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

Physician Assistant Reinstatement Information

If your license was revoked or suspended for disciplinary reasons, contact the Licensure Unit for the appropriate application

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To reinstate your license, you must:

1. Complete the attached application for reinstatement.
2. Have a valid Social Security #.
3. Be lawfully present in the U.S.
4. **Have already completed at least 50 Category 1 hours** of continuing education within the previous 24 months before submitting this application.
5. Pay the renewal, reinstatement and Patient Safety Fund fees. (see page 1 of the application)
   We do not accept credit/debit card payment.

If you reinstate your license at this time, the expiration date will be October 1st of the odd-numbered year.

If you are NOT a U.S. Citizen, you must submit:

1. Green Card, otherwise known as a Permanent Resident Card (Form I-551), both front and back of the card.
2. Form I-94 (Arrival-Departure Record) **AND** an unexpired foreign passport with a valid unexpired US visa.
3. Employment Authorization Document (EAD) (unexpired) AND at one of the following documents under the Federal REAL ID Act:
   - An approved deferred action status (DACA);
   - A pending application for asylum in the United States;
   - A pending or approved application for temporary protected status in the United States;
   - A pending application for adjustment of status to that of an alien lawfully admitted for permanent residence; or in the United States or conditional permanent resident status in the United States; or
4. Other document that shows current immigration status.

NOTE: Documents are verified by our office through the Department of Homeland Security. This process may take 4-6 weeks.

Practice After Expiration Date:

If you practiced after the expiration date of your license and prior to reinstatement, you are subject to an Administrative Penalty of $10 per day up to $1,000, or other action as provided in the statutes and regulations governing your profession (such as probation, limitation, censure, etc.).

Additionally, if you committed any other violation of the statutes or regulations governing your practice, the Department may deny the application for reinstatement or reinstate your license to active status and impose limitation(s) or other disciplinary actions on your license.

Questions:

If you have any questions regarding the procedure for reinstatement, please contact the Licensure Unit, at (402) 471-2118 or DHHS.medicaloffice@nebraska.gov

If your license is reinstated, you will receive an e-mail or mail notice so you can print your wallet card from our website:
TO PRINT YOUR WALLET CARD GO TO: https://www.nebraska.gov/LISSearch/search.cgi

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Division of Public Health - Licensure Unit
P.O. Box 94986 - Lincoln, Nebraska 68509-4986
Telephone #: 402-471-2118
DHHS.medicaloffice@nebraska.gov

PHYSICIAN ASSISTANT
REINSTATEMENT APPLICATION

This section for Office Use Only

Expiration Date: _____

Date of License: _____

Revised 02/2026

FEE: The fee due is listed by month and year. Make payable by ***check or money order*** to "Licensure Unit"
(The below fee includes the renewal fee of $110.00+reinstatement fee of $35.00) *We do not accept credit/debit card payment*

YEAR	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec
Even Numbered Year	**$145**	**$145**	**$145**	**$145**	**$145**	**$145**	**$145**	**$145**	**$145**	**$145**	**$145**	**$145**
Odd Numbered Year	**$145**	**$145**	**$145**	**72.50**	**72.50**	**72.50**	**72.50**	**72.50**	**$145**	**$145**	**$145**	**$145**

You must complete ALL sections of this application

SECTION A: PERSONAL INFORMATION

1	Legal Name:	First:	Middle/MI:	Last:

For **name changes**, you must submit a copy of marriage certificate, divorce decree, court order, etc. If not submitted, the license will be issued in the name as printed above.

2	Mailing Address: ☐ Check this box if NEW address	Street/PO/Route:		
		City:	State or Country:	Zip:
3	Date of Birth (Month/Day/Year):		Place of Birth (City/State or COUNTRY):	
4	Phone #:		E-Mail Address:	
5	License Number:			

To reinstate your license, you must have a valid Social Security Number

6	Social Security Number (SSN):		
	If you also have an A# or I-94#, check the correct box and provide your number:	☐ Alien Registration Number ("A#"):	
		☐ I-94 #:	

Neb. Rev. Stat. §§38-123 and 38-130 requires that you provide your social security number to DHHS. Although your number is not public information, DHHS may disclose it for child support enforcement purposes as well as to the Nebraska Department of Revenue, Department of Labor and for other Administrative purposes.

MILITARY SERVICE:

If you meet the following definition of 'military', you are NOT required to pay the renewal fee or meet the continuing education requirements. (The Reinstatement fee of $35.00 is a required fee)
(You must check the box and submit the requested document)

☐ **Military:** I have served in the regular armed forces of the United States or am actively engaged in military service (active duty for at least 30 days) during part of the 24 months immediately preceding the biennial renewal date. (You must attach your military orders)

SECTION B: CONVICTION AND LICENSE INFORMATION

Failure to list any conviction(s) or disciplinary action(s), could result in disciplinary action against your license.

Conviction Information:

You are NOT required to list infractions, diversions or dismissals. Misdemeanor and felony convictions can either be processed through traffic or criminal court, so when you check with the county court/district court, you should ask for both traffic and criminal court misdemeanor and felony convictions

1 Were you convicted of a misdemeanor or felony in any state/jurisdiction since your license was last renewed (or since you received your initial license if such was within the past 24 months). If you answer **YES** to this question, you must submit the following documents to the Licensure Unit:

- A copy of the entire/complete court record, which includes charges and disposition;
- Your 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;
- If you have a drug and/or alcohol offense, to assist in the evaluation of your drug and/or alcohol conviction(s), please submit all evaluation/discharge summaries where drug and/or alcohol treatment was obtained or required. All evaluations / discharge summaries must be submitted by the provider directly to DHHS; and
- If you are currently on probation, a letter from the probation officer addressing the terms and current status of your probation.

