APPLICATION FOR APPOINTMENT
PERFUSIONIST COMMITTEE
(PHYSICIAN MEMBER)

PLEASE PRINT OR TYPE
Name:

_____ _____
First Middle Last Credentials (ie, MD, 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 ☐

Do you have clinical experience with perfusionists? Yes ☐ No ☐

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 the practice of medicine and surgery _____

EDUCATION

Degree/Specialty	School Name & Location	From	To	Completion Date

PLEASE COMPLETE REVERSE SIDE

DETAILED DESCRIPTION OF WORK EXPERIENCE AS A PHYSICIAN WORKING WITH PERFUSIONISTS WITHIN THE LAST FIVE YEARS IN NEBRASKA

Position Title	Name & Location	From	To	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, P.O. Box 95026, Lincoln, NE 68509-5026
402/471-6515; FAX 402/471-0383; monica.gissler@nebraska.gov