information or Reporting • Leave the Scene of an Accident • Operator not Carrying License • Unlawful Display of Plates/Renewal tabs • Park Rule Violation / Curfew Violation • Dog at Large / Fail to Vaccinate Animal • Littering / Fireworks / Bad Check

LICENSE INFORMATION: The following questions relate to a license that you currently hold or have held in a state **other** than Nebraska.

1	Do you hold or have you held a license in any other state(s)?	If yes, what state(s)?	What type of license?	
	Yes ☐ No ☐			
	If YES, has your license ever been denied, refused renewal, limited, suspended, revoked or had other disciplinary measures taken against it?	Type of Action	Date of Action	Name of State Taking Action
	Yes ☐ No ☐			

SECTION H CONTINUED: CONVICTION AND LICENSURE INFORMATION

Failure to list any conviction(s) or disciplinary action(s), regardless of when the action occurred, could result in disciplinary action. 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

1	Have you ever had any disciplinary or adverse action imposed against a professional license or permit in any state or jurisdiction?	☐ YES	☐ NO
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?	☐ YES	☐ NO
3	Have you ever been requested to appear before any licensing agency?	☐ YES	☐ NO
4	Have you ever been notified of any charges, complaints or other actions filed against you by any licensing or disciplinary authority?	☐ YES	☐ NO
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?	☐ YES	☐ NO
6	Have you ever been asked to and/or permitted to withdraw an application for licensure or permit with any Board or jurisdiction?	☐ YES	☐ NO
7	Has any state or jurisdiction refused to issue, refused to renew or denied you a license or permit to practice?	☐ YES	☐ NO

SECTION II

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?	☐ YES	☐ NO

SECTION III

1	Have you ever 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?	☐ YES	☐ NO
2	Have you ever had hospital or institutional privileges denied, reduced, restricted, suspended, revoked, terminated or placed on probation?	☐ YES	☐ NO
3	Have you ever voluntarily resigned or suspended your hospital or institutional privileges while under investigation from a hospital, clinic, institution, or other medically related employment?	☐ YES	☐ NO
4	Have you ever been notified that any action against your hospital or institutional privileges is pending or proposed?	☐ YES	☐ NO
5	Have you ever been allowed to withdraw your staff privileges from a hospital or institution?	☐ YES	☐ NO
6	Have you ever been subject to staff disciplinary action or non-renewal of an employment contract?	☐ YES	☐ NO

SECTION IV

1	Have you ever been denied a Federal Drug Enforcement Administration (DEA) Registration or state controlled substances registration?	☐ YES	☐ NO
2	Have you ever been called before any licensing agency or lawful authority concerned with DEA controlled substances?	☐ YES	☐ NO
3	Have you ever surrendered your state or federal controlled substances registration?	☐ YES	☐ NO
4	Have you ever had your state or federal controlled substances registration restricted or disciplined in any way?	☐ YES	☐ NO

SECTION V

1	Have you ever 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?	☐ YES	☐ NO
2	Are you aware of any professional liability claims currently pending against you?	☐ YES	☐ NO

SECTION I: PRACTICE PRIOR TO LICENSE

If you practice prior to being issued a Nebraska license, you are subject to assessment of an Administrative Penalty of $10 per day up to $1,000, and you may be subject to other disciplinary action as provided in the statutes and regulations.

1	Have you practiced Medicine and Surgery in Nebraska without a Nebraska license?	Yes ☐ No ☐

If yes, what are the actual number of days you practiced in Nebraska without a Nebraska license and what is the business name, location and telephone number of the practice:	Number of days:
	Name of Business:
	City:
	Telephone #:

SECTION J: ATTESTATION

For the purpose of meeting 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.

☐ I am **NOT** a citizen of the United States. I am a qualified alien under the Federal Immigration and Nationality Act or a non-immigrant lawfully present in the United States, with documentation such as a permanent resident card, I-94 document, asylum, etc.

☐ I am **NOT** a citizen of the United States. I have an unexpired Employment Authorization Document (EAD) and documentation listed under the Federal REAL ID act, such as DACA, pending asylum, pending refugee, etc.

☐ I am **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. I am of good character and all statements on this application are true and complete.

