

Your renewal application and fee (if applicable) must be postmarked on or before 10-31-2019 to avoid expiration of your license. Mail to address above. If you practice after the expiration date, an administrative penalty of \$10 per day up to \$1,000 will be assessed for each day of practice. Online renewal is available at [dhhs.ne.gov/renew](http://dhhs.ne.gov/renew).

**A. Check Requested Status**

- Active**      **\$123**      **Make check or money order payable to DHHS-Licensure Unit**
- Active-Military**      **No Fee**      If you plan to use your NE LPN license to meet military licensing requirements, check with your superiors to determine if you can use Active-Military status. To be eligible for Active-Military status, you must have served for 30 consecutive days on full-time active duty or approved leave since 11/01/17. Military service is defined as full-time duty in the active military of the United States, a National Guard call to active service for more than 30 consecutive days, or active service as a commissioned officer of the Public Health Service or the National Oceanic and Atmospheric Administration. You may be required to submit a copy of your military orders to the DHHS Licensure Unit. There is no fee or continuing education requirement for Active-Military status.
- Inactive**      **No Fee**      If you choose Inactive status, you cannot practice nursing in Nebraska but you may represent yourself as having an inactive license. To change from Inactive to Active status, you must complete a reinstatement application and meet the reinstatement requirements that are in effect at the time the status change is requested

**B. Personal Information**

<b>LPN License #</b>			
<b>Legal Name</b>	First	Middle	Last
<b>Address</b> <input type="checkbox"/> Check if this is a new address	Street Address/PO Box		
	City	State	Zip
<b>Social Security Number:</b>			
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 as well as to the Nebraska Department of Revenue, Department of Labor and for other administrative purposes.			
If you are not a U.S. Citizen provide your:	<b>Alien #</b>	<b>I-94 #</b>	
<b>NAME CHANGES:</b> If your name has changed, submit a photocopy of marriage certificate, court order, etc., to provide proof of legal name. If not submitted, the license will be renewed in the name currently listed on your license.			

**C. Primary State of Residence.** Nebraska is a member of the Nurse Licensure Compact. You must declare your primary state of residence during each renewal. Your primary state of residence is the state where you have legal residency status. Proof of legal residency can include a driver's license, voter registration card, federal income tax return, Military Form 2058, or W2 form.

**My current primary state of residence is:** \_\_\_\_\_ (name of state).

If you have moved from Nebraska to another state that belongs to the Compact, you must apply for a license in your new home state. Federal employees may be exempt from this requirement.

- I am employed exclusively in the US Military or with the US Federal Government and am requesting a single-state license regardless of my primary state of residence.

**D. Convictions and Discipline**

1	<b>Were you convicted of a misdemeanor or felony in any state/jurisdiction since 11/01/2017?</b> If you answer <b>YES</b> to this question, you must submit the following documents to the Licensure Unit: <ul style="list-style-type: none"> <li>A list of any misdemeanor or felony convictions;</li> <li>A copy of the court record, which includes charges and disposition;</li> <li>Explanation of the events leading to the conviction (what, when, where, why) and a summary of actions you have taken to address the behaviors/actions related to the convictions;</li> <li>All addiction/mental health evaluations and proof of treatment, if the conviction involved a drug and/or alcohol related offense and if treatment was obtained and/or required; and</li> <li>A letter from the probation officer addressing probationary conditions and current status, if you are currently on probation.</li> </ul>	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>
2a	<b>Have you held a credential that was issued by another state/jurisdiction to provide health-related services or environmental services?</b> (If you answer "no" to 2a, answer "no" to 2b)	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>
2b	<b>Has this license been denied, refused renewal, or disciplined since 11/01/2017?</b> If "YES", provide a list of disciplinary actions taken against your license and a copy of the disciplinary action(s).	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>

**E. Continuing Competency – Do NOT submit continuing education certificates to this office unless they are requested.**

To renew with **active** status you **MUST** meet one of the continuing competency categories or waivers listed below. (This section is not required if you are requesting inactive status.) **Check one of the following:**

