

**APPLICATION FOR APPOINTMENT  
BOARD OF COSMETOLOGY, ELECTROLOGY, ESTHETICS, NAIL  
TECHNOLOGY, AND BODY ART  
(SCHOOL OWNER MEMBER)**

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**PLEASE PRINT OR TYPE**

**Name of School:**

\_\_\_\_\_  
School Name

\_\_\_\_\_  
License Number

**Legal Owner of School:** \_\_\_\_\_

**Type of Ownership:** Corporation  Limited Corporation  Partnership  Association  Society  Individual/Sole Proprietorship

**Name of Owner (Individual/Sole Proprietorship) or designated representative of owner:**

\_\_\_\_\_  
First

\_\_\_\_\_  
Middle

\_\_\_\_\_  
Last

\_\_\_\_\_  
Credentials (i.e. PhD, etc. if applicable)

**Mailing Address of Owner or designated representative of owner:**

\_\_\_\_\_  
Street/Box/RR

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

Business Telephone \_\_\_\_\_ Cell/Pager \_\_\_\_\_ Residence Telephone \_\_\_\_\_

Email Address \_\_\_\_\_ FAX Number \_\_\_\_\_

Are you available to meet, usually in Lincoln, on a monthly basis, if necessary or required for Board Meetings? Yes  No

Please indicate how you became aware of this vacancy on this Board. Professional Association  DHHS Web Page

Newspaper  Other  (please explain) \_\_\_\_\_

**ELIGIBILITY REQUIREMENTS**

Do you hold a current Nebraska license to practice as a cosmetologist, nail technician, or esthetician? Yes  No  (Statutes require the school owner member of the board shall have held and maintained an active cosmetologist, nail technician, or esthetician license for a period of five years just preceding appointment and shall maintain such license while serving as a board member.)

Have you been actively engaged in practice as a cosmetologist, nail technician, or esthetician for the five (5) years just preceding this application? Yes  No  (Statutes require the school owner member of the board shall have been actively engaged in practice as a cosmetologist, nail technician, or esthetician for a period of five years just preceding appointment and shall maintain such practice while serving as a board member. Active practice means devoting a substantial portion of time to rendering professional services.)

Provide the number of years you have been engaged in the practice of cosmetology, nail technology, or esthetics \_\_\_\_\_

Have you been a resident of the State of Nebraska for at least one (1) year? Yes  No  (Statutes require every member of the board shall have been a resident of Nebraska for one year and shall remain a resident of Nebraska while serving as a board member.)

Specify number of years the Legal Owner of School, or designated representative (listed above) has operated this school of cosmetology, esthetics, or nail technology \_\_\_\_\_ If you are the designated representative of the owner, what position do you currently hold at this school \_\_\_\_\_

Please indicate the name(s) of the cosmetology salon(s), esthetics salon(s), nail technology salon(s) or school(s) of cosmetology, esthetics, or nail technology with which the owner or designated representative are affiliated:

\_\_\_\_\_  
**PLEASE COMPLETE REVERSE SIDE**

**DETAILED DESCRIPTION OF WORK EXPERIENCE IN THE OPERATION OF A SCHOOL OF  
COSMETOLOGY, ESTHETICS, OR NAIL TECHNOLOGY IN NEBRASKA**

Position Title	Name & Location	From	To	Average # of Hours/Week
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**ADDITIONAL INFORMATION**

Describe your interest in this profession and why you wish to serve on this Board.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are you aware of any reason why your appointment might be considered a conflict of interest as defined in Title 172 NAC 3, Regulations Establishing Definitions of Conflicts of Interest for Members of the Boards of Examiners in the Health Professions? Yes  No  If yes, explain.

\_\_\_\_\_

\_\_\_\_\_

Have you, as the school owner or designated representative, ever had your statutory ability to practice or clinical privileges suspended or revoked? Yes  No

Are you, as the school owner or designated representative, currently under investigation? Yes  No

Are you a veteran of the U.S. Armed Forces, or National Guard? Yes  No

If yes, is your military experience related to your current practice? Yes  No

I swear or affirm that all information I have provided on this application is true and complete to the best of my knowledge.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Return completed Application to: Monica Gissler, State Board of Health,  
DHHS, Division of Public Health, Licensure Unit / RPQI, P.O. Box 95026, Lincoln, NE 68509-5026  
402/471-6515; FAX 402/471-0383; Monica.gissler@nebraska.gov**