

NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES



Pete Ricketts, Governor

Dear Applicant:

Thank you for your interest in becoming licensed to practice your profession in the State of Nebraska. Prior to submitting your application for licensure, it is important that you be aware of certain aspects of the application process.

The application form includes a series of questions about an applicant's history regarding licensure, physical and mental health, criminal conduct, and for some professions, malpractice. I encourage you to read these questions carefully. It is expected that applicants answer these questions completely and truthfully. If others are assisting you in the completion of your application, make sure to review the information completely before signing the application. An adverse event in your past is not an automatic disqualification from licensure. The Board will review all of the information surrounding the event in making a determination of your fitness to practice medicine and surgery.

It is important that you fully disclose all arrests, charges or convictions. Questions on the application ask about charges or complaints filed against you by any licensing or disciplinary authority and also about charges or complaints filed against you by any criminal prosecution authority. Even if the charges were dropped, dismissed, pled down or settled through diversion or if the sentencing was deferred or the conviction was expunged, set aside or pardoned, you must provide this information on the application. Failure to fully disclose could be considered as misrepresentation on your application which is grounds to deny your application for licensure.

Applicants are asked whether you have ever been convicted of a misdemeanor or felony. Some offenses that most people would consider as minor violations are actually misdemeanors, so it is important that you thoroughly review your history in order to provide accurate information regarding convictions. You may want to contact the court or seek the advice of an attorney to determine whether an event in your past resulted in a misdemeanor or felony conviction.

Applicants should also be aware that it is the policy of the Licensure Unit that applications may not be withdrawn to avoid or circumvent a denial decision or to circumvent public records and reporting requirements. Understand prior to submitting your application that you may not be allowed to withdraw. Applicants who do not meet the requirements for licensure will be denied.

Thank you for taking the time to read this letter. I hope my comments are helpful to you. If you have further questions regarding the application process, please contact the office at dhhs.medicaloffice@nebraska.gov or by telephone at 402/471-2118.

Sincerely,

Kathie Lueke, Program Manager
Licensure Unit

GENERAL INSTRUCTIONS FOR LICENSURE IN MEDICINE AND SURGERY AND OSTEOPATHIC MEDICINE AND SURGERY

COMPETENCY Neb. Rev. Stat. 38-2026(4) states that an applicant for a license in medicine and surgery must present proof satisfactory to the Department that he or she, within the three years immediately preceding the application for licensure, (a) has 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, (b) has had at least one year of graduate medical education as described in subdivision (2) of this section, (c) has completed continuing education in medicine and surgery approved by the board, (d) has completed a refresher course in medicine and surgery approved by the board, or (e) has completed the special purposes examination approved by the board.

Be advised that the Board of Medicine and Surgery **does not routinely accept continuing education or the special purposes examination alone as acceptable to meet the experience requirement in the absence of recent practice or other evidence of continued competency.**

Neb. Rev. Stat. 38-2026.01 gives the Department, with the recommendation of the Board, authority to issue a reentry license to a physician who has not actively practiced medicine for the two-year period immediately preceding the filing of an application for a license or who has not otherwise maintained continued competency during such period as determined by the Board.

Following is the website to the Statutes Relating to Medicine and Surgery where you can read the complete language regarding the reentry license. <http://dhhs.ne.gov/publichealth/Documents/Medicine%20and%20Surgery.pdf>

The Board of Medicine and Surgery will review applications for a license, either initial application or reinstatement of license, which do not clearly meet the requirements for experience (continued competency) as outlined in the statutes listed above. The Board will make a recommendation to the Department to either issue the license, deny the application or offer a reentry license to the applicant. (This assumes there are no matters whereby discipline would be appropriate.) **Please be aware, that if a reentry license is decided upon by the Board and Department, the process would be that the application be denied if the applicant does not accept the reentry license.**

Examination Applications can be based on: United States Medical Licensing Examination (USMLE), National Boards of Medical Examiners (NBME), National Boards of Osteopathic Medical Examiners (NBOME), Federation Licensing Examination (FLEX), Licentiate of the Medical Council of Canada (LMCC), or a State Board Examination.

All parts of the examination must be passed within ten years of passing the first examination.

An applicant who fails to pass any part of the examination within four attempts must have completed one additional year of postgraduate medical education at an accredited school of medicine.

You must request that official documentation of passing scores obtained on all parts of each national examination you took be sent directly from the official repository of scores to this office (See below):

USMLE and FLEX contact FSMB at (817) 868-4041 website at www.fsmb.org
NBME (215) 590-9592 website at www.nbme.org
NBOME (773) 714-0622 website at www.nbome.org
LMCC (613) 521-6012

If you took a **State Board Examination** the Board of Medicine and Surgery will review the requirements under which you were licensed in the other state for comparability with Nebraska requirements. Please have the state in which you took the Board examination forward your scores to this office.

EDUCATION

US and Canadian Graduates: A certified final transcript sent directly from the medical school is the only acceptable document to verify your completion of medical school. Substitutions, such as letters from the Registrar are NOT acceptable.