<input type="checkbox"/>	I was first licensed as an LPN in Nebraska <b>after 10/31/2017</b> . NOTE: Continuing education is not required.
<input type="checkbox"/>	I have graduated from a nursing program after <b>10/31/2014</b> AND have completed 20 hours of continuing education in the past 2 years ( <b>11/01/2017 to 10/31/2019</b> ). Of the 20 hours, no more than 4 hours are from CPR and BLS, and at least 10 hours are peer reviewed.
<input type="checkbox"/>	I have practiced nursing for at least 500 hours in the last five years ( <b>11/01/2014 to 10/31/2019</b> ) AND completed 20 hours of continuing education in the last two years ( <b>11/01/2017 to 10/31/2019</b> ). Of the 20 hours, no more than 4 hours are from CPR and BLS, and at least 10 hours are peer reviewed.
<input type="checkbox"/>	I have completed a board-approved refresher course within the last 5 years ( <b>11/01/2014 to 10/31/2019</b> ).
<input type="checkbox"/>	I have obtained/maintained current certification in a nursing specialty granted by a nationally recognized certifying organization.
<input type="checkbox"/>	I have developed and maintained a portfolio that includes my goals as a nursing licensee for current continuing competency goals and evidence/verification of professional activities to meet those goals.
<input type="checkbox"/>	<b>Waiver:</b> I have practiced nursing for at least 500 hours during the past 5 years ( <b>11/01/2014 to 10/31/2019</b> ). I request a waiver of the continuing education requirement due to: <input type="checkbox"/> military assignment in a location where continuing education is not available, <input type="checkbox"/> living outside of the USA and continuing education is not available, or <input type="checkbox"/> serving as a missionary in a foreign country.
<input type="checkbox"/>	<b>Military Waiver:</b> After <b>10/31/2017</b> I have served full-time duty in the active military service of the United States, a National Guard call to active service for more than 30 consecutive days, or active service as a commissioned officer of the Public Health Service or the National Oceanic and Atmospheric Administration. Military service may also include any period during which a service member is absent from duty on account of sickness, wounds, leave, or other lawful cause. You may be required to submit a copy of your military orders.

**F. Attestation**

For the purpose of complying with Neb. Rev. Stat. §§4-108 through 4-114 and 38-129, I attest that: (Check only **ONE** box below)

I am a citizen of the United States.

**OR**

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 U.S., 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, etc.

I further attest that:

- I have read the renewal application or have had the renewal application read to me; and
- All statements on this renewal application are true and complete.

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Phone/Fax (Optional): \_\_\_\_\_ E-mail (Optional): \_\_\_\_\_

**If you are not a U.S. citizen:** Submit evidence of lawful presence with this application. Examples of acceptable documents include a copy of your permanent resident card (front and back), Form I-94, OR an unexpired Employment Authorization Document (EAD) and one other document from a government agency verifying your status.

**NOTE:** If you have any criminal charges or license disciplinary actions pending that result in a misdemeanor or felony conviction or license discipline, you must report these to the Investigative Unit within 30 days of the conviction/action (Neb. Rev. Stat. 38-1,125). Failure to disclose any such convictions/license discipline could result in disciplinary action. Report to: <http://dhhs.ne.gov/Pages/Investigations.aspx>

**Disaster Response Volunteers Needed:** In an emergency event, your skills and abilities could be in great demand. The State of Nebraska Medical and Health Volunteer registry allows you to register as a healthcare volunteer before disaster strikes. This secure system allows disaster response officials to quickly identify those healthcare professionals necessary to meet the needs of a disaster or emergency situation. Your professional skills can then best be put to use in a coordinated and efficient manner, while granting you additional legal protection under the Nebraska Emergency Management Act (see Neb. Rev. Statute 81-829.36).

