NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES
Department of Health and Human Services
Division of Public Health - Licensure Unit
P.O. Box 94986 - Lincoln, Nebraska 68509-4986
E-mail: dhhs.medicaloffice@nebraska.gov
Telephone #: 402-471-2118

General Anesthesia/Deep Sedation

APPLICATION FOR REINSTATEMENT OF A PERMIT TO ADMINISTER

(Revoked, Expired, Placed on Inactive Status, or Lapsed)

I hereby apply for reinstatement of my permit to administer Moderate Sedation, Permit # _____ in the State of Nebraska and submit the required fee of $**(200.00 renewal fee and 35.00 reinstatement fee)**.

Name:
Address:

Date of Status:
DOB:
Place of Birth:

SECTION A PERSONAL INFORMATION (All applicants must complete this section) (***This information is not displayed on the internet)***

1	Phone #:		Fax #: (optional)		E-Mail Address:	
2	Check the Appropriate Box(s):	☐ Social Security Number (SSN); ☐ Alien Registration Number ("A#"); or ☐ Form I-94 (Arrival-Departure Record) number:		SSN# A# I-94 #		
	If you have both a SSN and an A# or I-94 number, you must report both. Social Security Numbers obtained are not public information but may be shared by the Department for administrative purposes if necessary and only under appropriate circumstances to ensure against any unauthorized access to this information.					

SECTION B CONVICTION AND LICENSURE INFORMATION (All applicants must complete this section)
Failure to disclose any such conviction or disciplinary action, regardless of when the action occurred, could result in disciplinary action, including, but not limited to, payment of a civil penalty.

NOTE: If you have any criminal charges or license disciplinary actions pending that results in conviction or license discipline, you are required to report such actions to the Investigations Unit within 30 days http://www.dhhs.ne.gov/pages/investigations.aspx or by telephone at 402-471-0175.

Answer each of the following questions by marking yes or no in the appropriate box (yes or no) and completing the information requested. All 'yes' responses MUST be explained in detail and you must submit the requested documentation.

Conviction Information:

#	Question	Yes	No	Type of Crime or Licensure Action	Date of Action	Name of Court/Entity Taking action
1	Have you been convicted of a misdemeanor or felony since your license was active?	☐	☐			

If you **answered YES**, you must submit the following documents:

a) The court record, which includes charges and disposition;
b) Arrest records;
c) A letter from the applicant of the events leading to the conviction (what, when, where, why) and a summary of actions the applicant has taken to address the behaviors/actions related to the convictions;
d) All addiction/mental health evaluations and proof of any treatment obtained; and
e) A letter from the probation officer addressing probationary conditions and current status if the applicant is currently on probation;

Licensure Information:

The following questions relate to a credential that you hold or have held in health services, health-related services or environmental services in another jurisdiction.

		Yes	No			
2	Are you licensed in any state?	☐	☐	If yes, what State(s) are you licensed in?	What type of license do you hold?	
	If yes, has your license ever been denied, refused renewal, limited, suspended, revoked or had other disciplinary measures taken against it?	☐	☐	Type of Licensure Action	Date of Action	Name of Entity taking Action

If you have had any disciplinary actions taken against your credential, you must submit a copy of the disciplinary action(s), including charges and disposition.

SECTION C QUESTIONS:

QUESTIONS		
All applicants for reinstatement must answer all the following questions by marking the appropriate box (yes or no). The questions pertain to the time period since the license was last active, unless otherwise specified. For any yes answers, explain the circumstances and outcome. The applicant will be notified of any additional documentation which is required by the Board/Department:		
SECTION I	**Yes**	**No**
1. 1. Has any credential you hold in the other jurisdiction(s) been denied, refused renewal, or disciplined by another jurisdiction(s) since the license was last active that has not been previously reported? (If NOT credentialed in another jurisdiction answer "NO".) 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 dispositions.	☐	☐
2. Have you voluntarily surrendered or voluntarily limited in any way a license or permit issued to you by a licensing or disciplinary authority?	☐	☐
3. Have you been requested to appear before any licensing agency?	☐	☐
4. Have you been notified of any charges, complaints or other actions filed against you by any licensing or disciplinary authority?	☐	☐
5. Are you aware of any pending disciplinary actions or of any on-going investigations of a complaint against your license or permit in any jurisdiction?	☐	☐
6. Have you been asked to and/or permitted to withdraw an application for licensure or permit with any Board or jurisdiction?	☐	☐
7. Has any state or jurisdiction refused to issue, refused to renew or denied you a license or permit to practice?	☐	☐
SECTION II	**Yes**	**No**
1. Have you abused or become dependent on or actively addicted to alcohol, any controlled substance, or any mid-altering substance?	☐	☐
2. Within the past 5 years, have you received any therapy/treatment or been admitted to any hospital or other in-patient care facility for reasons relating to your use/abuse of alcohol, narcotics, barbiturates, or other drugs?	☐	☐
3. Do you currently, or have you had, any physical, mental, or emotional condition which impaired, or does impair your ability to practice your health care profession safely and competently?	☐	☐
4. Within the past 5 years, has any licensing agency or credentialing organization initiated any inquiry into your physical, mental or emotional health?	☐	☐
5. Do you have the mental and physical capacity to administer Moderate sedation?	☐	☐
6. Have you practiced your profession while your ability to do so was impaired by alcohol, controlled substance, drugs, mind-altering substance, physical disability, mental disability, or emotional disability?	☐	☐