Foreign Medical School Graduates: Must use the enclosed Verification of Foreign Medical College form to verify your medical school. Please have your medical school complete the form and send it directly to this office.

A completed profile from FCVS may be submitted. The profile will be reviewed to determine if its components meet the documentation requirements for licensure. It is not automatic acceptance of the documentation verified by FCVS.

POST-GRADUATE MEDICAL EDUCATION

US and Canadian Graduates: Must have completed one year of ACGME accredited postgraduate education, or postgraduate education as approved by the Nebraska Board. You must use the enclosed Certificate of Post- Graduate Medical Education Form.

These forms must come directly from the Program to the Board. Do not submit them with the application. These forms cannot be completed, mailed or signed in advance of your completion of one year of post-graduate medical education.

Foreign Medical School Graduates: Must have completed three years of ACGME postgraduate education, or postgraduate education as approved by the Nebraska Board. You must use the enclosed Certificate of Post-Graduate Medical Education Form. **These forms must come directly from the Program to the Board. Do not submit them with the application. Forms cannot be completed, mailed or signed in advance of your completion of three years of post-graduate medical education.**

Educational Equivalency Foreign graduates must possess a permanent Educational Commission on Foreign Medical Graduates (ECFMG) Certificate that is Valid Indefinitely. You must request that an official ECFMG Certification Status Report be sent directly to this office from ECFMG (215) 386-5900 and the website is www.ECFMG.org.

Fifth Pathway is also accepted and will require appropriate documentation.

PROFESSIONAL ACTIVITIES These must be listed for the last ten years or since graduating from medical college if less than ten years ago. Also, please list all periods of non-professional activity. **This information is to be completed on the application form.**
PLEASE DO NOT PROVIDE CURRICULUM VITAE.

MEDICAL MALPRACTICE INFORMATION If You Answered YES To Section VI Question #1: **Indicate the total number of claims you have had which resulted in** (A) an adverse judgment against you; (B) a settlement made on your behalf, including those made prior to suit in which the patient released any professional liability claim against you; (C) an award was required or made by you or on your behalf.

Submit a **detailed explanation of each claim to include the following:**

1. Name, sex and age of patient
2. Date of occurrence
3. Initial event (procedure/diagnosis)
4. Subsequent event that precipitated the claim – include the time sequence in relation to the initial event
5. Damages – a description of damages or alleged damages resulting from the initial and subsequent events
6. Date of filing of malpractice claim in court (if applicable)
7. Outcome of claim – include the court disposition, whether or not the case was settled, and the amount of any monetary settlement or judgment made on your behalf.
8. Date of final outcome of claim.

If You Answered YES To Section VI Question #2: **Indicate the total number of malpractice claims that are currently pending against you.** Submit the following for each pending claim: (A) A **detailed explanation** of the claim to include the information as outlined above, numbers 1-6; (B) Copies of the court documents that outline the **statement of charges** (often called the “Complaint”); (C) **Letter from the attorney** stating the current status of the claim.

Criminal Background Check A criminal background check is required for all applicants for an initial license in medicine and surgery or osteopathic medicine and surgery. Standard processing time for background checks is 8-10 weeks. Background checks will not be expedited. **Please carefully follow the enclosed instructions for this procedure.**

CONVICTION & LICENSURE INFORMATION If you answer “Yes” to any question(s) on pages 5 and 6 of the application you will be required to provide additional information regarding the circumstances and outcomes. Please refer to page 9 of the application for specific information regarding the documentation required. After your application has been received, the Department/Board may request additional information based on your answers.

LICENSURE IN OTHER STATES List **ALL** states where you have ever held an active or inactive medical to include: residency in training/permits, locum tenens, temporary medical license, and/or permanent medical license. **You will need to have each state where you have ever held a license send a certification of licensure to this office.**

PHOTOCOPY OF AN ACTIVE FEDERAL DEA CERTIFICATE must be sent with the application if controlled substances will be prescribed, administered or dispensed by the licensee. This is not required for licensure.

FEE: Pay the fee indicated in the month/year you’re submitting your application. Depending on **issuance** of the license, additional fees may be required. Processing time for applications depends on how busy the office is. Because you submit your application with a certain fee paid does not guarantee your license will be issued within that time frame. Money order and checks need to be made **payable to: Nebraska Licensure Unit.**

YEAR	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec
Even	\$300	\$300	\$300	\$75	\$75	\$75	\$75	\$75	\$300	\$300	\$300	\$300
Odd	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$300	\$300

***When a license will expire within 180 days after its initial issuance date the initial licensure fee is ¼ of the full fee. The full renewal fee will be due by October 1. You may request that your license be issued after October 1 by indicating that in writing with the application. Issuance of the license after October 1 will require the full \$300 fee.**

WITHDRAWAL/DENIAL OF APPLICATION Once an application has been completed with all the required documents submitted, the applicant will not be allowed to withdraw the application. If the applicant does not meet the requirements for licensure, a denial will be issued.

