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

Specialty Care Provider

Complete and return this application and all supporting documentation to one of the following:

Email (preferred method):
DHHS.EMSLicensing@nebraska.gov

Fax: (402) 742-2322

Department of Health and Human Services
Office of Emergency Health Systems
PO Box 95026
Lincoln, Nebraska 68509-5026

SECTION A – APPLICATION TYPE:	
☐	**Initial Application** as a Specialty Care Provider.
☐	**Reinstatement of Licensure** from expired, inactive status, voluntary surrender NOT related to disciplinary action. ***NOTE:*** ***Reinstatement fee of $35.00****, check or money order is required before application is processed.*

SECTION B – LICENSE TYPE: May only apply for one licensing level per application.			
☐	Critical Care Paramedic	☐	Community Care Provider
☐	Check here if your spouse is an active-duty member of the U.S. Armed Forces Stationed in Nebraska		
☐	Check here if you are an active-duty, reserve, or veteran member of the U.S. Armed Forces		

SECTION C – PERSONAL INFORMATION:			
Information in this section is public information and can be viewed at dhhs.ne.gov/lookup			
Legal First Name:		Middle/MI:	
Legal Last Name:		Maiden Name:	
Other Names you are known by (AKA):			
Current Address:	Street/Box/Route:		
	City:	State:	Zip:
This section is NOT public information			
Date of Birth:		Place of Birth:	
Primary Phone Number:		E-Mail Address:	

If you have a SSN and an A#, 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**:

SECTION D – U.S. CITIZEN/LAWFUL PRESENCE:
Applicant MUST submit a copy of one of the following for:

U.S. Citizen:

- *Birth Certificate issued by a state, county, municipal authority, or outlying possession of the U.S bearing official seal*
- *U.S. Passport (unexpired or expired)*
- *Certificate of Naturalization*
- *Other legal documents that show U.S. citizenship*
- *Driver's License and Social Security Card is* ***NOT*** *acceptable*

Not a U.S. Citizen (current immigration status):

- *Green Card (Permanent Resident Card) Form I-551(front and back copy of card)*
- *Form I-94 (Arrival-Departure Record)* ***AND*** *an unexpired foreign passport with valid unexpired U.S. Visa*
- *Employment Authorization Card* ***AND one of the following:***
  - *Approved deferred action status (DACA)*
  - *Pending U.S. asylum application*
  - *Pending or approved application for temporary protected status in the U.S.*

- *Pending application for adjustment of status to that of alien lawfully admitted for permanent residence in the U.S. or conditional permanent resident status in the U.S.*
- *Other document showing current immigration status*

NOTE: *Documents other than those showing U.S. citizenship are verified by our office through the Department of Homeland Security. This process may take 4-6 weeks.*

SECTION E – OTHER LICENSURE OR CERTFICATION

Are you now, or have you ever been licensed or certified to provide health services, health-related services, or environmental services in Nebraska?	☐ Yes	☐ No
Are you now, or have you ever been licensed or certified to provide health services, health-related services, or environmental services in another jurisdiction or state?	☐ Yes	☐ No

If you have been licensed or certified in another jurisdiction or state, provide the following information:
NOTE: If there are multiple states, please add additional pages as needed.

Jurisdiction/State:	Credential Number:	Type of Credential:	Issue Date:	Expiration Date:

Certification of all credentials held is required. (See Attachment A)

Have you practiced as an emergency care provider within the three years preceding this application?	☐ Yes	☐ No

IF YES, provide the following information:

Name of Service or Employer:	Address:	Start Date:	End Date:

Has any disciplinary action ever been taken against any license/certificate to provide health services, health-related services, or environmental services that you hold now or have held in the past by any licensing agency, or is any currently pending?	☐ Yes	☐ No

IF YES, list the action(s) and **provide a copy of the record(s)**, including charges and disposition.

Have you ever been denied a credential?	☐ Yes	☐ No

IF YES, provide an explanation of the basis for the denial.

Have you ever been denied the right to take an examination?	☐ Yes	☐ No

IF YES, provide an explanation of the basis for the denial.

SECTION F – CONVICTION INFORMATION

Please note that failure to disclose any conviction or disciplinary action, regardless of when it occurred, could result in disciplinary action, including, but not limited to, payment of a civil penalty.

For reinstatement applicants, list convictions in any jurisdiction since your license was last renewed or issued (whenever is later).