Print Name: _____

Signature: _____ Date: _____

MILITARY: To view licensing services available to members of the military and their spouses, visit our website at https://dhhs.ne.gov/licensure/Pages/Professions-and-Occupations.aspx

State of Nebraska, Department of Health and Human Services
Division of Public Health, Licensure Unit
301 Centennial Mall South
PO Box 94986, Lincoln NE 68509-4986

CERTIFICATE OF POST-GRADUATE MEDICAL EDUCATION

Applicants must have the **current Program Director** of the institution where they completed their post-graduate medical education complete the following form and **affix the Official School Seal**. An **original** signature from the Program Director is required. **Forms need to be sent to the Licensure Unit directly from the program. Do not submit with your application. These forms cannot be completed, mailed or signed in advance of your completion of one/two years of post-graduate medical education.**

Print Name _____SS# _____

NOTE: The information below must be completed ONLY by an official of the program/facility and not the applicant.

It is hereby certified that: _____
(Name of Applicant)

Has successfully completed _____
(Name of Residency/Internship/Fellowship)

located at : _____**in**_____
(Name of Hospital/Teaching Institution) (City, State, Country)

From _____ **to** _____
(Month/Day/Year) (Month/Day/Year)

At the time this applicant was enrolled in this Program, this Program was:

_____ **ACGME* or AOA* accredited** *ACGME - Accreditation Council for Graduate Medical Education
*AOA – American Osteopathic Association
_____ **RCPSC* or CFPC* accredited** *RCPSC – Royal College of Physicians and Surgeons of Canada
*CFPC – College of Family Physicians of Canada
_____ **was not accredited by any of the above listed entities**

Any Disciplinary Action? Yes _____ No _____ If yes, provide details of the disciplinary action.

Any Probation Information? Yes _____ No_____ If yes, provide details of the probationary information.

_____
Signature of CURRENT PROGRAM DIRECTOR
(Signature stamp **NOT** acceptable)

Print Name_____

Title _____

Date (month/day/year) _____

Phone # _____

E-mail _____

INSTITUTIONAL SEAL

(If your institution does not have an official seal, this form must be notarized)

State of Nebraska, Department of Health and Human Services
Division of Public Health, Licensure Unit
301 Centennial Mall South,
PO Box 94986, Lincoln NE 68509-4986 (402) 471-2118

VERIFICATION OF FOREIGN MEDICAL COLLEGE

_____
Name of University

_____
Street

_____
City State Zip

I, _____, MD/DO have applied for a license to practice in the State of Nebraska.
(Print full name)

As part of the application process, the State of Nebraska requires a verification of my Foreign Medical College.

I hereby authorize _____, its staff or representative to provide the State of Nebraska
(Name of College)

any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above named society and/or person for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice. Further, I request that this completed form be sent directly to the State of Nebraska. I understand that completed forms returned to me will not be accepted for verification purposes.

Sincerely, _____ Date of Birth _____/_____/_____
(Signature of Applicant) MO DAY YEAR

Social Security Number _____ Date of Graduation _____/_____/_____
MO DAY YEAR

For verification of FOREIGN MEDICAL COLLEGE ONLY. Please provide exact dates. The following section must be completed by the dean or registrar of the foreign medical school and returned directly to the State of Nebraska. Verifications returned directly to the applicant will not be accepted. Do not complete if photograph is not attached. Any substitutions must contain all required information or it will not be accepted for verification purposes.

This certifies that _____
(Full name of applicant)

Enrolled in _____ on _____/_____/_____ graduated _____/_____/_____
(Name of Foreign Medical College) MO DAY YEAR MO DAY YEAR

and received the **DEGREE** of _____

Any disciplinary/probation action on file? Yes (please explain)_____ **No** _____

Further, the records of this institution indicate that the attached photograph
(check one) _____ **Represents a true likeness of the above named applicant**
_____**Does not represent a true likeness of the above-named applicant**.

By _____ SEAL Attach
Original Signature of the dean or registrar Passport size
(stamped or electronic signatures will NOT be accepted) Photograph Here

_____
Print or Type Official's Name and Title

_____
e-mail address if possible

Signed and the college Seal affixed on _____/_____/_____ Medical College seal MUST be imprinted partially on photograph
MO Day Year