Registration only takes a moment and does not obligate you to respond to any future disasters; instead, registration allows you to be contacted for your availability during a local, state, or national emergency. Saving lives in an effective response to an emergency or disaster often depends on quickly identifying and contacting volunteer healthcare professionals such as yourself who have the specific skills necessary to care for people who are injured or ill. Please take a moment to register at: <https://volunteers.ne.gov/ESAR-VHP/faces/jsp/login.jsp>

# Practical Nursing Workforce Survey 2019

<b>1. What is your license #?</b>	_____
<b>2. What is your race?</b>  <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Black/African American <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Other _____	<b>2a. Hispanic origin or descent?</b>  <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>2b. If you speak another language other than English, please indicate.</b>  <input type="checkbox"/> Spanish <input type="checkbox"/> Vietnamese <input type="checkbox"/> Chinese <input type="checkbox"/> Arabic <input type="checkbox"/> Native American Language <input type="checkbox"/> Other <input type="checkbox"/> None	<b>3. What is your primary state of residence?</b>  _____
<b>4. List all states in which you hold an active single-state license to practice as an LPN:</b>  _____	<b>5. List all states in which you are currently practicing:</b>  _____
<b>6. Where was the location of the basic nursing education program that prepared you to take the LPN licensing examination?</b>  <input type="checkbox"/> Nebraska <input type="checkbox"/> Iowa <input type="checkbox"/> Kansas <input type="checkbox"/> Missouri <input type="checkbox"/> South Dakota <input type="checkbox"/> Wyoming <input type="checkbox"/> Colorado <input type="checkbox"/> Other State or US territory <input type="checkbox"/> Foreign country	<b>7. Which nursing education programs have you completed? (Mark all that apply)</b>  <input type="checkbox"/> Practical Nursing Program Diploma <input type="checkbox"/> Vocational/Practical Nursing Certificate
<b>8. Are you currently enrolled in a nursing education program leading to a degree/certificate?</b>  <input type="checkbox"/> Not currently enrolled <input type="checkbox"/> Baccalaureate Degree Program <input type="checkbox"/> Associate Degree Program <input type="checkbox"/> Master's Degree Program <input type="checkbox"/> Diploma Program <input type="checkbox"/> Other	<b>9. If you have a non-nursing degree(s), did you earn this degree <u>before</u> entering your basic nursing education program that prepared you for LPN licensure?</b>  <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>10. Which of the following best describes your current primary work situation? (Select one).</b>  <input type="checkbox"/> <b>Actively employed in nursing:</b> <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Per diem  <input type="checkbox"/> <b>Working in nursing only as a volunteer</b>	<b>11. If unemployed, please indicate the reasons:</b>  <input type="checkbox"/> Disciplinary conditions <input type="checkbox"/> Family <input type="checkbox"/> Inadequate salary <input type="checkbox"/> Difficulty in finding a nursing position <input type="checkbox"/> Other <input type="checkbox"/> Disabled <input type="checkbox"/> Enrolled in education program <input type="checkbox"/> Type of position for which I have experience/education is not available
<input type="checkbox"/> <b>Actively employed in a field other than nursing:</b> <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Per diem  <input type="checkbox"/> <b>Unemployed:</b> <input type="checkbox"/> Seeking work as a nurse <input type="checkbox"/> Not seeking work as a nurse  <input type="checkbox"/> <b>Retired</b>	