Applicant MUST provide the following documentation for each conviction:

- A **copy of the court record**, which includes charges and disposition. If a record is no longer available, provide a signed statement from the court to that effect. A printout from JUSTICE does not fulfill our requirements;
- A **letter of explanation** from you detailing the events leading to the conviction (what, when, where, and 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;
- **A letter from your probation officer** addressing probationary conditions and current status, if you are currently on probation; and
- Additional information may be requested by the Department after initial review of your application.

Have you **ever** been convicted of a misdemeanor or a felony?	☐ Yes	☐ No

IF YES, provide the following information:
NOTE: If there are multiple convictions, please add additional pages as needed.

Crime:	Date of Conviction:	Name and Location of Court:

SECTION G – PRACTICE PRIOR TO LICENSURE

An individual who practices prior to issuance of a license is subject to assessment of an administrative penalty in the amount of $10.00 per day of practice, not to exceed a total of $1,000 as provided in 38-1,116(1) or such other action as provided in the statutes and regulations governing the licensure.

Have you actively practiced as an out-of-hospital emergency medical care provider in Nebraska at the level for which you are applying prior to submitting this application?	☐ Yes	☐ No

IF YES, provide the name(s) and location(s) of practice and the number of days that you practiced there.

Name:	Location:	Number of Days:

SECTION H – Training

Nebraska Emergency Care Provider (EMT, AEMT, Paramedic) License Number:

Proof of certification is required.

Please submit documentation of International Board of Specialty Certification documentation with expiration date for:

☐ *Critical Care Paramedic must have IBSC Critical Care Paramedic CCP-C or the Flight Paramedic FP-C Certification.*
- *Must be licensed as a Nebraska paramedic.*

☐ *The Community Care Provider must have the IBSC Community Paramedicine CP-C Certification.*
- *Must have a Nebraska license as an emergency medical technician, advanced emergency medical technician, or paramedic.*

SECTION I– Attestation

Subsection 1 – For the purposes of Neb. Rev. Stat. §4-108 through 4-114 and 38-129, (*check **ONE** of the boxes below*):

I attest that I am:

- ☐ I am a citizen of the United States.
- ☐ I am NOT a citizen of the United States. I am a qualified alien under the Federal Immigration and Nationality Act or a non-immigrant lawfully present in the United States, with documentation such as a permanent resident card, I-94 document, asylum, etc.
- ☐ I am NOT a citizen of the United States. I have an unexpired Employment Authorization Document (EAD) and documentation listed under the Federal REAL ID act, such as DACA, pending asylum, pending refugee, etc.
- ☐ I am NOT a citizen of the United States, a nonimmigrant, nor a qualified alien under the Federal Immigration and Nationality Act

Subsection 2 – I further attest that:

- I have read the application, or have had the application read to me;
- All statements on the application are true and complete;
- I am of good character; and
- I have not committed any act that would be grounds for denial under UCA 38-178.
  If you have committed any act(s), you must provide an explanation of all such act(s).

Print Name: _____

Signature: _____ Date: _____

The Department:

- May request additional information as needed.
- Requires any documents written in a language other than English must be accompanied by a complete translation into the English language. The translation must be an original document and contain the notarized signature of the translator. An individual may not translate his/her own documents.

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DEPT. OF HEALTH AND HUMAN SERVICES

Request for Verification of Certification/Licensure from Another State/Jurisdiction "Attachment A"

State of Nebraska
Department of Health and Human Services
Office of Emergency Health Systems
PO Box 95026 – Lincoln, Nebraska 68509-5026
Fax: (402) 742-2322 or Email: DHHS.EMSLicensing@nebraska.gov

SECTION A – To Be Completed By The Applicant If Licensed In Another State Or Jurisdiction.
Please complete this section and send it to each agency outside of Nebraska that issued you a license or certification to provide health services, health-related services, or environmental services.

Name: _____

Social Security Number: _____ Date of Birth: _____

SECTION B – To Be Completed and Submitted By The Issuing Agency.

Our records certify that the aforementioned individual was granted License/Certificate Number _____

in the State/Jurisdiction of _____ to practice as a/an:

☐ Emergency Medical Responder ☐ Advanced Emergency Medical Technician
☐ Emergency Medical Technician ☐ Paramedic ☐ Other _____

Issuance Date: _____ Expiration Date: _____

Has this individual's certification/license ever been:

	Yes	No	
Suspended:	☐	☐	**IF YES**, explain:
Revoked:	☐	☐	**IF YES**, explain:
Other disciplinary action:	☐	☐	**IF YES**, explain:

Name and Title: _____

Licensing Agency: _____

Address: _____

City/State/Zip: _____

Signature: _____ Date: _____