

# RENEWAL NOTICE

## Licensed Practical Nurse (LPN)

### EXPIRES 10/31/2017

**License Information:**

<p>Your renewal application and fee (if applicable) must be <b>POSTMARKED ON OR BEFORE 10-31-2017 to avoid expiration of your license.</b> If you practice after the expiration date, an administrative penalty of \$10 per day up to \$1,000 will be assessed for each day of practice.</p>		<p><b>YOU MUST CHECK A BOX BELOW:</b></p> <p><input type="checkbox"/> ACTIVE \$123.00</p> <p><input type="checkbox"/> INACTIVE (no fee required)</p> <p><input type="checkbox"/> MILITARY WAIVER (no fee required)</p> <p>Make payable to:</p> <p>DHHS Licensure Unit</p> <p><b>(You will not receive receipt)</b></p>
License #:		
Legal Name:		
Address:		
<input type="checkbox"/> Check if this is a NEW Address		
City/State/Zip:		
<p>To renew your license, you must have a valid Social Security Number, Alien Registration Number, and/or I-94 Number. Enter all numbers you hold below.</p>		
Social Security Number		
Alien Registration Number		
Form I-94 (Arrival-Departure Record)		
<p>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 as well as to the Nebraska Department of Revenue, Department of Labor and for other Administrative purposes.</p>		
<p><b>NAME CHANGES:</b> If your name has changed, you must submit a photocopy of marriage certificate, court order, etc., to provide proof of legal name. If not submitted, the license will be issued in the name currently listed on your license.</p>		

**ONLINE LICENSE RENEWAL:** You may renew your license online at <https://nebraska.mylicense.com/>. To register you will need your license number, your social security number and a credit or debit card with a MasterCard, Visa, or Discover logo.

**INACTIVE STATUS:** If you choose not to renew your license, you may select Inactive Status. Inactive means that you may represent yourself as having an inactive license. To change from Inactive to Active Status, you **MUST** contact this office for an application and meet the reinstatement requirements which are in effect at the time the status change is requested.

**Primary State of Residence:**

**Nebraska is a member of the Nurse Licensure Compact for RN and LPN licensure.** As a condition of licensure in a compact state, you are required to declare your primary state of residence.

**You MUST declare your primary state of residence during EACH renewal.** This state is referred to as your home state under the Nurse Licensure Compact and means that it is your declared fixed permanent and principal home for legal purposes and is your domicile. Indicators of a domicile include, but are not limited to, where real property is located, where the person pays state taxes, votes, is licensed to operate a motor vehicle, etc.

**MY CURRENT PRIMARY STATE OF RESIDENCE IS: \_\_\_\_\_ (Name of State)**

\_\_\_\_ I am employed exclusively in the US Military (Active Duty) or with the US Federal Government and am requesting a single state license regardless of my primary state of residence.

**Conviction/Discipline Questions:**

1	<p>Were you convicted of a misdemeanor or felony in any state/jurisdiction between <b>11/01/2015 and 10/31/2017?</b> If you answer <b>YES</b> to this question, you must submit the following documents to the Licensure Unit:</p> <ul style="list-style-type: none"> <li>A list of any misdemeanor or felony convictions;</li> <li>A copy of the court record, which includes charges and disposition;</li> <li>Explanation of the events leading to the conviction (what, when, where, why) and a summary of actions you have taken to address the behaviors/actions related to the convictions;</li> <li>All addiction/mental health evaluations and proof of treatment, if the conviction involved a drug and/or alcohol related offense and if treatment was obtained and/or required; and</li> <li>A letter from the probation officer addressing probationary conditions and current status, if you are currently on probation.</li> </ul>	<input type="checkbox"/> Yes <input type="checkbox"/> No
2a	<p>Have you held a credential that was issued by another state/jurisdiction(s) to provide health-related services or environmental services? (If you answer <b>NO</b> to 2a, answer <b>NO</b> to 2b)</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
2b	<p>Has this license been denied, refused renewal, or disciplined between <b>11/01/2015 AND 10/31/2017?</b> (If "YES", please provide a list of any disciplinary actions taken against your license and a copy of the disciplinary action(s).)</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Continuing Education (CE):** Do NOT submit CE Certificates to this office unless they are requested

You **MUST** have **completed education, between 11/01/2015 AND 10/31/2017** in order for your license to be renewed to ACTIVE status (not required if you request inactive status) or be eligible for a waiver. **Please check ONE of the following:**

