NEBRASKA
Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Jim Pillen, Governor

Dear applicant for Pharmacist reinstatement:

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

1. A complete application for reinstatement; and
2. The renewal and reinstatement fees; and
3. Additional documentation requested, if applicable based on the answers you give to the questions on the application for reinstatement

**FEES: To determine the total fee due for reinstatement of your Nebraska pharmacist license, please see the chart below.** If you are applying for reinstatement within 180 days prior to the expiration date of the license (January 1 of even years) the fee will be a total of $79.50. Personal checks ARE accepted. Make checks payable to DHHS Licensure Unit.

| YEAR | Jan | Feb | Mar | Apr | May | June | July | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Even Numbered Year** | $213 | $213 | $213 | $213 | $213 | $213 | $213 | $213 | $213 | $213 | $213 | $213 |
| **Odd Numbered Year** | $213 | $213 | $213 | $213 | $213 | $213 | 79.50 | 79.50 | 79.50 | 79.50 | 79.50 | 79.50 |

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

If you have questions regarding the procedure for reinstatement, please e-mail dhhs.medicaloffice@nebraska.gov or call (402) 471-2118 and ask for the PHARMACY DESK.

Sincerely,

Office of Medical & Specialized Health

Attachments

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DEPT. OF HEALTH AND HUMAN SERVICES

# PHARMACIST APPLICATION FOR REINSTATEMENT OF A LICENSE TO PRACTICE PHARMACY

Department of Health and Human Services
Division of Public Health - Licensure Unit
P.O. Box 94986 - Lincoln, Nebraska 68509-4986
Telephone #: 402-471-2118
E-mail any questions to: ATTN Pharmacy Desk at: dhhs.medicaloffice@nebraska.gov

NAME: ________________________________________ PHARMACIST LICENSE #: _______________

ADDRESS: _____________________________________ DOB: _________________________________

CITY/STATE/ZIP: ________________________________

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

| | | | | | | |
|---|---|---|---|---|---|---|
| 1 | Phone #: (optional) | | Fax #: (optional) | | E-Mail Address: (optional) | |
| 2 | Check the Appropriate Box(s): | ☐ Social Security Number (SSN);<br>☐ Alien Registration Number ("A#"); or<br>☐ Form I-94 (Arrival-Departure Record) number: | SSN#<br>A#<br>I-94 # | | | |
| | If you have both a SSN and an A# or I-94 number, you must report both.<br>Neb. Rev. Stat. §38-123 mandates disclosure of your social security number to DHHS. Although your number is not public information, DHHS may disclose it for child support enforcement purposes and to the Nebraska Department of Revenue. | | | | | |

**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 result in conviction or license discipline, you are required to report such actions to the Investigations Unit within 30 days https://dhhs.ne.gov/licensure/Pages/Complaints-and-Discipline-Index-Page.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? | ☐ | ☐ | | | |
| | | | | | | |
| | | | | | | |

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.

NAME________________________________

**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.

| 2 | Are you licensed in any state? | **Yes** ☐ | **No** ☐ | If yes, in what State(s) are you licensed? | What type of license do you hold? | |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | If yes, has your license ever been denied, refused renewal, limited, suspended, revoked or had other disciplinary measures taken against it? | ☐ | ☐ | Type of Licensure Action | Date of Action | Name of Entity taking Action |
| | | | | | | |
| | | | | | | |

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

## SECTION C - CONTINUING COMPETENCY:

### CONTINUING COMPETENCY REQUIREMENTS

You must have completed **30 hours** of acceptable continuing education during the **24 months immediately preceding the date of application for reinstatement**. The Board of Pharmacy has approved the following providers of continuing education:

1) The Accreditation Council for Pharmacy Education (ACPE);
2) The Accreditation Council for Continuing Medical Education (ACCME) - category 1 continuing education;
3) The Nebraska Council on Continuing Pharmaceutical Education;
4) Other providers demonstrating the same quality standards as those established in the Criteria for Quality of ACPE

| **All applicants for reinstatement must answer the following question by placing a (✓) in the appropriate box (yes or no):** | **Yes** | **No** |
|---|---|---|
| Have you met the continuing competency requirements as outlined above? | ☐ | ☐ |

