

## **Nursing Home Administrator Reinstatement Information:**

If the license was disciplined, please contact the Licensure Unit [DHHS.Licensure2117@nebraska.gov](mailto:DHHS.Licensure2117@nebraska.gov) for the appropriate reinstatement application

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### **To reinstate your license**, you must:

1. Complete the attached application for reinstatement.
2. Have a valid Social Security #.
3. Be lawfully present in the U.S.
4. **Have already completed at least 50 hours** of continuing education within the previous 24 months before submitting this application or meet one of the CE waivers (if applicable).
5. Pay the renewal and reinstatement fees. (see last page of the application)  
*We do not accept credit/debit card payment.*

If you reinstate your license at this time, the expiration date will be December 31<sup>st</sup> of the even numbered year.

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### **If you are NOT a U.S. Citizen**, you must submit:

1. Green Card, otherwise known as a Permanent Resident Card (Form I-551), both front and back of the card.
2. Form I-94 (Arrival-Departure Record) **AND** an unexpired foreign passport with a valid unexpired US visa.
3. Employment Authorization Document (EAD) (unexpired) **AND** at one of the following documents under the Federal REAL ID Act:
  - 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;
  - A pending application for adjustment of status to that of an alien lawfully admitted for permanent residence; or in the United States or conditional permanent resident status in the United States; or
4. Other document that shows current immigration status.

**NOTE:** Documents are verified by our office through the Department of Homeland Security. This process may take 4-6 weeks.

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### **Practice After Expiration Date:**

If you practiced after the expiration date of your license and prior to reinstatement, you are subject to an Administrative Penalty of \$10 per day up to \$1,000, or other action as provided in the statutes and regulations governing your profession (such as probation, limitation, censure, etc.).

Additionally, if you committed any other violation of the statutes or regulations governing your practice, the Department may deny the application for reinstatement or reinstate your license to active status and impose limitation(s) or other disciplinary actions on your license.

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### **Questions:**

If you have any questions regarding the procedure for reinstatement, please contact the Licensure Unit, at (402) 471-2117 or [DHHS.licensure2117@nebraska.gov](mailto:DHHS.licensure2117@nebraska.gov)

If your license is reinstated, you will receive an e-mail or mail notice so you can print your wallet card from our website:

**TO PRINT YOUR WALLET CARD GO TO:** <https://www.nebraska.gov/LISSearch/search.cgi>

## Licensure Unit Reinstatement Application

**License Type:**            **Nursing Home Administrator**

**Enter License #:**        \_\_\_\_\_

Enter **LEGAL NAME** below

First Name:			
Middle Name:			
Last Name:		Suffix:	

**DEMOGRAPHICS**

List any other names the applicant has ever been known as (AKA), including maiden and your last name on the birth certificate.).	
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Mailing Address

Country:		Zip Code:	
Address Line 1:		City:	
Address Line 2:		State:	
Social Security Number (SSN):			
<p><u>Neb. Rev. Stat.</u> §§38-123 and 38-130 requires the applicant to provide their social security number to DHHS. Although this number is not public information, DHHS may share the social security number for child support enforcement or other administrative purposes and provide it to the Department of Revenue or the Department of Labor.</p>			
Is the applicant a US Citizen?	Yes <input type="checkbox"/> No <input type="checkbox"/>		
If not a U.S. Citizen, list the A# or I-94#:	<input type="checkbox"/> A#		
	<input type="checkbox"/> I-94 #		
Date of Birth:			
Place of Birth (City/State or Country):			
Phone Number:	<input type="checkbox"/> Mobile		
<input type="checkbox"/> Check box if # Outside U.S.	<input type="checkbox"/> Work	Ext:	
E-Mail Address:			

**CONVICTIONS**

Is the applicant currently on court-ordered probation? Yes  No

(If yes, submit a letter from the probation officer addressing the terms and current status of probation)

Was the applicant convicted of a misdemeanor or felony in any state/jurisdiction since the license **was last renewed** (or since the issuance of an initial license if such was within the past 24 months).

Yes  No

If yes, list below misdemeanor or felony convictions.