SECTION III	Yes	No
1. Have you been restricted, suspended, terminated, requested to voluntarily resign, placed on probation, counseled, received a warning or been subject to any remedial or disciplinary action during dental school or postgraduate training?	☐	☐
2. Have you had hospital or institutional privileges denied, reduced, restricted, suspended, revoked, terminated or placed on probation?	☐	☐
3. Have you been requested to voluntarily resign or suspend hospital or institutional privileges while under investigation from a hospital, clinic, institution, or other medically related employment?	☐	☐
4. Have you been notified that any action against your hospital or institutional privileges is pending or proposed?	☐	☐
5. Have you been allowed to withdraw your staff privileges from a hospital or institution?	☐	☐
6. Have you been subject to staff disciplinary action or non-renewal of an employment contract?	☐	☐
SECTION IV	**Yes**	**No**
1. Have you been convicted of a felony?	☐	☐
2. Have you been convicted of a misdemeanor?	☐	☐
3. Have you been notified of any charges, complaints or other actions filed against you by any criminal prosecution authority?	☐	☐
SECTION V	**Yes**	**No**
1. Have you been denied a Federal Drug Enforcement Administration (DEA) Registration or state controlled substances registration?	☐	☐
2. Have you been called before any licensing agency or lawful authority concerned with DEA controlled substances?	☐	☐
3. Have you surrendered your state or federal controlled substances registration?	☐	☐
4. Have you had your state or federal controlled substances registration restricted or disciplined in any way?	☐	☐
SECTION VI	**Yes**	**No**
1. Have you been notified of any professional liability claim that resulted in an adverse judgment, settlement, or award, including settlements made prior to suit in which the patient releases any professional liability claim against the applicant?	☐	☐
2. Are you aware of any professional liability claims currently pending against you?	☐	☐
SECTION VII	**Yes**	**No**
1. Have you committed any immoral or dishonorable acts that would evidence unfitness to practice dentistry as a Dentist?	☐	☐
2. Have you practiced as a Dentist: • Fraudulently? • Beyond your authorized scope? • With gross incompetence or gross negligence? • In a pattern of incompetent or negligent conduct?	☐	☐
3. Have you permitted, aided, or abetted the practice of any profession by a person not credentialed to do so?	☐	☐
4. Have you used untruthful, deceptive, or misleading advertising?	☐	☐
5. Have you been convicted of fraudulent or misleading advertising, or of violating the Uniform Deceptive Trade Practices Act?	☐	☐
6. Have you unlawfully distributed intoxication liquors, controlled substances, or drugs?	☐	☐
7. Have you violated: • The Uniform Credentialing Act? • Mandatory Reporting Regulations? • The Uniform Controlled Substances Act?	☐	☐
8. Have you invaded a field of practice for which you are not credentialed?	☐	☐
9. Have you committed any acts of unprofessional conduct relating to dentistry? (Refer to the Practice Act and Regulations for Dentistry and Dental Hygiene.)	☐	☐
10. Have you been denied the right to take a Credentialing Examination?	☐	☐

