



RENEWAL NOTICE

Licensed Practical Nurse (LPN)

Your Licensed Practical Nurse credential EXPIRES 10/31/2015. THE RENEWAL FEE OF \$123.00 AND THIS DOCUMENT MUST BE POSTMARKED ON OR BEFORE 10/31/2015 to avoid expiration of your credential and removal of authorization to practice. An administrative penalty of \$10 per day up to \$1,000 will be assessed for practicing after your credential expires.

YOU MUST CHECK A BOX BELOW:

- ACTIVE \$123.00
- INACTIVE (no fee required)
- MILITARY WAIVER (no fee required)

Make check payable to:
 DHHS – Licensure Unit
 (you will not receive a receipt)

License #:	
Name:	
Address: <input type="checkbox"/> CHECK IF NEW ADDRESS	
City/State/Zip:	

TWO-YEAR RENEWAL

NAME & ADDRESS CHANGES: If your name or address is incorrect, cross out the incorrect information and print the correction. For name changes, you must submit a photocopy of marriage certificate, court order, etc., to provide proof of legal name. If not submitted, the credential will be issued in the name as printed above.

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

INACTIVE STATUS: If you elect not to renew your credential, you may select Inactive Status. Inactive means that you cannot practice but may represent yourself as having an inactive credential. 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.

MILITARY WAIVER OF FEE: If you have served in the regular armed forces of the United States or are actively engaged in military service (active duty for at least 30 days) during part of the 24 months immediately preceding the biennial licensure renewal date, you may request a waiver of the renewal fee. If you meet this exemption, **you must submit a copy of the military orders.**

PRIMARY STATE OF RESIDENCE: Nebraska is a member of the Nurse Licensure Compact. **As a condition of licensure in a compact state, you are required to declare your primary state of residence. You may only hold ONE license with compact privileges which is issued by the compact state where you hold a primary residence.**

- If you declare NEBRASKA as your primary state of residence, you will be issued a multi-state license, which will allow you to practice in ANY COMPACT STATE.
- If you declare another COMPACT STATE as your primary state of residence you cannot renew your Licensed Practical Nurse license in Nebraska unless you are employed in a federal facility. If you are not a federal employee, you must obtain a new multi-state license in the new state of your primary residence.
- If you declare a NON-COMPACT STATE as your primary state of residence, you will be issued a Nebraska single-state license which authorizes you to practice only in Nebraska.

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.

1	To renew your credential, you must have a valid Social Security Number, Alien Registration Number, and/or I-94 Number. Enter your number below. 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.	
	Social Security Number Alien Registration Number Form I-94 (Arrival-Departure Record)	<input style="width: 100%; height: 20px;" type="text"/> <input style="width: 100%; height: 20px;" type="text"/> <input style="width: 100%; height: 20px;" type="text"/>
2	Were you convicted of a misdemeanor or felony in any jurisdiction between 11/1/13 and 10/31/15 that was not previously reported? If you answer YES to this question, you must submit the following documents to the Licensure Unit: <ul style="list-style-type: none"> • A list of any misdemeanor or felony convictions; • A copy of the court record, which includes charges and disposition; 	<input type="checkbox"/> Yes <input type="checkbox"/> No

	<ul style="list-style-type: none"> • 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; 	
3a	Have you held a credential that was issued by another jurisdiction(s) to provide health services, health-related services, or environmental services?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3b	Has such credential been denied, refused renewal, or disciplined between 10/31/2013 AND 10/31/2015? (If "YES", please provide a list of any disciplinary actions taken against your credential and a copy of the disciplinary action(s), including charges and disposition.	<input type="checkbox"/> Yes <input type="checkbox"/> No

NOTE: If you have any criminal charges or credential disciplinary actions pending that result in misdemeanor or felony conviction or credential discipline, you must report such actions to this Department within 30 days of the conviction/action (Neb. Rev. Stat. 38-1,125). Failure to disclose any such convictions/credential discipline could result in disciplinary action.

***** Do NOT submit continuing competency certificates to this office unless they are requested *****

CONTINUING COMPETENCY REQUIREMENTS: You **MUST** have **completed education, between 11/01/2013 AND 10/31/2015** in order for your credential to be renewed to **ACTIVE** status (not required if you request inactive status). **Please check ONE of the following:**

<input type="checkbox"/>	I have graduated from a <u>nursing</u> program within the last 2 years (Between 11/1/13 and 10/31/15)
<input type="checkbox"/>	I have graduated from a <u>nursing</u> program in more than 2, but less than 5 years (Between 11/1/10 and 10/31/13) AND have completed at least 20 contact hours of acceptable continuing education/in-service within the past 2 years (Between 11/1/13 and 10/31/15). 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 (Between 11/1/10 and 10/31/15) AND completed at least 20 contact hours of acceptable continuing education/in-service education within the past 2 years (Between 11/1/13 and 10/31/15). 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 (Between 11/1/10 and 10/31/15).
<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. This is not the same as having your 500 work hours and 20 contact hours.
<input type="checkbox"/>	I have practiced nursing for at least 500 hours during the past 5 years. (Between 11/1/10 and 10/31/15) 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 _____; or serving as a missionary in a foreign country _____.