LICENSURE TIMELINE Licenses will not be issued until all required documentation has been received and will be issued in date order. Applications are dealt with in a fair and equal manner. One application will not be expedited at the expense of another. Also, the less time specialists spend responding to duplicate e-mails and telephone calls, the faster applications can be reviewed. Please refer to the “Deadlines For Receipt of Licensure Applications and Supporting Documents” for more information. The Department has up to 150 days to act upon any completed application. We are unable to provide estimates of the time it takes to obtain a license, as each application timeline will be unique.

LICENSE RENEWAL The period for biennial renewal of medical licenses in the State of Nebraska is October 1st of even-numbered years. Renewal notices are mailed at least 30 days prior to the expiration date of your license. **It is your responsibility to keep this office advised of your current address so that correspondence will reach you.**

Deadlines for Licensure Applications and Supporting Documents

The following are the deadlines for receipt of licensure applications and supporting documents for applications required to be reviewed by the Board of Medicine and Surgery. Some applications will require review by the Board of Medicine and Surgery at their regular meeting. These deadlines will apply if the Department determines that your application will need Board review. Please submit your application according to this schedule, assuming that your application will be reviewed by the Board. If your application does not need Board review, you will receive a license document in the mail.

Application deadline: *The completed application form and check/money order must be received in the Licensure Unit office by this date. If you choose to mail your application Express or Overnight Delivery, please note that the delivery/signed for date may not reflect receipt of your application in our office. All mail is initially processed through a central mail room.*

Documents deadline: All supporting documents and additional information that our office requests must be received in our office by this date. Late submissions will cause your application to be reviewed at the next meeting date.

Please Note: Just because your application may be received by the deadlines above, does not guarantee a spot at that particular meeting. Applications are reviewed in the order they are received and depending on the work load of the office, applications can be pushed to the next meeting. We will try our best to review applications in a timely manner to meet the deadlines above.

APPLICATION DEADLINES	DOCUMENT DEADLINE	MEETING DATE
December 15, 2016	December 29, 2016	January 20, 2017
February 2, 2017	February 16, 2017	March 10, 2017
March 30, 2017	April 13, 2017	May 5, 2017
May 11, 2017	May 25, 2017	June 16, 2017
July 13, 2017	July 27, 2017	August 18, 2017
September 7, 2017	September 21, 2017	October 13, 2017
October 26, 2017	November 9, 2017	December 1, 2017
December 21, 2017	January 4, 2018	January 26, 2018

CRIMINAL BACKGROUND CHECKS

Instructions – Revised 12/2016

Criminal Background Check Notification: Pursuant to Neb. Rev. Stat. §38-131 (provided below), an applicant for an initial license to practice as a registered nurse or a licensed practical nurse or to practice a profession which is authorized to prescribe controlled substances shall be subject to a criminal background check. Applicants are able to receive any national criminal history record that may pertain to them directly from the FBI, pursuant to 28 CFR Sections 16.30-16.34, and may then freely disclose any such information to whomever they choose. Applicants must authorize the dissemination of any national criminal history record that may pertain to them to the Department of Health and Human Services (DHHS) when applying for licensure. Applicants are entitled to challenge the accuracy and completeness of any information contained in any such report and will be provided a copy of the criminal history background report, if any, received if they appear at the DHHS in person and present proper identification. Information on how to challenge an applicant's federal report can be found at FBI.gov. To challenge an applicant's Nebraska state record, contact the Nebraska State Patrol-Criminal Identification Division. Applicants may obtain a prompt determination as to the validity of their challenge before the DHHS makes a final decision about their application for licensure.

Neb. Rev. Stat. §38-131 - **Criminal background check; when required.** (1) An applicant for an initial license to practice as a registered nurse or a licensed practice nurse or to practice a profession which is authorized to prescribe controlled substances shall be subject to a criminal background check. Except as provided in subsection (3) of this section, the applicant shall submit with the application a full set of fingerprints which shall be forwarded to the Nebraska State Patrol to be submitted to the Federal Bureau of Investigation for a national criminal history record information check. The applicant shall authorize release of the results of the national criminal history record information check to the department. The applicant shall pay the actual cost of the fingerprinting and criminal background check. (2) This section shall not apply to a dentist who is an applicant for a dental locum tenens under section 38-1122, to a physician or osteopathic physician who is an applicant for a physician locum tenens under section 38-2036, or to a veterinarian who is an applicant for a veterinarian locum tenens under section 38-3335. (3) An applicant for a temporary educational permit as defined in section 38-2019 shall have ninety days from the issuance of the permit to comply with subsection (1) of this section and shall have his or her permit suspended after such ninety-day period if the criminal background check is not complete or revoked if the criminal background check reveals that the applicant was not qualified for the permit. Source: Laws 2005, LB 306, § 2; Laws 2005, LB 382, § 15; Laws 2006, LB 833, § 1; R.S.Supp 2006, § 71-104.01; Laws 2007, LB247, § 60; Laws 2007, LB463, § 31; Laws 2007, LB481, § 2; Laws 2011, LB687, § 1; Laws 2015, LB129. Effective Date: August 30, 2015

FINGERPRINTING PROCEDURE – Please read and follow these instructions carefully to avoid delays in processing.