SECTION D OFFICE FACILITIES, EQUIPMENT, RECORDS, DRUGS, AND BASIC LIFE SUPPORT

Operating Room	**Yes**	**No**
1. Is operating room large enough to adequately accommodate the patient on a table or in an operating chair?	☐	☐
2. Does the operating room permit an operating team of at least two individuals to freely move about the patient?	☐	☐
Operating Chair or Table	**Yes**	**No**
1. Does the operating chair or table permit the patient to be positioned to allow the operating team to maintain the airway?	☐	☐
2. Does the operating chair or table permit the team to quickly alter the patient's position in an emergency?	☐	☐
3. Does the operating chair or table provide a firm platform for management of cardiopulmonary resuscitation?	☐	☐
Lighting System	**Yes**	**No**
1. Does lighting system permit evaluation of the patient's skin and mucosal color?	☐	☐
2. Is there a backup lighting system which is battery powered or on-site generator powered?	☐	☐
3. Is backup lighting system of sufficient intensity to permit completion of any operation underway at the time of general power failure?	☐	☐
Suction Equipment	**Yes**	**No**
1. Does suction equipment permit aspiration of the oral and pharyngeal cavities?	☐	☐
2. Is there a backup suction device available?	☐	☐
Oxygen Delivery System	**Yes**	**No**
1. Does oxygen delivery system have full-face masks and connectors?	☐	☐
2. Is it capable of delivering 100% oxygen to the patient under positive pressure?	☐	☐
3. Is there a backup oxygen delivery system available?	☐	☐
Recovery Area (Recovery area can be the operating room)	**Yes**	**No**
1. Does recovery area have oxygen available?	☐	☐
2. Does recovery area have suction available?	☐	☐
3. Does recovery area have lighting?	☐	☐
4. Does recovery area have available electrical outlets?	☐	☐
5. Can the patient be observed by a member of the staff at all times during the recovery period?	☐	☐
Ancillary Equipment	**Yes**	**No**
1. Is there a working laryngoscope complete with a selection of blades, spare batteries, and bulb?	☐	☐
2. Are there endotracheal tubes and connectors?	☐	☐
3. Are there oral airway(s)?	☐	☐
4. Are there endotracheal tube forceps?	☐	☐
5. Is there a CO2 monitor?	☐	☐
6. Is there a pre cardio-stethoscope?	☐	☐
7. Is there an EKG?	☐	☐

RECORDS – ARE THE FOLLOWING RECORDS MAINTAINED?	Yes	No
1. A medical history of the patient and physical evaluation records?	☐	☐
2. Anesthesia/Sedation records showing blood pressure?	☐	☐
3. Anesthesia/Sedation records showing pulse readings?	☐	☐
4. Anesthesia/Sedation records listing the drugs and amounts administered?	☐	☐
5. Anesthesia/Sedation records reflecting the length of the procedure?	☐	☐
6. Anesthesia/Sedation records listing any complications of anesthesia?	☐	☐
7. Does the record include a listing of the name(s) of those assisting the dentist?	☐	☐
8. Does the record include verification that the dentist and any person who assists the dentist in the administration of general anesthesia/deep sedation has a current certification in basic life-support skills for health care providers and either advanced cardiac life support or an appropriate emergency management course for anesthesia and dental sedation?	☐	☐
ARE DRUGS WITH CURRENT DATES AVAILABLE FOR TREATMENT OF THE FOLLOWING MEDICAL EMERGENCIES?	**Yes**	**No**
1. Laryngospasm (general anesthesia/deep sedation only)	☐	☐
2. Bronchospasm	☐	☐
3. Angina Pectoris	☐	☐
4. Myocardial Infarction (general anesthesia/deep sedation only)	☐	☐
5. Hypotension	☐	☐
6. Hypertension	☐	☐
7. Cardiac Arrest	☐	☐
8. Allergic Reactions	☐	☐
9. Convulsions	☐	☐
10. Respiratory Arrest	☐	☐
11. Medication for reversal of anesthesia/sedation agents	☐	☐
BASIC LIFE SUPPORT – DENTAL ASSISTANTS	**Yes**	**No**
1. Do all assistants have a current certification in basic life support?	☐	☐

Names and Assistants	Date of Certification	Date of Expiration

BASIC LIFE SUPPORT – DENTIST	Yes	No
1. Does the dentist have a current certification in basic life support?	☐	☐

Date of Certification	Date of Expiration

PROFESSIONAL PRACTICE ACTIVITIES
List your professional practice activities since your Moderate Sedation Permit was expired.

SECTION E ATTESTATION

An individual who practices prior to issuance of a credential is subject to assessment of an Administrative Penalty of $10 per day up to $1,000, or such other action as provided in the statutes and regulations governing the credential.

1	I have administered moderate sedation in Nebraska since I last held an active credential?	☐ Yes ☐ No
2	If yes, what are the actual number of days you administered moderate sedation in Nebraska and what is the business name, location and telephone number of the practice:	# of days: _____
		Name of Business:
		City:

Lawful Presence in the United States Attestation:

For the purpose of complying with Neb. Rev. Stat. §38-129, I attest as follows:
*Please check **ONLY ONE** of the boxes below:*

☐ 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 issued 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: _____