<input type="checkbox"/>	<b>Waiver:</b> I received my LPN License within the past 24 months ( <b>issued after 10/31/2015</b> ). NOTE: Continuing education is not required.
<input type="checkbox"/>	I have graduated from a <u>nursing</u> program in more than 2, but less than 5 years ( <b>between 11/01/2012 and 10/31/2015</b> ) AND have completed at least 20 contact hours of acceptable continuing education/in-service within the past 2 years ( <b>between 11/01/2015 and 10/31/2017</b> ). Of the 20 hours, no more than 4 hours are from CPR and BLS, and at least 10 hours are peer reviewed.
<input type="checkbox"/>	I have practiced nursing for at least 500 hours during the past 5 years ( <b>between 11/01/2012 and 10/31/2017</b> ) AND completed at least 20 contact hours of acceptable continuing education/in-service education within the past 2 years ( <b>between 11/01/2015 and 10/31/2017</b> ). Of the 20 hours attested to, no more than 4 hours are from CPR and BLS, and at least 10 hours are peer reviewed.
<input type="checkbox"/>	I have completed a board-approved refresher course within the last 5 years ( <b>between 11/01/2012 and 10/31/2017</b> ).
<input type="checkbox"/>	I have obtained/maintained current certification in a nursing specialty granted by a nationally recognized certifying organization.
<input type="checkbox"/>	I have developed and maintained a portfolio that includes my current continuing competency goals and evidence/verification of professional activities to meet those goals. Such evidence may include, but not be limited to, specialized training or experiences, continuing education, employer performance evaluation, or other evidence of demonstrated competency. <b>This is not the same as having your 500 work hours and 20 contact hours.</b>
<input type="checkbox"/>	<b>Waiver:</b> I have practiced nursing for at least 500 hours during the past 5 years ( <b>between 11/01/2012 and 10/31/2017</b> ). I request a waiver of the continuing education/in-service requirement due to: _____ military assignment in a location where continuing education/in-service is not available _____ living outside of the USA and continuing education is not available _____ serving as a missionary in a foreign country
<input type="checkbox"/>	<b>Military Waiver: After 10/31/2015</b> I have served full-time duty in the active military service 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. Military service may also include any period during which a service member is absent from duty on account of sickness, wounds, leave, or other lawful cause. <b>If you meet this waiver, you are not required to pay the renewal fee or meet the continuing education requirements. You must submit copies of your active service papers.</b>

**Attestation:** 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.e.: permanent resident (green) card, I-94 document, asylum, etc.)

I am a nonimmigrant lawfully present in the United States. (i.e.: permanent resident (green) card, I-94 document, asylum, etc.)

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. (i.e.: DACA, pending asylum, pending refugee, etc.)

**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.)

If you are **NOT a citizen of the United States**, you must submit proof of lawful presence in the U.S. Your certificate will NOT be renewed until such proof is received by our office and verified through the Department of Homeland Security (may take 4-6 weeks).

**Signature and Application Attestation:** I attest that:

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

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Phone/Fax (Optional): \_\_\_\_\_ E-mail (Optional): \_\_\_\_\_

**NOTE:** If you have any criminal charges or license disciplinary actions pending that result in a misdemeanor or felony conviction or license discipline, you must report these to the Investigative Unit within 30 days of the conviction/action (Neb. Rev. Stat. 38-1,125). Failure to disclose any such convictions/license discipline could result in disciplinary action. Report to: [www.dhhs.ne.gov/Pages/reg\\_investi.aspx](http://www.dhhs.ne.gov/Pages/reg_investi.aspx)

**Disaster Response Volunteers Needed:** In an emergency event, your skills and abilities could be in great demand. The State of Nebraska Medical and Health Volunteer registry allows you to register as a healthcare volunteer before disaster strikes. This secure system allows disaster response officials to quickly identify those healthcare professionals necessary to meet the needs of a disaster or emergency situation. Your professional skills can then best be put to use in a coordinated and efficient manner, while granting you additional legal protection under the Nebraska Emergency Management Act (see Neb. Rev. Statute 81-829.36).

