APPLICATION FOR APPOINTMENT
PHYSICIAN ASSISTANT COMMITTEE
(MEDICAL BOARD MEMBER)

PLEASE PRINT OR TYPE
Name:

_____
First Middle Last Credentials (ie, PhD, etc., if applicable)

Mailing Address:

_____
Street/Box/RR

_____
City State Zip

Are you a resident of the State of Nebraska? Yes No

Business Telephone _____ Cell/Pager _____ Residence Telephone _____

Email Address _____ FAX Number _____

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

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

Newspaper Other (please explain)_____

ELIGIBILITY REQUIREMENTS

Do you hold a current Nebraska license to practice as a physician? Yes No Are you a resident of Nebraska? Yes No

Are you currently supervising a physician assistant in Nebraska? Yes No

What is the ending date of your current term on the Board of Medicine and Surgery? _____

Are you expecting to remain in active practice for the duration of the term if you are appointed? Yes No If no, explain.

_____

_____

Provide the number of years you have been engaged in practice as a physician assistant _____

EDUCATION

Degree/Specialty	School Name & Location	From	To	Completion Date

PLEASE COMPLETE REVERSE SIDE

DETAILED DESCRIPTION OF WORK EXPERIENCE AS A PHYSICIAN ASSISTANT WITHIN THE LAST FIVE YEARS IN NEBRASKA

Position Title	Name & Location	From	To	Average Number of Hours Per Week

ADDITIONAL INFORMATION

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

_____

_____

_____

_____

_____

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

_____

_____

Have you ever had your statutory ability to practice or clinical privileges suspended or revoked? Yes ☐ No ☐

Are you currently under investigation? Yes ☐ No ☐

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

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

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

_____ _____

Signature Date

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