PLEASE COMPLETE THE FOLLOWING ATTESTATIONS: (All Credential holders complete this section and **must sign and date this form.**)

For the purpose of complying with Neb. Rev. Stat. §38-129, I attest as follows:

Please check **ONLY ONE** of the boxes below. **If you are a US citizen Please check only the first box.**

- 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).

Your credential will **NOT** be renewed 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.

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: _____

Phone/Fax (Optional): _____ E-mail (Optional): _____

Practical Nursing Workforce Survey 2015

1. What is your license #?	_____
2. What is your race? <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 _____	2.a. Hispanic origin or descent? <input type="checkbox"/> Yes <input type="checkbox"/> No
2.b. If you speak another language other than English, please indicate. <input type="checkbox"/> Spanish <input type="checkbox"/> German <input type="checkbox"/> French	2.c. Are you fluent in sign language? <input type="checkbox"/> Yes <input type="checkbox"/> No
3. Where was the location of the basic nursing education program that prepared you to take the LPN licensing examination? <input type="checkbox"/> Nebraska <input type="checkbox"/> Other State or US territory <input type="checkbox"/> Foreign country	4. Which nursing education programs have you completed? (Mark all that apply) <input type="checkbox"/> Practical Nursing Program Diploma <input type="checkbox"/> Practical Nursing Program – Associate Degree
5. Are you currently enrolled in a nursing education program leading degree/certificate? <input type="checkbox"/> Not currently enrolled <input type="checkbox"/> Master's Degree Program <input type="checkbox"/> Associate Degree Program <input type="checkbox"/> Master's degree-other field <input type="checkbox"/> Associate degree-other field <input type="checkbox"/> Diploma Program <input type="checkbox"/> Baccalaureate Degree Program <input type="checkbox"/> Baccalaureate degree-other field <input type="checkbox"/> Other (please specify): _____	6. If you have a non-nursing degree(s), did you earn this degree before entering your basic nursing education program that prepared you for LPN licensure? <input type="checkbox"/> Yes <input type="checkbox"/> No
	7. Are you currently an LPN-C? (LPN certified for IV therapy) <input type="checkbox"/> Yes <input type="checkbox"/> No
	8. If yes, are you currently working in that role? <input type="checkbox"/> Yes <input type="checkbox"/> No
9. Which of the following best describes your current primary work situation? (Select one). <input type="checkbox"/> Actively employed in nursing: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Per diem <input type="checkbox"/> Working in nursing only as a volunteer	10. If unemployed, please indicate the reasons: <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, please specify _____
<input type="checkbox"/> Actively employed in a field other than nursing: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Per diem <input type="checkbox"/> Unemployed: <input type="checkbox"/> Seeking work as a nurse <input type="checkbox"/> Not seeking work as a nurse <input type="checkbox"/> Retired	<p style="text-align: center;"><i>Please answer questions 11 - 29 only if you are actively employed in nursing.</i></p>