Registration only takes a moment and does not obligate you to respond to any future disasters; instead, registration allows you to be contacted for your availability during a local, state, or national emergency. Saving lives in an effective response to an emergency or disaster often depends on quickly identifying and contacting volunteer healthcare professionals such as yourself who have the specific skills necessary to care for people who are injured or ill. Please take a moment to register at: <https://volunteers.ne.gov/ESAR-VHP/faces/jsp/login.jsp>

# Practical Nursing Workforce Survey 2017

<b>1. What is your license #?</b> _____			
<b>2. What is your race?</b>  <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Black/African American <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Other _____	<b>2. a. Hispanic origin or descent?</b>  <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>2. b. If you speak another language other than English, please indicate.</b>  <input type="checkbox"/> Spanish <input type="checkbox"/> German <input type="checkbox"/> French <input type="checkbox"/> Other	<b>2. c. Are you fluent in sign language?</b>  <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>3. Where was the location of the basic nursing education program that prepared you to take the LPN licensing examination?</b>  <input type="checkbox"/> Nebraska <input type="checkbox"/> Other State or US territory  <input type="checkbox"/> Foreign country	<b>4. Which nursing education programs have you completed? (Mark all that apply)</b>  <input type="checkbox"/> Practical Nursing Program Diploma  <input type="checkbox"/> Vocational/Practical Nursing Certificate		
<b>5. Are you currently enrolled in a nursing education program leading to a degree/certificate?</b>  <input type="checkbox"/> Not currently enrolled <input type="checkbox"/> Baccalaureate Degree Program <input type="checkbox"/> Associate Degree Program <input type="checkbox"/> Master's Degree Program <input type="checkbox"/> Diploma Program <input type="checkbox"/> Other _____	<b>6. If you have a non-nursing degree(s), did you earn this degree <u>before</u> entering your basic nursing education program that prepared you for LPN licensure?</b>  <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>7. Which of the following best describes your current primary work situation? (Select one).</b>  <input type="checkbox"/> <b>Actively employed in nursing:</b> <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Per diem  <input type="checkbox"/> <b>Working in nursing only as a volunteer</b>	<input type="checkbox"/> <b>Actively employed in a field other than nursing:</b> <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Per diem  <input type="checkbox"/> <b>Unemployed:</b> <input type="checkbox"/> Seeking work as a nurse <input type="checkbox"/> Not seeking work as a nurse <input type="checkbox"/> Retired	<b>8. If unemployed, please indicate the reasons:</b>  <input type="checkbox"/> Taking care of home and family <input type="checkbox"/> Disabled <input type="checkbox"/> Inadequate Salary <input type="checkbox"/> School <input type="checkbox"/> Difficulty in finding a nursing position <input type="checkbox"/> Other	

9a. I have successfully completed a Nebraska approved LPN-C course and will submit evidence of completing the course to [dhhs.nursingrenewals@nebraska.gov](mailto:dhhs.nursingrenewals@nebraska.gov) (this includes LPN program graduates after May 1, 2016).

Yes  No

9b. I have completed an 8-hour IV therapy didactic course in Nebraska and will submit verification of completion to [dhhs.nursingrenewals@nebraska.gov](mailto:dhhs.nursingrenewals@nebraska.gov)

Yes  No

9c. I have completed an IV therapy course in another state and have licensed in Nebraska by endorsement and will submit verification of completion of an IV course to [dhhs.nursingrenewals@nebraska.gov](mailto:dhhs.nursingrenewals@nebraska.gov)

Yes  No

9d. If you answered NO to question 9a, 9b or 9c, you will be required to complete an 8 hour IV theory course over the next five years to maintain your LPN license. I acknowledge the new requirement.

Yes  NA

Please answer questions 10 - 28 only if you are actively employed in nursing.

10. In how many positions are you currently employed as a nurse?

1  2  3 or more

11. What is the average number of hours worked during a typical week in nursing positions?

HOUR	

12. Please indicate the zip code, county and state of your PRIMARY EMPLOYER:

ZIP CODE				

County \_\_\_\_\_ State \_\_\_\_\_

13. How many miles do you travel one way to get to work at your principal nursing employment?

0 – 5 miles  21 – 30 miles  
 6 – 10 miles  31 – 50 miles  
 11 – 20 miles  > 50 miles

14. a. What is your current annual salary for all nursing employment?