<p><b>12a. Do you volunteer as a nurse?</b></p> <p><input type="checkbox"/> Yes    <input type="checkbox"/> No</p>	<p><b>12b. If you volunteer, on average how many hours do you volunteer per month?</b></p> <p>_____</p>										
<p>Please answer questions 13 - 28 only if you are actively employed in nursing.</p>											
<p><b>13. In how many positions are you currently employed as a nurse?</b></p> <p><input type="checkbox"/> 1    <input type="checkbox"/> 2    <input type="checkbox"/> 3 or more</p>	<p><b>14. What is the average number of hours worked during a typical week in nursing positions?</b></p> <table border="1" style="margin-left: auto; margin-right: auto; border-collapse: collapse;"> <tr> <th colspan="2" style="padding: 2px;">HOURS</th> </tr> <tr> <td style="width: 30px; height: 20px;"></td> <td style="width: 30px; height: 20px;"></td> </tr> </table>	HOURS									
HOURS											
<p><b>15. Please indicate the zip code, county and state of your PRIMARY EMPLOYER:</b></p> <table border="1" style="margin-left: auto; margin-right: auto; border-collapse: collapse;"> <tr> <th colspan="5" style="padding: 2px;">ZIP CODE</th> </tr> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table> <p style="margin-left: 100px;">_____ County      _____ State</p>	ZIP CODE										<p><b>16. How many miles do you travel one way to get to work at your principal nursing employment?</b></p> <p><input type="checkbox"/> 0 – 5 miles                      <input type="checkbox"/> 21 – 30 miles</p> <p><input type="checkbox"/> 6 – 10 miles                      <input type="checkbox"/> 31 – 50 miles</p> <p><input type="checkbox"/> 11 – 20 miles                      <input type="checkbox"/> &gt; 50 miles</p>
ZIP CODE											
<p><b>17. Do you utilize tele-health in your primary or secondary positions?</b></p> <p><input type="checkbox"/> Yes    <input type="checkbox"/> No</p>	<p><b>18. If yes, when utilizing tele-health, are patients ever located in a different state?</b></p> <p><input type="checkbox"/> Yes    <input type="checkbox"/> No</p>										
<p><b>19a. If you are a SALARIED employee or practice owner in your PRIMARY nursing employment, what is your current annual salary?</b></p> <p><input type="checkbox"/> Less than \$5,000                      <input type="checkbox"/> At least \$45,000 but less than \$55,000</p> <p><input type="checkbox"/> 5,000 - \$25,000                      <input type="checkbox"/> At least \$55,000 but less than \$65,000</p> <p><input type="checkbox"/> More than \$25,000 but less than \$35,000                      <input type="checkbox"/> At least \$65,000, but less than \$85,000</p> <p><input type="checkbox"/> At least \$35,000 but less than \$45,000                      <input type="checkbox"/> At least \$85,000, but less than \$105,000</p> <p style="margin-left: 100px;"><input type="checkbox"/> \$105,000 and more</p>	<p><b>20. Which setting BEST describes your PRIMARY work/practice site?</b></p> <p><input type="checkbox"/> Ambulatory Surgical                      <input type="checkbox"/> Military /DoD</p> <p><input type="checkbox"/> Assisted Living                      <input type="checkbox"/> Nursing Home (SNF/NF)</p> <p><input type="checkbox"/> Birthing Center                      <input type="checkbox"/> Occupational/Employee/ Workplace Health</p> <p><input type="checkbox"/> Clinic                      <input type="checkbox"/> Policy/Planning/Regulatory/ Licensing Agency</p> <p><input type="checkbox"/> College Health                      <input type="checkbox"/> Psych-Mental Health</p> <p><input type="checkbox"/> Correctional/Prison Facility                      <input type="checkbox"/> Public Health</p> <p><input type="checkbox"/> Developmental Disabilities                      <input type="checkbox"/> Research</p> <p><input type="checkbox"/> Dialysis Center                      <input type="checkbox"/> Retail Clinic</p> <p><input type="checkbox"/> Emergency Dept.                      <input type="checkbox"/> Rural Health Clinic</p> <p><input type="checkbox"/> Federally Qualified Health Center (FQHC)                      <input type="checkbox"/> School Health Service</p> <p><input type="checkbox"/> Health Department                      <input type="checkbox"/> Substance Use/Addiction</p> <p><input type="checkbox"/> Home Health                      <input type="checkbox"/> University/Academic</p> <p><input type="checkbox"/> Hospice/Palliative Care                      <input type="checkbox"/> Urgent Care</p> <p><input type="checkbox"/> Hospital                      <input type="checkbox"/> VA Facility</p> <p><input type="checkbox"/> Insurance Claims/Benefits                      <input type="checkbox"/> Volunteer Clinic</p> <p><input type="checkbox"/> Industry/Sales/IT                      <input type="checkbox"/> Other _____</p>										
<p><b>19b. What is your average hourly wage for your primary nursing position?</b></p> <p>_____</p>											

