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

Division of Public Health
Licensure Unit
PO Box 94986
Lincoln, NE 68509-4986
402-471-4376

Email: dhhs.nursingrenewals@nebraska.gov Fax: (402) 742-1163

RENEWAL NOTICE
Licensed Practical Nurse (LPN)
EXPIRES 10/31/2017

License Information:

Your renewal application and fee (if applicable) must be POSTMARKED ON OR BEFORE **10-31-2017 to avoid expiration of your license. 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.

License #:	
Legal Name:	
Address: ☐ Check if this is a NEW Address	
City/State/Zip:	

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.

Social Security Number	
Alien Registration Number	
Form I-94 (Arrival-Departure Record)	

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.

YOU MUST CHECK A BOX BELOW:

☐ ACTIVE $123.00
☐ INACTIVE (no fee required)

☐ MILITARY WAIVER (no fee required)

Make payable to:

DHHS
Licensure Unit

(You will not receive receipt)

NAME CHANGES: 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.

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	Were you convicted of a misdemeanor or felony in any state/jurisdiction between **11/01/2015 and 10/31/2017?** If you answer **YES** to this question, you must submit the following documents to the Licensure Unit: • A list of any misdemeanor or felony convictions; • A copy of the court record, which includes charges and disposition; • 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; • 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 • A letter from the probation officer addressing probationary conditions and current status, if you are currently on probation.	☐ Yes ☐ No
2a	Have you held a credential that was issued by another state/jurisdiction(s) to provide health-related services or environmental services? (If you answer NO to 2a, answer NO to 2b)	☐ Yes ☐ No
2b	Has this license been denied, refused renewal, or disciplined between **11/01/2015 AND 10/31/2017?** (If "YES", please provide a list of any disciplinary actions taken against your license and a copy of the disciplinary action(s).	☐ Yes ☐ 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:**

☐	**Waiver:** I received my LPN License within the past 24 months (**issued after 10/31/2015)**. NOTE: Continuing education is not required.
☐	I have graduated from a nursing program in more than 2, but less than 5 years (**between 11/01/2012 and 10/31/2015**) AND have completed at least 20 contact hours of acceptable continuing education/in-service within the past 2 years (**between 11/01/2015 and 10/31/2017**). Of the 20 hours, no more than 4 hours are from CPR and BLS, and at least 10 hours are peer reviewed.
☐	I have practiced nursing for at least 500 hours during the past 5 years (**between 11/01/2012 and 10/31/2017**) AND completed at least 20 contact hours of acceptable continuing education/in-service education within the past 2 years (**between 11/01/2015 and 10/31/2017**). Of the 20 hours attested to, no more than 4 hours are from CPR and BLS, and at least 10 hours are peer reviewed.
☐	I have completed a board-approved refresher course within the last 5 years (**between 11/01/2012 and 10/31/2017**).
☐	I have obtained/maintained current certification in a nursing specialty granted by a nationally recognized certifying organization.
☐	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. **This is not the same as having your 500 work hours and 20 contact hours.**
☐	**Waiver:** I have practiced nursing for at least 500 hours during the past 5 years (**between 11/01/2012 and 10/31/2017**). 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
☐	**Military Waiver: After 10/31/2015** 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. **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.**

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:**

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: _____ 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

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

1. What is your license #? _____

2. What is your race?

☐ White/Caucasian
☐ Black/African American
☐ Asian
☐ Native Hawaiian or Other Pacific Islander
☐ American Indian or Alaska Native
☐ Other_____

2. a. Hispanic origin or descent?

☐ Yes ☐ No

2. b. If you speak another language other than English, please indicate.

☐ **Spanish** ☐ **German** ☐ **French** ☐ **Other**

2. c. Are you fluent in sign language?

☐ Yes ☐ No

3. Where was the location of the basic nursing education program that prepared you to take the LPN licensing examination?

☐ **Nebraska** ☐ **Other State or US territory**

☐ **Foreign country**

4. Which nursing education programs have you completed? (Mark all that apply)

☐ Practical Nursing Program Diploma

☐ Vocational/Practical Nursing Certificate

5. Are you currently enrolled in a nursing education program leading to a degree/certificate?

☐ Not currently enrolled
☐ Associate Degree Program
☐ Diploma Program
☐ Baccalaureate Degree Program
☐ Master's Degree Program
☐ Other

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?