Fingerprints must be obtained and submitted to the Department with your application for licensure. The Department is required to verify to the Nebraska State Patrol that you have made application for licensure in Nebraska prior to the Nebraska State Patrol processing your request for a criminal background check. The applicant must send the fee for the Criminal Background Check (\$45.25) separately, directly to the Nebraska State Patrol as explained below.

AS OF JANUARY 1, 2017 THE FEE FOR BACKGROUND CHECKS CHANGED TO \$45.25.

Criminal background checks are NOT expedited for any reason.

1. If you received a printed application from the Licensure Unit, two fingerprint cards were enclosed. Take the fingerprint cards (2) to any State Patrol office or law enforcement agency. Contact information for the Nebraska State Patrol offices is included with these instructions. You must call ahead to schedule an appointment at the Nebraska State Patrol offices. Please note that some offices have limited hours when fingerprinting will be conducted.
2. If you obtained your application online, fingerprint cards can be obtained by contacting the Licensure Unit. Fingerprint cards may also be available at any State Patrol office or law enforcement agency. The fingerprint cards are the standard FBI Applicant format, form number FD 258, and are blue and white cards.
3. **DO NOT FOLD THE FINGERPRINT CARDS.**
4. Live Scan fingerprinting refers to both the technique and the technology used by law enforcement agencies and private facilities to capture fingerprints electronically, without the need for the more traditional method of ink and paper. Live Scan is available at all Nebraska State Patrol locations. If Live Scan is used in Nebraska to capture your fingerprints, the Nebraska State Patrol will NOT give you cards to submit with your application. They will submit the cards to the Department directly for verification of application. Although other states may have Live Scan available, it is common that other states will not capture fingerprints using Live Scan for persons who are being fingerprinted for purposes outside of that state. Applicants outside of Nebraska may have traditional ink and paper fingerprints done where they are located, or they may travel to a Nebraska State Patrol location to use Live Scan.
5. The Nebraska State Patrol does not charge for the service of taking your fingerprints. However, other law enforcement agencies in Nebraska or in other states may charge a fee.
6. You must take one form of photo ID with you when obtaining your fingerprints. Acceptable forms of ID include a driver's license, visa or passport. If you are from a foreign country and do not have one of these forms of photo identification, provide any documentation issued by your country, legal sovereign or consulate.
7. Please print your full name, address with zip code, *Social Security Number, date and place of birth, and physical identifiers on the fingerprint cards. **DO NOT sign the fingerprint cards until** the law enforcement officer has verified your signature with the form of identification that you provide. **DO NOT write in the field labeled ORI.**

**Social Security Number: If you do not have a United States Social Security Number, you must provide in the "Miscellaneous No: MNU" section a Government issued identification number, a "consulate" number or a Passport Number. Please indicate the type of number provided.*

8. If you are one of the following professions: Dental, Physician, APRN*, Physician Assistant, Optometrist, Podiatrist, Veterinarian, Temporary Educational Permit or Wholesale Drug Distributor, put Controlled Substance License in the box labeled "Reason Fingerprinted". If you are applying for an RN or LPN license put Nursing License in the box labeled "Reason Fingerprinted".

New APRN/RN applicants (individuals applying for both at the same time) will need to submit two different sets of cards and pay twice (one "Controlled Substance License" one "Nursing"). Each license applied for requires an individual background check.

9. After the fingerprinting procedure is completed, the cards should **NOT** be given to you.

- If you obtained the cards from the Licensure Unit, request the person who took your fingerprints to place the cards in the envelope provided by the Licensure Unit along with your completed application for licensure, and mail the envelope to the Department.
- If you obtained the cards from a State Patrol office or other law enforcement agency, request the person who took your fingerprints to place the cards in an envelope provided by you (**DO NOT FOLD THE FINGERPRINT CARDS**) along with your completed application for licensure, and mail the envelope addressed to: **Nebraska DHHS, Division of Public Health, Licensure Unit, 301 Centennial Mall South, P.O. Box 94986, Lincoln, NE 68509-4986**

The fee for Criminal Background Check is to be sent separately, directly to the Nebraska State Patrol. The \$45.25 fee, made payable to the Nebraska State Patrol, can be paid by a personal check, money order, cashier's check and credit card. **When sending payment, it is important to include a note that clearly identifies the name of the person for whom the criminal background check is requested, and the type of license for which the person is applying.**

Payment must be mailed directly to: **Nebraska State Patrol, ATTN: CID, 3800 NW 12th ST, STE A, Lincoln NE 68521.**

Pay by credit card at www.ne.gov/go/nsp. This is an internet pay site through PayPort. You can pay by echeck (additional fee of \$1.75) or credit card (additional fee of \$.90). The website will ask you to select the type of payment you are making. You need to choose "Controlled Substance License or Nursing" depending on your profession (see #8). You will then need to put in the applicant's name, date of birth and the last 4 digits of social security number (optional). If a company is paying for an applicant – the applicant's information needs to be submitted on this page. The second page of the website will ask for information about the payer, which may or may not be the applicant.