<input type="checkbox"/> Less than \$5,000	<input type="checkbox"/> At least \$45,000 but less than \$55,000
<input type="checkbox"/> 5,000 - \$25,000	<input type="checkbox"/> At least \$55,000 but less than \$65,000
<input type="checkbox"/> More than \$25,000 but less than \$35,000	<input type="checkbox"/> At least \$65,000, but less than \$85,000
<input type="checkbox"/> At least \$35,000 but less than \$45,000	<input type="checkbox"/> At least \$85,000, but less than \$105,000
	<input type="checkbox"/> 105,000 and more

15.a. Please identify the type of setting that most closely corresponds to your PRIMARY nursing practice position:

<input type="checkbox"/> Academic Setting	<input type="checkbox"/> Hospital
<input type="checkbox"/> Ambulatory Care Setting	<input type="checkbox"/> Insurance
<input type="checkbox"/> Assisted Living Facility	<input type="checkbox"/> Nursing Home/Extended
<input type="checkbox"/> Community Health	<input type="checkbox"/> Occupational Health
<input type="checkbox"/> Correctional Facility	<input type="checkbox"/> Other
<input type="checkbox"/> Dialysis	<input type="checkbox"/> Policy/Planning/Regulatory
<input type="checkbox"/> Home Health	<input type="checkbox"/> Public Health
<input type="checkbox"/> Hospice	<input type="checkbox"/> School Health Service

14. b. What is your average hourly wage for your primary nursing position? \_\_\_\_\_

15.b. Please identify the position title that most closely corresponds to your PRIMARY nursing practice position:

<input type="checkbox"/> Staff Nurse	<input type="checkbox"/> Nurse Manager
<input type="checkbox"/> Consultant	<input type="checkbox"/> Nurse Faculty/ educator
<input type="checkbox"/> Nurse Researcher	<input type="checkbox"/> Other

15.c. Please identify the employment specialty that most closely corresponds to your PRIMARY nursing practice position:

<input type="checkbox"/> Acute Care/Critical Care	<input type="checkbox"/> Medical Surgical	<input type="checkbox"/> Public Health
<input type="checkbox"/> Adult Health	<input type="checkbox"/> Occupational Health	<input type="checkbox"/> Rehabilitation
<input type="checkbox"/> Anesthesia	<input type="checkbox"/> Oncology	<input type="checkbox"/> School Health
<input type="checkbox"/> Community	<input type="checkbox"/> Other	<input type="checkbox"/> Tele-health
<input type="checkbox"/> Family Health	<input type="checkbox"/> Palliative Care	<input type="checkbox"/> Trauma
<input type="checkbox"/> Geriatric/Gerontology	<input type="checkbox"/> Pediatrics/Neonatal	<input type="checkbox"/> Women's Health
<input type="checkbox"/> Home Health	<input type="checkbox"/> Primary Care	
<input type="checkbox"/> Maternal-Child Health	<input type="checkbox"/> Psychiatric/Mental Health/ Substance Abuse	

16.a. Please identify the type of setting that most closely corresponds to your SECONDARY nursing practice position:

- |   |   |
|---|---|
| <input type="checkbox"/> Academic Setting         | <input type="checkbox"/> Hospital                   |
| <input type="checkbox"/> Ambulatory Care Setting  | <input type="checkbox"/> Insurance                  |
| <input type="checkbox"/> Assisted Living Facility | <input type="checkbox"/> Nursing Home/Extended      |
| <input type="checkbox"/> Community Health         | <input type="checkbox"/> Occupational Health        |
| <input type="checkbox"/> Correctional Facility    | <input type="checkbox"/> Other                      |
| <input type="checkbox"/> Dialysis                 | <input type="checkbox"/> Policy/Planning/Regulatory |
| <input type="checkbox"/> Home Health              | <input type="checkbox"/> Public Health              |
| <input type="checkbox"/> Hospice                  | <input type="checkbox"/> School Health Service      |

16.b. Please identify the position title that most closely corresponds to your SECONDARY nursing practice position:

- |   |  |
|---|--|
| <input type="checkbox"/> Staff Nurse      | <input type="checkbox"/> Nurse Manager           |
| <input type="checkbox"/> Consultant       | <input type="checkbox"/> Nurse Faculty/ educator |
| <input type="checkbox"/> Nurse Researcher | <input type="checkbox"/> Other                   |