Name of Conviction	Date of Conviction	Name of Court Taking Action

**Provide a letter of explanation** for each conviction that you entered above.

**If the applicant's convictions were in a state other than Nebraska**, attach copies of the court documents for each conviction.

**Drug or Alcohol Related Convictions.** If the applicant has drug or alcohol related conviction(s), to aid in the application review, the applicant may submit evaluation and discharge summaries where drug or alcohol treatment was obtained or required. Evaluations and discharge summaries may be submitted by the provider directly to the department.

**NOTE:** If the applicant has **any criminal charges or license disciplinary actions pending that result in a conviction** or license discipline, they 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**.

**OTHER LICENSES**

Yes  No  Does the applicant hold or has held licenses to provide health-related services, health services, professional services, or environmental services in a state **other** than Nebraska?

Type of License:		State Licensed:	
<b>If YES,</b> has the license ever been denied, refused renewal, limited, suspended, revoked or had other disciplinary measures taken against it?	Type of Action (list below)	Date of Action	Name of State Taking Action
Yes <input type="checkbox"/> No <input type="checkbox"/>			

**Disciplinary Action:** If the applicant has had any disciplinary action(s) taken against their credential, request a copy of the disciplinary action(s), including charges and findings be sent directly from the State Licensing Board.

**CONTINUING EDUCATION**

To reinstate the license, the applicant must have already completed the required continuing education (at least 50 hours) within the previous 24 months before submitting this application.

**Continuing Education:**

Has the applicant met the continuing education requirements? Yes  No

**Waiver:** If the continuing education has not been met, the applicant may qualify for a waiver; select the waiver being requested in the section below.

<input type="checkbox"/>	<b><u>Initial License:</u></b> First licensed within the previous 24 months before submitting this application for reinstatement.
<input type="checkbox"/>	<b><u>Military:</u></b> Actively engaged in military service and served for 30 consecutive days on full-time active duty or approved leave within the previous 24 months before submitting this application for reinstatement. 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.  <b>Submit</b> a copy of the military orders to the DHHS Licensure Unit. There is no fee or continuing education requirement for military status.
<input type="checkbox"/>	<b><u>Circumstances Beyond Applicant's Control:</u></b> Did not complete the continuing competency education requirements due to circumstances beyond the applicant's control.  Waivers of continuing education may be considered for circumstances lasting longer than 30 consecutive days that DHHS determines are beyond the applicant's control. Such circumstances can include, but are not limited to, a shortage of available continuing competency courses resulting from an officially declared state of emergency.  <b>Provide the following information:</b> 1. List the reason(s) the applicant was not able to complete the required continuing competency/education. <div style="border: 1px solid black; height: 100px; width: 100%;"></div> 2. Did this last longer than 30 consecutive days? <input type="checkbox"/> Yes <input type="checkbox"/> No  3. Is the applicant requesting a waiver of the total hours of continuing education or a partial waiver? <input type="checkbox"/> Total <input type="checkbox"/> Partial  If a partial waiver, how many hours are being requested? # of Hours: _____

**PRACTICE WIHOUT AN ACTIVE LICENSE**

An Administrative Penalty of \$10 per day up to \$1,000 may be assessed, or other action as provided in the statutes and regulations, for practice without an active license.

Did the applicant practice this profession in Nebraska without an active license?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, what are the actual number of days practiced in Nebraska without an active Nebraska license and what is the business name, location and telephone number of the practice:	Number of days:		
	Name of Business:		
	City:		
	Telephone #:		

**ATTESTATION**

For the purpose of meeting Neb. Rev. Stat. §§4-108 through 4-114 and 38-129 (check **ONE** of the boxes below):

**The applicant attests that they are:**

A citizen of the United States.

OR

**NOT** a citizen of the United States. They are 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.

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

**NOT** a citizen of the United States, a nonimmigrant, nor a qualified alien under the Federal Immigration and Nationality Act.

**The applicant further attests that they:**

1. Have read the application or have had the application read to them; and
2. Are of good character and all statements on this application are true and complete.

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**APPLICATION FEE**

The reinstatement fee is \$201; if applying within 6 months of the expiration date (7.1 to 12.31 even years), the fee is \$76.50.

**Pay by check or money order to: Licensure Unit**

Debit or credit card is not accepted.