AS OF JANUARY 1, 2017 THE FEE FOR BACKGROUND CHECKS CHANGED TO \$45.25.

10. ****This process takes several weeks for the results of your criminal background check to be received by the Department.****
No licensing decision will be made until all information is received.

Office of the Nebraska State Patrol

Days/Hours that Fingerprinting Conducted

Troop A
4411 S 108th ST
Omaha, NE 68137
Phone: 402-331-3333

Monday through Friday 8:00 a.m. to 4:30 p.m.
(appointment required)

Troop B
1401 Eisenhower AVE
Norfolk NE 68701
Phone: 402-370-3456

Usually on Tuesdays
(appointment required)

Troop C
3431 Potash
Grand Island NE 68802
Phone: 308-385-6000

Mondays from 10:00 a.m. to noon
and from 1:00 p.m. to 2:45 p.m.
(appointment required)

Troop D
300 West South River Rd
North Platte NE 69101
Phone: 308-535-8265 ext. 219

Monday, Tuesday, Thursday, Friday
from 8:30 a.m. to 5:00 p.m.
Wednesday from 8:30 a.m. to 2:30 p.m.
(appointment required)

Troop E
4500 Avenue I
Scottsbluff NE 69361
Phone: 308-632-1211

Wednesdays after 1:00 p.m.
(appointment required)

Criminal Identification Division (CID)
3800 NW 12th ST STE A
Lincoln NE 68521
Phone: 402-479-4971

Monday through Friday 8:00 a.m. to 4:00 p.m.
(appointment required)
Last person fingerprinted at 4:00 p.m.

This form may be completed online and mailed to the address listed below.



Department of Health and Human Services
 Division of Public Health - Licensure Unit
 301 Centennial Mall South
 P.O. Box 94986 - Lincoln, Nebraska 68509
 Telephone #: 402-471-2118

Lic# _____
Date: _____
Office Use Only

APPLICATION FOR A LICENSE TO PRACTICE MEDICINE

Medicine and Surgery **Osteopathic Medicine and Surgery**
 Fee: \$300 (see fee schedule)

SECTION A – PERSONAL INFORMATION: (All applicants must complete this section) Items 1 and 2 are public information. Name and Licensure information will be displayed on the INTERNET at http://www.nebraska.gov/LISSearch/search.cgi					
<i>NOTE: All mailings will be sent to the address you indicate below– if you change your address, you must advise this office.</i>					
1	Legal Name	First:	Middle Name:	Last:	
	Maiden Name	Other Names you are known as (AKA):			
2	Mailing Address	Street/PO/Route:			
		City:	State or Country:	Zip:	
3	Date of Birth (M/D/Y):	Place of Birth (city/state/country):		Gender: M F	
4	Check the Appropriate Box(es)	<input type="checkbox"/> Social Security Number (SSN);		SSN#	
		<input type="checkbox"/> Alien Registration Number (“A#”);		A#	
		<input type="checkbox"/> Form I-94 (Arrival-Departure Record) number		I-94 #	
If you have both a SSN and an A# or I-94 number, you must report both. 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.					
Phone			Fax (optional)		
Licensee E-mail Address			Credentialing contact e-mail Address (optional)		

Office Use Only					
Board	Yes	No	Federation	Yes	No
Cards	Yes	No	NPDB	Yes	No
			NDEN	Yes	No

SECTION B – EXAMINATION (All application must complete this section)

I have requested that an official copy of my score reports for any and all of the national examinations that I have taken (check ALL that apply) be sent to your office:

Application by Examination:

USMLE NBME FLEX NBOME LMCC

Combination of USMLE/FLEX Combination of USMLE/NBME

Application Based on License in Another State or Territory of the United States:

State Exam (list state) _____ I have requested a copy of my state examination from that Board

Foreign medical graduates must indicate their ECFMG number: _____

Do you currently have a FCVS profile? Yes No

SECTION C – EDUCATION (All applicants must complete this section) List in chronological order, beginning with high school and ending with medical school, the name and location of all institutions attended. List the diplomas or certificates earned and dates received for all preliminary (high school), pre-medical education and medical education. (Attach additional pages if necessary).