☐ Yes ☐ No

7. Which of the following best describes your current primary work situation? (Select one).

☐ **Actively employed in nursing:**
- ☐ Full-time
- ☐ Part-time
- ☐ Per diem

☐ **Actively employed in a field other than nursing:**
- ☐ Full-time
- ☐ Part-time
- ☐ Per diem

☐ **Unemployed:**
- ☐ Seeking work as a nurse
- ☐ Not seeking work as a nurse

☐ **Retired**

☐ **Working in nursing only as a volunteer**

8. If unemployed, please indicate the reasons:

☐ Taking care of home and family
☐ Inadequate Salary
☐ Difficulty in finding a nursing position
☐ Disabled
☐ School
☐ 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 (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

☐ 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

☐ 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?

# of H O U RS _____

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?

☐ Less than $5,000
☐ 5,000 - $25,000
☐ More than $25,000 but less than $35,000
☐ At least $35,000 but less than $45,000
☐ At least $45,000 but less than $55,000
☐ At least $55,000 but less than $65,000
☐ At least $65,000 but less than $85,000
☐ At least $85,000, but less than $105,000
☐ $105,000 and more

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

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

☐ Academic Setting
☐ Ambulatory Care Setting
☐ Assisted Living Facility
☐ Community Health Facilty
☐ Correctional Facility
☐ Dialysis
☐ Home Health
☐ Hospice
☐ Hospital
☐ Insurance
☐ Nursing Home/Extended
☐ Occupational Health
☐ Other
☐ Policy/Planning/Regulatory
☐ Public Health
☐ School Health Service

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

☐ Staff Nurse
☐ Consultant
☐ Nurse Researcher
☐ Nurse Manager
☐ Nurse Faculty/ educator
☐ Other

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

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

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

- ☐ Academic Setting
- ☐ Ambulatory Care Setting
- ☐ Assisted Living Facility
- ☐ Community Health
- ☐ Correctional Facility
- ☐ Dialysis
- ☐ Home Health
- ☐ Hospice
- ☐ Hospital
- ☐ Insurance
- ☐ Nursing Home/Extended
- ☐ Occupational Health
- ☐ Other
- ☐ Policy/Planning/Regulato
- ☐ Public Health
- ☐ School Health Service

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

- ☐ Staff Nurse
- ☐ Consultant
- ☐ Nurse Researcher
- ☐ Nurse Manager
- ☐ Nurse Faculty/ educator
- ☐ Other

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

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

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)

- ☐ Benefits (insurance, paid vacation, retirement, etc.)
- ☐ Location
- ☐ People with whom I work (co-workers)
- ☐ Work itself
- ☐ Hours/schedule
- ☐ People for whom I provide service (patients)
- ☐ Salary
- ☐ Other_____

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

- ☐ Benefits (insurance, paid vacation, retirement, etc.)
- ☐ Location
- ☐ People with whom I work (co-workers)
- ☐ Work itself
- ☐ Hours/schedule
- ☐ People for whom I provide service (patients)
- ☐ Salary
- ☐ Nothing, there isn't anything I don't like
- ☐ Other_____

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

☐ **Very unlikely** ☐ **Somewhat unlikely** ☐ **Somewhat likely** ☐ 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)

- ☐ Dissatisfaction with job
- ☐ Dissatisfaction with salary
- ☐ Family/personal leave
- ☐ Lack of opportunity for upward mobility in the organization
- ☐ Retirement
- ☐ Returning to school
- ☐ Obtaining RN license
- ☐ Does not apply to me
- ☐ Other

21. How satisfied are you with your current job?

☐ **Very Satisfied** ☐ **Somewhat Satisfied** ☐ **Dissatisfied** ☐ 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?

	☐ **Very Satisfied** ☐ **Somewhat Satisfied** ☐ **Dissatisfied** ☐ 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? ☐ Yes ☐ No	**28. If yes, when utilizing tele-health, are patients ever located in a different state?** ☐ Yes ☐ No

THANK YOU FOR COMPLETING THE SURVEY!