<p><b>21. What do you like MOST about your primary nursing employment? (Select one)</b></p> <p><input type="checkbox"/> Autonomy</p> <p><input type="checkbox"/> Benefits (insurance, paid vacation, retirement, etc.)</p> <p><input type="checkbox"/> Location</p> <p><input type="checkbox"/> People with whom I work (co-workers)</p> <p><input type="checkbox"/> Work itself</p> <p><input type="checkbox"/> There is opportunity for advancement</p> <p><input type="checkbox"/> Hours/schedule</p> <p><input type="checkbox"/> People for whom I provide service (patients)</p> <p><input type="checkbox"/> Salary</p> <p><input type="checkbox"/> Other _____</p>	<p><b>22. What do you like LEAST about your primary nursing employment? (Select one)</b></p> <p><input type="checkbox"/> Lack of autonomy</p> <p><input type="checkbox"/> Benefits (insurance, paid vacation, retirement, etc.)</p> <p><input type="checkbox"/> Location</p> <p><input type="checkbox"/> People with whom I work (co-workers)</p> <p><input type="checkbox"/> Work itself</p> <p><input type="checkbox"/> No opportunity to advance</p> <p><input type="checkbox"/> Hours/schedule</p> <p><input type="checkbox"/> People for whom I provide service (patients)</p> <p><input type="checkbox"/> Salary</p> <p><input type="checkbox"/> Nothing, there isn't anything I don't like</p> <p><input type="checkbox"/> Other _____</p>
<p><b>23. How likely are you to leave your principal employment in the next 12 months?</b></p> <p><input type="checkbox"/> Very unlikely</p> <p><input type="checkbox"/> Somewhat unlikely</p> <p><input type="checkbox"/> Somewhat likely</p> <p><input type="checkbox"/> Very likely</p>	<p><b>24. If very likely or somewhat likely that you will leave your principal employment in the next 12 months, what is the main reason? (Select one)</b></p> <p><input type="checkbox"/> Dissatisfaction with manager/people I work with</p> <p><input type="checkbox"/> Dissatisfaction with job</p> <p><input type="checkbox"/> Dissatisfaction with salary</p> <p><input type="checkbox"/> Family/personal</p> <p><input type="checkbox"/> Lack of autonomy</p> <p><input type="checkbox"/> Lack of opportunity for advancement</p> <p><input type="checkbox"/> Retirement</p> <p><input type="checkbox"/> Returning to school</p> <p><input type="checkbox"/> Obtaining RN license</p> <p><input type="checkbox"/> Other</p>
<p><b>25a. Have you felt physically unsafe in your current workplace in the last 6 months?</b></p> <p><input type="checkbox"/> Always    <input type="checkbox"/> Very often    <input type="checkbox"/> Sometimes    <input type="checkbox"/> Rarely    <input type="checkbox"/> Never</p>	<p><b>25c. Does your workplace have a system for reporting incivility/bullying?</b></p> <p><input type="checkbox"/> Yes    <input type="checkbox"/> No</p>
<p><b>25b. Do you have resources (i.e., equipment, staffing, training) to provide safe patient care?</b></p> <p><input type="checkbox"/> Yes    <input type="checkbox"/> No</p>	<p><b>25d. Rate your comfort level with reporting incivility/ bullying in your workplace:</b></p> <p><input type="checkbox"/> Always comfortable    <input type="checkbox"/> Very often comfortable    <input type="checkbox"/> Sometimes comfortable    <input type="checkbox"/> Rarely comfortable    <input type="checkbox"/> Never comfortable</p>
<p><b>26a. Have you experienced incivility/bullying in your workplace in the previous 6 months?</b></p> <p><input type="checkbox"/> Yes    <input type="checkbox"/> No</p>	<p><b>27. Are you a traveling nurse?</b></p> <p><input type="checkbox"/> Yes    <input type="checkbox"/> No</p>
<p><b>26b. Rate your ability to control incivility/bullying in your workplace:</b></p> <p><input type="checkbox"/> Always able to control</p> <p><input type="checkbox"/> Very often able to control</p> <p><input type="checkbox"/> Sometimes able to control</p> <p><input type="checkbox"/> Rarely able to control</p> <p><input type="checkbox"/> Never able to control</p>	<p><b>28. How satisfied are you with nursing as a career?</b></p> <p><input type="checkbox"/> Very Satisfied</p> <p><input type="checkbox"/> Somewhat Satisfied</p> <p><input type="checkbox"/> Dissatisfied</p> <p><input type="checkbox"/> Very Dissatisfied</p>

**PLEASE REMEMBER TO ENTER YOUR LICENSE NUMBER ON PAGE 1.**

**THANK YOU FOR COMPLETING THE SURVEY!**