PRELIMINARY AND PRE-MEDICAL EDUCATION

<u>NAME OF HIGH SCHOOL</u>	
City/State/Country	
Diploma/Certificate	
Date: (MO/YR)	
<u>NAME OF PRE-MEDICAL COLLEGE</u>	
City/State/Country	
Diploma/Certificate	
Date: (MO/YR)	
<u>NAME OF PRE-MEDICAL COLLEGE</u>	
City/State/Country	
Diploma/Certificate	
Date: (MO/YR)	

MEDICAL EDUCATION

<u>NAME OF MEDICAL SCHOOL</u>	
City/State/Country	
Attended	From (M/D/Y): _____ To (M/D/Y): _____
Degree Conferred	Date Conferred (M/D/Y): _____
<u>NAME OF MEDICAL SCHOOL</u>	
City/State/Country	
Attended	From (M/D/Y): _____ To (M/D/Y): _____
Degree Conferred	Date Conferred (M/D/Y): _____

SECTION D- POST-GRADUATE MEDICAL EDUCATION (All applicants must complete this section) Indicate whether service was Internship, Residency or Fellowship.

Name of Institution	
Name of Specialty	<input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Fellowship
City/State/Country	
Attended From:	(M/D/Y)
Attended To:	(M/D/Y)
Name of Institution	
Name of Specialty	<input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Fellowship
City/State/Country	
Attended From:	(M/D/Y)
Attended To:	(M/D/Y)
Name of Institution	
Name of Specialty	<input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Fellowship
City/State/Country	
Attended From:	(M/D/Y)
Attended To:	(M/D/Y)
Name of Institution	
Name of Specialty	<input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Fellowship
City/State/Country	
Attended From:	(M/D/Y)
Attended To:	(M/D/Y)

SECTION E – COMPETENCY (All applicants must complete this section) Indicate that, within the three years immediately preceding the application for licensure, you have met **ONE** of the following:

<input type="checkbox"/>	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.
<input type="checkbox"/>	I have had at least one year of approved graduate medical education.
<input type="checkbox"/>	I have completed continuing medical education. <u>Submit proof of attendance at continuing education, as well as information about the content for Board approval. *See below*</u>
<input type="checkbox"/>	I have completed a refresher course in medicine and surgery. <u>Submit proof of attendance at a refresher course, as well as information about the content for Board approval. *See below*</u>
<input type="checkbox"/>	I have completed a special purposes examination. <u>Have your score sent directly to this office for Board approval. *See below*</u>

*Neb. Rev. Stat. 38-2026(4) states that an applicant for a license in medicine and surgery must present proof satisfactory to the Department that he or she, within the three years immediately preceding the application for licensure, (a) has 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, (b) has had at least one year of graduate medical education, (c) has completed continuing education in medicine and surgery approved by the board, (d) has completed a refresher course in medicine and surgery approved by the board, or (e) has completed the special purposes examination approved by the board.

Be advised that the Board of Medicine and Surgery **does not routinely accept continuing education or the special purposes examination alone as acceptable to meet the experience requirement in the absence of recent practice or other evidence of continued competency.**

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Following is the website to the Statutes Relating to Medicine and Surgery where you can read the complete language regarding the reentry license.
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The Board of Medicine and Surgery will review applications for a license, either initial application or reinstatement of license, which do not clearly meet the requirements for experience (continued competency) as outlined in the statutes listed above. The Board will make a recommendation to the Department to either issue the license, deny the application or offer a reentry license to the applicant. (This assumes there are no matters whereby discipline would be appropriate.) **Please be aware, that if a reentry license is decided upon by the Board and Department, the process would be that the application be denied if the applicant does not accept the reentry license.**

SECTION F - PROFESSIONAL ACTIVITIES (All applicants must complete this section) List in chronological order all of your medical activities for the last ten years, or since graduation from medical college if less than ten years ago to present. Also list all periods of non-professional activity or employment for periods of non-medical activity of more than three months. Please account for all time and explain all gaps of more than three months. (Attach additional pages if necessary). This information must be completed below. **Do not attach CV or other work history forms.**

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

SECTION G – CONTROLLED SUBSTANCES REGISTRATION (Check one that applies)

1	<input type="checkbox"/> I have enclosed a photocopy of my current Federal Controlled Substances Registration. <input type="checkbox"/> Federal Controlled Substances Registration #: _____ Expiration Date: _____
2	<input type="checkbox"/> I am currently applying for a Federal Controlled Substances Registration, and will send a photocopy of such when I receive the registration.
3	<input type="checkbox"/> 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 H – LICENSURE IN OTHER STATE (All applicants must complete this section)

Have you ever been licensed as a physician, physician in training license/permit, educational or residency license/permit or any other license or permit allowing you to practice medicine in another state or jurisdiction? YES NO

List all other states, jurisdictions, or territories of the U.S. where you have been or are currently licensed, including license number, issue date, and expiration date. **(Include educational training/permit licenses). Attach list if needed.**

State	License #	Issue Date	Expiration Date

SECTION I – 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, include, but not limited to, payment of a civil penalty.

Answer the following questions either yes or no by placing a (✓) in the appropriate box. **All 'yes' responses MUST be explained in detail and you must submit the requested documentation (see pages 8 & 9 of application).** Additional documentation may be requested by the Board/Department after submission of initial information.

