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

Pete Ricketts, Governor

November 1, 2018

Dear Dr:

Our office is in receipt of your request to reinstate your license to practice medicine and surgery. Our records indicate that your license was suspended, limited, revoked, placed on probationary terms/conditions or voluntarily surrendered to resolve a disciplinary matter, in lieu of discipline, or in response to a notice of disciplinary action.

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

1. A complete application for reinstatement (form enclosed).

2. Reinstatement fee:

   If you have not paid the license renewal fee within the last 24 months please submit the renewal fee of $ **121.00.**

   If you have paid the license renewal fee within the last 24 months there is **no fee due** for reinstatement.

Please be advised that should you reinstate your license at this time, the expiration date will be October 1, 2020**.** At least 30 days prior to that date you will be sent notification of the need to submit a completed renewal application, the renewal fee payment and evidence of the required continuing competency, on or before the expiration date.

If you have any questions regarding the procedure for reinstatement, please contact me at (402) 471-2118.

Sincerely,

Jan Gadeken-Harris
Health Licensing Coordinator
Office of Medical & Specialized Health
PO Box 94986
Lincoln, NE 68509-4986

jgh

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DEPT. OF HEALTH AND HUMAN SERVICES

Department of Health and Human Services
Division of Public Health - Licensure Unit
P.O. Box 94986 - Lincoln, Nebraska 68509-4986
E-mail: medicaloffice@dhhs.ne.gov
Telephone #: 402-471-2118

PHYSICIAN OR OSTEOPATHIC PHYSICIAN AND SURGEON APPLICATION FOR REINSTATEMENT OF A LICENSE TO PRACTICE FOLLOWING SUSPENSION, LIMITATION, REVOCATION, OR VOLUNTARY SURRENDER TO RESOLVE A PENDING DISCIPLINARY MATTER, IN LIEU OF DISCIPLINE, OR IN RESPONSE TO A NOTICE OF DISCIPLINARY ACTION

I hereby apply for reinstatement of my license to practice as a Physician, **License #** _____ in the State of Nebraska and submit the required fee of $ _____. The reason I believe my license should be reinstated is:

_____

_____

Name: _____

Address: _____

_____

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); ☐ Alien Registration Number ("A#"); or ☐ Form I-94 (Arrival-Departure Record) number:			SSN# A# I-94 #	

If you have both a SSN and an A# or I-94 number, you must report both.

Social Security Numbers obtained are not public information but may be shared by the Department for administrative purposes if necessary and only under appropriate circumstances to ensure against any unauthorized access to this information.

SECTION B CONVICTION AND LICENSURE INFORMATION (All applicants must complete this section)
Failure to disclose any such conviction or disciplinary action, regardless of when the action occurred, could result in disciplinary action, including, but not limited to, payment of a civil penalty.

NOTE: If you have any criminal charges or license disciplinary actions pending that results in conviction or license discipline, you are required to report such actions to the Investigations Unit within 30 days http://www.dhhs.ne.gov/reg/investi.htm 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;

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.

		Yes	No			
2	Are you licensed in any state?	☐	☐	If yes, what State(s) are you licensed in? State / License #		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

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

SECTION C CONTINUING COMPETENCY:

You must have earned ONE of the following within the 24 months immediately preceding that date of application for reinstatement:

- 50 hours of Category 1 continuing education approved by the Accreditation Council for Continuing Medical Education (ACCME) or the American Osteopathic Association (AOA); OR
- One year of participation in an approved graduate medical education program; OR
- The AMA Physician's Recognition Award or the AOA CME certification (awarded within the 24 months immediately preceding the date of application for reinstatement).

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 in the regular armed forces of the United States during part of the 24 months immediately preceding the biennial licensure renewal date. (Attach official documentation stating dates of service) If you meet this exemption, you are not required to pay the renewal fee.
☐	**Initial License:** I was first licensed within the 24 months immediately preceding my date of application for active status.

SECTION D EXPERIENCE:

Indicate that within the three years immediately preceding the application for reinstatement, you meet 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. List this information in the section below.

☐ I have had at least one year of approved graduate medical education. List this information in the section below.

☐ I have completed continuing medical education approved by the Board. Submit proof of attendance at continuing education, as well as information about the content for Board approval.

☐ I have completed a refresher course in medicine and surgery approved by the Board. Submit proof of attendance at a refresher course as well as information about the content for Board approval.

☐ I have completed the special purposes examination approved by the Board. Have your scores sent directly to this office.

List your professional activities for the three years preceding date of application, or since your license was last active, whichever time period is longer.

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

SECTION E CONTROLLED SUBSTANCES REGISTRATION

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 F 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:

SECTION I	**Yes**	**No**
1. Have you had any disciplinary or adverse action imposed against a professional license or permit in any state or jurisdiction?	☐	☐
2. Have you voluntarily surrendered or voluntarily limited in any way a 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?	☐	☐
SECTION II	**Yes**	**No**
1. Are you currently, or have you been, addicted to, dependent upon or chronically impaired by alcohol, narcotics, barbiturates, or other drugs which may cause physical and/or psychological dependence?	☐	☐
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?	☐	☐
SECTION III	**Yes**	**No**
1. Have you 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?	☐	☐
2. Have you had hospital or institutional privileges denied, reduced, restricted, suspended, revoked, terminated or placed on probation?	☐	☐
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?	☐	☐
4. Have you been notified that any action against your hospital or institutional privileges is pending or proposed?	☐	☐
5. Have you been allowed to withdraw your staff privileges from a hospital or institution?	☐	☐
6. Have you been subject to staff disciplinary action or non-renewal of an employment contract?	☐	☐
SECTION IV	**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?	☐	☐
SECTION V	**Yes**	**No**
1. Have you been denied a Federal Drug Enforcement Administration (DEA) Registration or state controlled substances registration?	☐	☐
2. Have you been called before any licensing agency or lawful authority concerned with DEA controlled substances?	☐	☐
3. Have you surrendered your state or federal controlled substances registration?	☐	☐
4. Have you had your state or federal controlled substances registration restricted or disciplined in any way?	☐	☐
SECTION VI	**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?	☐	☐

SECTION G PRACTICE PRIOR TO CREDENTIAL

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 (profession) in Nebraska since I last held an active credential?	☐ Yes ☐ No
2	If yes, what are the actual number of days you practiced in Nebraska and what is the business name, location and telephone number of the practice:	# of days: _____
		Name of Business:
		City:

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

☐ I am a citizen of the United States.

☐ I am a qualified alien under the Federal Immigration and Nationality Act (i.e.: permanent resident (green) card, I-94 document, asylum, etc.) **YOU MUST SUBMIT A COPY OF THIS DOCUMENT WITH YOUR RENEWAL**

☐ I am a nonimmigrant lawfully present in the United States. (i.e.: permanent resident (green) card, I-94 document, asylum, etc.) **YOU MUST SUBMIT A COPY OF THIS DOCUMENT WITH YOUR RENEWAL**

☐ 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. **YOU MUST SUBMIT A COPY OF THIS DOCUMENT WITH YOUR RENEWAL**

NOTE: You may still be eligible for a certificate 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.(i.e.: DACA, pending asylum, pending refugee, etc.)

Signature and Application Attestation: I attest that:

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

Print Name: _____

Original Signature: _____ Date: _____

Email (Optional): _____