16.c. Please identify the employment specialty that most closely corresponds to your SECONDARY nursing practice position:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Acute Care/Critical Care | <input type="checkbox"/> Medical Surgical                           | <input type="checkbox"/> Public Health  |
| <input type="checkbox"/> Adult Health             | <input type="checkbox"/> Occupational Health                        | <input type="checkbox"/> Rehabilitation |
| <input type="checkbox"/> Anesthesia               | <input type="checkbox"/> Oncology                                   | <input type="checkbox"/> School Health  |
| <input type="checkbox"/> Community                | <input type="checkbox"/> Other                                      | <input type="checkbox"/> Tele-health    |
| <input type="checkbox"/> Family Health            | <input type="checkbox"/> Palliative Care                            | <input type="checkbox"/> Trauma         |
| <input type="checkbox"/> Geriatric/Gerontology    | <input type="checkbox"/> Pediatrics/Neonatal                        | <input type="checkbox"/> Women's Health |
| <input type="checkbox"/> Home Health              | <input type="checkbox"/> Primary Care                               |   |
| <input type="checkbox"/> Maternal-Child Health    | <input type="checkbox"/> Psychiatric/Mental Health/ Substance Abuse |   |

**Questions #17 through #24 ask about your satisfaction level with your nursing career**

17. What do you like **MOST** about your principal nursing employment? (Select one)

- |  |   |
|--|---|
| <input type="checkbox"/> Benefits (insurance, paid vacation, retirement, etc.) | <input type="checkbox"/> Hours/schedule                               |
| <input type="checkbox"/> Location  | <input type="checkbox"/> People for whom I provide service (patients) |
| <input type="checkbox"/> People with whom I work (co-workers)                  | <input type="checkbox"/> Salary                                       |
| <input type="checkbox"/> Work itself   | <input type="checkbox"/> Other _____                                  |

18. What do you like **LEAST** about your principal nursing employment? (Select one)

- |  |   |
|--|---|
| <input type="checkbox"/> Benefits (insurance, paid vacation, retirement, etc.) | <input type="checkbox"/> Hours/schedule                               |
| <input type="checkbox"/> Location  | <input type="checkbox"/> People for whom I provide service (patients) |
| <input type="checkbox"/> People with whom I work (co-workers)                  | <input type="checkbox"/> Salary                                       |
| <input type="checkbox"/> Work itself   | <input type="checkbox"/> Nothing, there isn't anything I don't like   |
|  | <input type="checkbox"/> Other _____                                  |

19. How likely are you to leave your principal employment in the next 12 months?

- |  |  |  |                                      |
|--|--|--|--------------------------------------|
| <input type="checkbox"/> Very unlikely | <input type="checkbox"/> Somewhat unlikely | <input type="checkbox"/> Somewhat likely | <input type="checkbox"/> Very likely |
|--|--|--|--------------------------------------|

20. If very likely or somewhat likely that you will leave your principal employment in the next 12 months, what is the main reason? (Select one)

- |  |   |
|--|---|
| <input type="checkbox"/> Dissatisfaction with job                                    | <input type="checkbox"/> Retirement           |
| <input type="checkbox"/> Dissatisfaction with salary                                 | <input type="checkbox"/> Returning to school  |
| <input type="checkbox"/> Family/personal leave                                       | <input type="checkbox"/> Obtaining RN license |
| <input type="checkbox"/> Lack of opportunity for upward mobility in the organization | <input type="checkbox"/> Does not apply to me |
|  | <input type="checkbox"/> Other _____          |

21. How satisfied are you with your current job?

- |   |   |                                       |  |
|---|---|---------------------------------------|--|
| <input type="checkbox"/> Very Satisfied | <input type="checkbox"/> Somewhat Satisfied | <input type="checkbox"/> Dissatisfied | <input type="checkbox"/> Very Dissatisfied |
|---|---|---------------------------------------|--|

22. If you had to do it over, would you choose nursing as a career?

- Yes  No

23. Would you encourage others to choose nursing as a career?

- Yes  No

24. How satisfied are you with nursing as a career?

	<input type="checkbox"/> Very Satisfied <input type="checkbox"/> Somewhat Satisfied <input type="checkbox"/> Dissatisfied <input type="checkbox"/> Very Dissatisfied
25. Please list all states in which you hold an active license to practice as an LPN:  _____	26. Please list all states in which you are currently practicing:  _____
27. Do you utilize tele-health in your primary or secondary positions?  <input type="checkbox"/> Yes <input type="checkbox"/> No	28. If yes, when utilizing tele-health, are patients ever located in a different state?  <input type="checkbox"/> Yes <input type="checkbox"/> No

**THANK YOU FOR COMPLETING THE SURVEY!**