**WAIVER OF CONTINUING COMPETENCY:** If you **have not** completed the continuing competency requirement, and wish to apply for a waiver of the continuing competency requirement, check the appropriate reason below:

| | |
|---|---|
| ☐ | **Military:** I have served full-time duty in the active military service of the United States, or 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 during part of the 24 months immediately preceding the date of application for reinstatement to active status (attach official documentation stating dates of service). |
| ☐ | **Initial License:** I was first licensed within the 24 months immediately preceding my date of application for active status. |
| ☐ | **Circumstances Beyond My Control:** I was not able to complete my continuing education requirement due to circumstances beyond my control.<br>Waivers of continuing education may be considered for circumstances lasting longer than 30 consecutive days that DHHS determines are beyond your 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.<br>**Submit** the following information:<br>1. List the reason(s) you were not able to complete the required continuing education.<br>2. Did this last longer than 30 consecutive days?<br>3. Are you requesting a waiver of the total hours of continuing education, or a partial waiver? If partial waiver, how many hours are your requesting be waived? |

NAME________________________________

## SECTION D – QUESTIONS:

### QUESTIONS

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

| SUB-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. | ☐ | ☐ |
| 2. Have you ever voluntarily surrendered or voluntarily limited in any way a professional license or permit issued to you by a licensing or disciplinary authority? | ☐ | ☐ |
| 3. Have you been requested to appear before any licensing agency? | ☐ | ☐ |
| 4. Have you been notified of any charges, complaints or other actions filed against you by any licensing or disciplinary authority? | ☐ | ☐ |
| 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? | ☐ | ☐ |
| 6. Have you been asked to and/or permitted to withdraw an application for licensure or permit with any Board or jurisdiction? | ☐ | ☐ |
| 7. Has any state or jurisdiction refused to issue, refused to renew or denied you a license or permit to practice? | ☐ | ☐ |
| **SUB-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? | ☐ | ☐ |
| 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? | ☐ | ☐ |
| 3. Do you currently, or have you had, any physical, mental, or emotional condition which impaired, or does impair your ability to practice your health care profession safely and competently? | ☐ | ☐ |
| 4. Within the past 5 years, has any licensing agency or credentialing organization initiated any inquiry into your physical, mental or emotional health? | ☐ | ☐ |
| **SUB-SECTION III** | **Yes** | **No** |
| 1. Have you been convicted of a felony? | ☐ | ☐ |
| 2. Have you been convicted of a misdemeanor? | ☐ | ☐ |
| 3. Have you been notified of any charges, complaints or other actions filed against you by any criminal prosecution authority? | ☐ | ☐ |
| **SUB-SECTION IV** | **Yes** | **No** |
| 1. Have you been notified of any professional liability claim that resulted in an adverse judgment, settlement, or award, including settlements made prior to suit in which the patient releases any professional liability claim against the applicant? | ☐ | ☐ |
| 2. Are you aware of any professional liability claims currently pending against you? | ☐ | ☐ |

NAME________________________________

## SECTION E

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 as a pharmacist in Nebraska since I last held an active credential. | ☐ Yes ☐ No | |
| 2 | **<u>IF YES</u>**: What are the actual number of days you practiced in Nebraska? Supply the business name, location and phone number of the pharmacy where you worked without an active credential. | # of days: _______________ | |
| | | Business Name: | |
| | | City: | Phone Number: |

## SECTION F -- ATTESTATION

**<u>Attestation:</u>** For the purpose of complying with Neb. Rev. Stat. §§4-108 through 4-114 and 38-129 (*check **ONE** of the boxes below):*

**I attest that:**

☐ I am a citizen of the United States.

**OR**

☐ I am a qualified alien under the Federal Immigration and Nationality Act.

☐ I am a nonimmigrant lawfully present in the United States.

☐ Check this box if you are **NOT** a citizen of the United States, a nonimmigrant, nor a qualified alien under the Federal Immigration and Nationality Act.

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

**<u>Application Attestation:</u> I attest that:**

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

Print Name: ____________________________________

Signature: ______________________________________ Date: ___________________

**Please Note:** Nebraska requires that your application be completed within **<u>150 days</u>** from the date your application is received by the Department. If the process is not completed within 150 days, your application and supporting documentation will be destroyed and a refund will be processed, less the administrative fee of $25.00.

**If you are going to have a company pay your required fee, please include a copy of their W-9. This will help with processing any refunds that might occur due to the licensure process not being completed.**