Section I

1	Have you ever had any disciplinary or adverse action imposed against a professional license or permit in any state or jurisdiction?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
2	Have you ever voluntarily surrendered or voluntarily limited in any way a license or permit issued to you by a licensing or disciplinary authority?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
3	Have you ever been requested to appear before any licensing agency?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
4	Have you ever been notified of any charges, complaints or other actions filed against you by any licensing or disciplinary authority?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
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?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
6	Have you ever been asked to and/or permitted to withdraw an application for licensure or permit with any Board or jurisdiction?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
7	Has any state or jurisdiction refused to issue, refused to renew or denied you a license or permit to practice?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

Section II

1	Are you currently, or have you ever been, addicted to, dependent upon or chronically impaired by alcohol, narcotics, barbiturates, or other drugs which may cause physical and/or psychological dependence?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
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?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
3	Do you currently, or have you ever had, any physical, mental, or emotional condition which impaired, or does impair your ability to practice your health care profession safely and competently?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
4	Within the past 5 years, has any licensing agency or credentialing organization initiated any inquiry into your physical, mental or emotional health?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

SECTION I (CONTINUED) – 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, include, but not limited to, payment of a civil penalty.

Answer the following questions either yes or no by placing a (✓) in the appropriate box. **All 'yes' responses MUST be explained in detail and you must submit the requested documentation (see pages 15 & 16 of application).**
 Additional documentation may be requested by the Board/Department after submission of initial information.

Section III

1	Have you ever 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?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
2	Have you ever had hospital or institutional privileges denied, reduced, restricted, suspended, revoked, terminated or placed on probation?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
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?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
4	Have you ever been notified that any action against your hospital or institutional privileges is pending or proposed?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
5	Have you ever been allowed to withdraw your staff privileges from a hospital or institution?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
6	Have you ever been subject to staff disciplinary action or non-renewal of an employment contract?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

Section IV

1	Have you ever been convicted of a felony? Failure to disclose any such convictions regardless of when the conviction occurred could result in disciplinary action, including but not limited to a minimum of \$500 civil fine.	<input type="checkbox"/> YES	<input type="checkbox"/> NO
2	Have you ever been convicted of a misdemeanor? Failure to disclose any such convictions regardless of when the conviction occurred could result in disciplinary action, including but not limited to a minimum of \$500 civil fine.	<input type="checkbox"/> YES	<input type="checkbox"/> NO
3	Have you ever been notified of any charges, complaints or other actions filed against you by any criminal prosecution authority?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

Section V

1	Have you ever been denied a Federal Drug Enforcement Administration (DEA) Registration or state controlled substances registration?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
2	Have you ever been called before any licensing agency or lawful authority concerned with DEA controlled substances?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
3	Have you ever surrendered your state or federal controlled substances registration?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
4	Have you ever had your state or federal controlled substances registration restricted or disciplined in any way?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

Section VI

1	Have you ever 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?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
2	Are you aware of any professional liability claims currently pending against you?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

SECTION J – PRACTICE PRIOR TO CREDENTIAL (All applicants must complete this section) 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 physician/osteopathic physician & surgeon in Nebraska before issuance of the Nebraska license.	<input type="checkbox"/> YES	<input type="checkbox"/> NO
2	<p>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:</p> <p><i>Students of medicine and surgery enrolled in an accredited college of medicine who gratuitously practice medicine and surgery under the supervision of a licensed physician are exempt from needing a Permit or License in the State of Nebraska, pursuant to Neb. Rev. Stat. 38-2025(4)). Once an individual has graduated from medical school, however, a Permit or License is required in the State of Nebraska in order to practice medicine and surgery. The question above, therefore, refers to the time since you have graduated from medical school until such time as you have received a Permit or License to practice medicine and surgery in the State of Nebraska.</i></p>	<p># of days: _____</p> <p>Name of Business: _____</p> <p>City: _____</p> <p>Telephone #: _____</p>	

SECTION K – ATTESTATION (All applicants must complete this section)

Lawful Presence in the United States Attestation: For the purpose of complying with Neb. Rev. Stat. §38-129, I attest as follows:

Please check only one of the boxes below:

- I am a citizen of the United States; or
- I am an alien lawfully admitted into the United States who is eligible for a credential under the Uniform Credentialing Act; or
- I am a non-immigrant lawfully present in the United States who is eligible for a credential under the Uniform Credentialing Act.

Alien or Non-Immigrant Status: If you are a qualified alien lawfully admitted into the United States OR a non-immigrant lawfully present in the United States, you must submit evidence of lawful presence which may include a copy of:

1. A “Green Card” otherwise known as a Permanent Resident Card (Form I-551), both front and back of the card; or
2. An unexpired foreign passport with an unexpired Temporary I-551 stamp bearing the same name as the passport; or
3. A document showing an Alien Registration Number (“A#”), an Employment Authorization Card/Document is **NOT** acceptable; or
4. A Form I-94 (Arrival-Departure Record).

If you are an Alien or Non-Immigrant, your credential will **NOT** be issued until such proof is received by our office and your documents are verified by our office through the Department of Homeland Security. This process may take four to six weeks.