<p>11. In how many positions are you currently employed as a nurse?</p> <p><input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 or more</p>	<p>12. How many hours do you work during a typical week in all your nursing positions?</p> <table border="1" style="margin-left: auto; margin-right: auto; border-collapse: collapse;"> <tr> <th colspan="2" style="padding: 2px;">HOURS</th> </tr> <tr> <td style="width: 30px; height: 20px;"></td> <td style="width: 30px; height: 20px;"></td> </tr> </table>	HOURS																														
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<p>13. Please indicate the zip code, county and state of your PRIMARY EMPLOYER:</p> <table border="1" style="margin-left: auto; margin-right: auto; border-collapse: collapse;"> <tr> <th colspan="5" style="padding: 2px;">ZIP CODE</th> </tr> <tr> <td style="width: 20px; height: 20px;"></td> </tr> </table> <p style="margin-left: 100px;"> <input type="text"/> County <input type="text"/> State </p>	ZIP CODE										<p>14. How many miles do you travel one way to get to work at your principal nursing employment?</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> 0 – 5 miles</td> <td><input type="checkbox"/> 21 – 30 miles</td> </tr> <tr> <td><input type="checkbox"/> 6 – 10 miles</td> <td><input type="checkbox"/> 31 – 50 miles</td> </tr> <tr> <td><input type="checkbox"/> 11 – 20 miles</td> <td><input type="checkbox"/> > 50 miles</td> </tr> </table>	<input type="checkbox"/> 0 – 5 miles	<input type="checkbox"/> 21 – 30 miles	<input type="checkbox"/> 6 – 10 miles	<input type="checkbox"/> 31 – 50 miles	<input type="checkbox"/> 11 – 20 miles	<input type="checkbox"/> > 50 miles															
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<p>15. What is your current annual salary for all nursing employment?</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Less than \$5,000</td> <td><input type="checkbox"/> At least \$45,000 but less than \$55,000</td> </tr> <tr> <td><input type="checkbox"/> 5,000 - \$25,000</td> <td><input type="checkbox"/> At least \$55,000 but less than \$65,000</td> </tr> <tr> <td><input type="checkbox"/> More than \$25,000 but less than \$35,000</td> <td><input type="checkbox"/> At least \$65,000, but less than \$85,000</td> </tr> <tr> <td><input type="checkbox"/> At least \$35,000 but less than \$45,000</td> <td><input type="checkbox"/> At least \$85,000, but less than \$105,000</td> </tr> <tr> <td></td> <td><input type="checkbox"/> 105,000 and more</td> </tr> </table>	<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	<p>16.a. Please identify the type of setting that most closely corresponds to your PRIMARY nursing practice position:</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Hospital</td> <td><input type="checkbox"/> Community Health</td> </tr> <tr> <td><input type="checkbox"/> Nursing Home/Extended Care/Assisted Living Facility</td> <td><input type="checkbox"/> School Health Service</td> </tr> <tr> <td><input type="checkbox"/> Home Health</td> <td><input type="checkbox"/> Occupational Health</td> </tr> <tr> <td><input type="checkbox"/> Correctional Facility</td> <td><input type="checkbox"/> Ambulatory Care Setting</td> </tr> <tr> <td><input type="checkbox"/> Academic Setting</td> <td><input type="checkbox"/> Insurance Claims/Benefits</td> </tr> <tr> <td><input type="checkbox"/> Public Health</td> <td><input type="checkbox"/> Policy/Planning/Regulatory/Licensing Agency</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> </tr> </table>	<input type="checkbox"/> Hospital	<input type="checkbox"/> Community Health	<input type="checkbox"/> Nursing Home/Extended Care/Assisted Living Facility	<input type="checkbox"/> School Health Service	<input type="checkbox"/> Home Health	<input type="checkbox"/> Occupational Health	<input type="checkbox"/> Correctional Facility	<input type="checkbox"/> Ambulatory Care Setting	<input type="checkbox"/> Academic Setting	<input type="checkbox"/> Insurance Claims/Benefits	<input type="checkbox"/> Public Health	<input type="checkbox"/> Policy/Planning/Regulatory/Licensing Agency		<input type="checkbox"/> Other _____							
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<p>18. What do you like MOST about your principal nursing employment? (Select one)</p> <p> <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 _____ </p>	<p>19. What do you like LEAST about your principal nursing employment? (Select one)</p> <p> <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 _____ </p>
<p>20. How likely are you to leave your principal employment in the next 12 months?</p> <p> <input type="checkbox"/> Very unlikely <input type="checkbox"/> Somewhat unlikely <input type="checkbox"/> Somewhat likely <input type="checkbox"/> Very likely </p>	<p>21. 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)</p> <p> <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 <input type="checkbox"/> Other _____ <input type="checkbox"/> Lack of opportunity for upward mobility in the organization <input type="checkbox"/> Does not apply to me </p>
<p>22. How satisfied are you with your current job?</p> <p> <input type="checkbox"/> Very Satisfied <input type="checkbox"/> Somewhat Satisfied <input type="checkbox"/> Dissatisfied <input type="checkbox"/> Very Dissatisfied </p>	<p>23. If you had to do it over, would you choose nursing as a career?</p> <p> <input type="checkbox"/> Yes <input type="checkbox"/> No </p>
<p>24. Would you encourage others to choose nursing as a career?</p> <p> <input type="checkbox"/> Yes <input type="checkbox"/> No </p>	<p>25. How satisfied are you with nursing as a career?</p> <p> <input type="checkbox"/> Very Satisfied <input type="checkbox"/> Somewhat Satisfied <input type="checkbox"/> Dissatisfied <input type="checkbox"/> Very Dissatisfied </p>
<p>26. Please list all states in which you hold an active license to practice as an LPN:</p> <p>_____</p>	<p>27. Please list all states in which you are currently practicing:</p> <p>_____</p>
<p>28. Do you utilize tele-health in your primary or secondary positions?</p> <p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure </p>	<p>29. If yes, when utilizing tele-health, are patients ever located in a different state?</p> <p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure </p>

THANK YOU FOR COMPLETING THE SURVEY!