☐ Yes ☐ No

List below misdemeanor or felony convictions

Name of Conviction	Date of Conviction	Name of Court

NOTE: If you have any criminal charges or credential disciplinary actions pending that result in misdemeanor or felony conviction or license discipline, you must report such actions to of Division of Public Health Office of Investigation within 30 days of the conviction or disciplinary action (Neb. Rev. Stat. 38-1,125). Reporting forms are available at: https://dhhs.ne.gov/Pages/Investigations.aspx or by calling 402-471-0175

Licensure Information:

The following questions relate to a license/certificate/registration that you currently **hold or have held** to provide health related services in a state/jurisdiction **other** than Nebraska.

		Yes	No			
2	Do you hold or have you held a license in any state? If you answer 'yes' to this question, you must respond to question 2a	☐	☐	If yes, what State(s) are you licensed in?	What type of license do you hold?	
2a	If YES, has your license ever been denied, refused renewal, limited, suspended, revoked or had other disciplinary measures taken against it, or voluntarily surrendered or limited? If you answered YES to this question, you must submit Official Documents from the State Board in which the disciplinary action was taken.	☐	☐	Type of License Action	Date of Action	Name of State taking Action
3	Have you ever been denied the right to take a licensing examination in any state?	☐	☐	Please Explain:		

Licensure Information Continued:
The following questions pertain to the time period since the license was last active, unless otherwise specified. **All 'yes' responses MUST be explained in detail.** Additional documentation may be requested by the Board/Department after submission of initial information.

SECTION I	Yes	No
1. Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical and professional manner?	☐	☐

SECTION II	Yes	No
1. Have you had hospital or institutional privileges denied, reduced, restricted, suspended, revoked, terminated or placed on probation?	☐	☐
2. 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?	☐	☐
3. Have you been notified that any action against your hospital or institutional privileges is pending or proposed?	☐	☐
4. Have you been allowed to withdraw your staff privileges from a hospital or institution?	☐	☐
5. Have you been subject to staff disciplinary action or non-renewal of an employment contract?	☐	☐

SECTION III	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 IV	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 C: CONTINUING EDUCATION
You must have already completed **50** hours of continuing education within the previous 24 months before submitting this application for reinstatement**.**

CONTINUING EDUCATION HOURS:

☐ Yes ☐ No	Have you met the continuing education requirements for your profession? If no, you may qualify for a waiver under the 'waiver' section below.

Continuing Education requirements are listed below:

1. Earn 50 hours of Category 1 continuing education approved as follows:
   a) Approved by the Accreditation Council for Continuing Medical Education (ACCME); the American Osteopathic Association (AOA) or the American Academy of Physician Assistants (AAPA); or
   b) Meet the National Commission on Certification of Physician Assistants (NCCPA) requirements within the previous 24 month period.
2. Hours are to be earned within 24 months of the date of expiration, except that a licensee who has earned more than 50 hours required for renewal for one 24 month renewal period, is allowed to carry over up to 25 hours to the next 24 month renewal period.

WAIVER OF CONTINUING EDUCATION HOURS:

If you **have not** completed the continuing education and you qualify for a waiver, check the appropriate reason below:

☐	**Initial License:** I was first licensed within the previous 24 months before submitting this application for reinstatement.
☐	**Circumstances Beyond My Control:** I was not able to complete my continuing education requirement due to circumstances beyond my control. Waivers of continuing education may be considered for circumstances lasting longer than 30 consecutive days that DHHS determines are beyond your control. Such circumstances can include, but are not limited to, a shortage of available continuing competency courses resulting from an officially declared state of emergency. **Submit** the following information: 1. List the reason(s) you were not able to complete the required continuing education. 2. Did this last longer than 30 consecutive days? 3. Are you requesting a waiver of the total hours of continuing education, or a partial waiver? If partial waiver, how many hours are your requesting be waived?

Documents (if requested above) must be provided to support your request for waiver of continuing education.
If the requested documents are not submitted, review and processing of your reinstatement application will not occur.

SECTION D: PRACTICE AFTER EXPIRATION OR INACTIVE STATUS

If you practice after the expiration date and prior to reinstatement of your license, you are 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 your profession.

1	Have you practiced medicine and surgery as a physician assistant in Nebraska since your license expired or was placed on inactive status?	☐ Yes ☐ No
2	If yes, what are the actual number of days you practiced in Nebraska and what is the business name, location and telephone number of the practice: # of days: _____	_____ Name of Business: _____ City: _____ Telephone #: _____

SECTION E: ATTESTATION

For the purpose of meeting Neb. Rev. Stat. §4-108 through §4-114 and §38-129, **I attest that**:

*(check only **ONE** of the boxes below)*

☐ I am a citizen of the United States.

OR

☐ I am a qualified alien under the Federal Immigration and Nationality Act.

☐ I am a nonimmigrant lawfully present in the United States.

☐ Check this box if you are **NOT** a citizen of the United States, a nonimmigrant, nor a qualified alien under the Federal Immigration and Nationality Act.

I further attest that:

1. I have read the application or have had the application read to me; and
2. All statements on this application are true and complete.

Print Name: _____

Signature: _____ Date: _____

TO PRINT YOUR WALLET CARD GO TO: https://www.nebraska.gov/LISSearch/search.cgi