Criminal Background Check Notification: Pursuant to Neb. Rev. Stat. §38-131, an applicant for an initial license to practice a profession which is authorized to prescribe controlled substances shall be subject to a criminal background check. I understand that I am able to receive any national criminal history record that may pertain to me directly from the FBI, pursuant to 28 CFR Sections 16.30-16.34, and that I could then freely disclose any such information to whomever I choose. By signing this application, it is my intent to authorize the dissemination of any national criminal history record that may pertain to me to the Department of Health and Human Services (DHHS) with whom I am applying for licensure. I understand that I am entitled to challenge the accuracy and completeness of any information contained in any such report, and that you will provide me a copy of the criminal history background report, if any, you receive on me if I appear at the DHHS in person and present proper identification. Information on how to challenge your federal report can be found at FBI.gov. To challenge your Nebraska state record, contact the Nebraska State Patrol-Criminal Identification Division. I may obtain a prompt determination as to the validity of my challenge before you make a final decision about my application for licensure.

Application Attestation: I further attest that:

1. I have read the application or have had the application read to me;
2. All statements on the application are true and complete; and
3. I am of good character.

Print Name _____ Signature _____ Date _____

ORIGINAL SIGNATURE REQUIRED

CERTIFICATE OF POST-GRADUATE MEDICAL EDUCATION

Applicants must have the **current Program Director** of the institution where they completed their post-graduate medical education complete the following form and **affix the Official School Seal**. An **original** signature from the Program Director is required. **Forms need to be sent to the Licensure Unit directly from the program. Do not submit with your application. These forms cannot be completed, mailed or signed in advance of your completion of one/three years of post-graduate medical education.**

Print Name _____ SS# _____

.....
NOTE: The information below must be completed ONLY by an official of the program/facility and not the applicant.

It is hereby certified that: _____
(Name of Applicant)

Has successfully completed _____
(Name of Residency/Internship/Fellowship)

located at : _____ **in** _____
(Name of Hospital/Teaching Institution) (City, State, Country)

From _____ **to** _____
(Month/Day/Year) (Month/Day/Year)

At the time this applicant was enrolled in this Program, this Program was:

_____ **ACGME* or AOA* accredited** *ACGME - Accreditation Council for Graduate Medical Education

*AOA – American Osteopathic Association

_____ **RCPSC* or CFPC* accredited** *RCPSC – Royal College of Physicians and Surgeons of Canada

*CFPC – College of Family Physicians of Canada

_____ **was not accredited by any of the above listed entities**

Any Disciplinary Action? Yes _____ No _____ If yes, provide details of the disciplinary action.

Any Derogatory Information? Yes _____ No _____ If yes, provide details of the derogatory information.

Signature of CURRENT PROGRAM DIRECTOR
(Signature stamp **NOT** acceptable)

Print Name _____

Title _____

Date (month/day/year) _____

Phone # _____

E-mail _____



State of Nebraska, Department of Health and Human Services
Division of Public Health, Licensure Unit
301 Centennial Mall South,
PO Box 94986, Lincoln NE 68509-4986 (402) 471-2118

VERIFICATION OF FOREIGN MEDICAL COLLEGE

Name of University

Street

City

State

Zip

I, _____, MD/DO have applied for a license to practice in the State of Nebraska.
(Print full name)

As part of the application process, the State of Nebraska requires a verification of my Foreign Medical College.

I hereby authorize _____, its staff or representative to provide the State of Nebraska
(Name of College)

any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above named society and/or person for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice. Further, I request that this completed form be sent directly to the State of Nebraska. I understand that completed forms returned to me will not be accepted for verification purposes.

Sincerely, _____ Date of Birth _____ / _____ / _____
(Signature of Applicant) MO DAY YEAR

Social Security Number _____ Date of Graduation _____ / _____ / _____
MO DAY YEAR

For verification of FOREIGN MEDICAL COLLEGE ONLY. Please provide exact dates. The following section must be completed by the dean or registrar of the foreign medical school and returned directly to the State of Nebraska. Verifications returned directly to the applicant will not be accepted. Do not complete if photograph is not attached. Any substitutions must contain all required information or it will not be accepted for verification purposes.

This certifies that _____
(Full name of applicant)

Enrolled in _____ on _____ / _____ / _____ graduated _____ / _____ / _____
(Name of Foreign Medical College) MO DAY YEAR MO DAY YEAR

and received the **DEGREE** of _____

Any disciplinary action on file? Yes (please explain) _____ No _____

Further, the records of this institution indicate that the attached photograph
(check one) _____ **Represents a true likeness of the above named applicant**
_____ **Does not represent a true likeness of the above-named applicant.**

By _____
Original Signature of the dean or registrar
(stamped or electronic signatures will NOT be accepted)

SEAL Attach
Passport size
Photograph Here

Print or Type Official's Name and Title

e-mail address if possible

Signed and the college Seal affixed on _____ / _____ / _____ Medical College seal MUST be imprinted partially on photograph
MO Day Year