

NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES



Pete Ricketts, Governor

Dear Applicant:

Our office is in receipt of your request to reinstate your Physician Assistant license, License # _____. Our records indicate that your license was expired on _____.

In order to reinstate your license, you must submit the following documentation:

1. A complete application for reinstatement (form enclosed).
2. The renewal and reinstatement fees.

The breakdown of the specific renewal fees now due are as follows:

License Renewal Fee	\$ 110.00
Reinstatement Fee	\$ 35.00
Total fee due	\$ 145.00

3. You must request a certificate of licensure from each state be sent to the department no matter the status of your license in the states in which you have held or hold a license.

Please be advised that should you reinstate your license at this time, the expiration date will be 10/01/2017. At least 30 days prior to that date you will be sent notification of the need to submit a completed renewal application, the renewal fee payment and evidence of the required 50 hours of continuing competency, on or before the expiration date.

If you have any questions regarding the procedure for reinstatement, please contact Tressa, Health Licensing Specialist, at (402) 471-2118.

Sincerely,

Tressa Waterman, Health Licensing Specialist
Licensure Unit
PO Box 94986
301 Centennial Mall South
Lincoln, NE 68509
Phone: 402-471-2118 Fax: 402-471-8614
tressa.waterman@nebraska.gov

Attachments

Physician Assistant Reinstatement Application

I hereby apply for reinstatement of my license to practice as a Physician Assistant, License # _____ in the State of Nebraska and submit the required fee of **\$145.00**

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):	<input type="checkbox"/> Social Security Number (SSN); <input type="checkbox"/> Alien Registration Number (“A#”); or <input type="checkbox"/> Form I-94 (Arrival-Departure Record) number:			SSN#	
					A#	
					I-94 #	
<p>If you have both a SSN and an A# or I-94 number, you must report both.</p> <p>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.</p>						

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://dhhs.ne.gov/Pages/req_investi.aspx or by telephone at 402-471-0175.

Answer each of the following questions by placing a (✓) 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?	<input type="checkbox"/>	<input type="checkbox"/>			

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. You must request a certificate of licensure from each state be sent to the department no matter the status of your license in the states in which you have held or hold a license.

2	Are you licensed in any state?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	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?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	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 - CONTINUING COMPETENCY:		
<p>You must have earned <u>ONE</u> of the following within the 24 months immediately preceding that date of application for reinstatement:</p> <ul style="list-style-type: none"> ● 50 hours of Category 1 continuing education approved by the Accreditation Council for Continuing Medical Education (ACCME) or the American Osteopathic Association (AOA) or the American Academy of Physician Assistants (AAPA); OR ● Meet the National Commission on Certification of Physician Assistants (NCCPA re-registration requirements within the previous 24 month period. 		
<p>All applicants for reinstatement must answer the following question by placing a (✓) in the appropriate box (yes or no): Have you met the continuing competency requirements as outlined above?</p>	Yes	No
	<input type="checkbox"/>	<input type="checkbox"/>

WAIVER OF CONTINUING COMPETENCY: If you **have not** completed the continuing competency requirement, and wish to apply for a waiver of the continuing competency requirement, check the appropriate reason below:

<input type="checkbox"/>	Military: I have served in the regular armed forces of the United States during part of the 24 months immediately preceding the biennial licensure renewal date. (Attach official documentation stating dates of service) If you meet this exemption, you are not required to pay the renewal fee.
<input type="checkbox"/>	Initial License: I was first licensed within the 24 months immediately preceding my date of application for active status.

SECTION D – QUESTIONS: All applicants for reinstatement must answer the following questions by placing a (✓) in 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. 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.	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you voluntarily surrendered or voluntarily limited in any way a license or permit issued to you by a licensing or disciplinary authority?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you been requested to appear before any licensing agency?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you been notified of any charges, complaints or other actions filed against you by any licensing or disciplinary authority?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you been asked to and/or permitted to withdraw an application for licensure or permit with any Board or jurisdiction?	<input type="checkbox"/>	<input type="checkbox"/>
7. Has any state or jurisdiction refused to issue, refused to renew or denied you a license or permit to practice?	<input type="checkbox"/>	<input type="checkbox"/>

SECTION II	Yes	No
1. Have you abused or become dependent on or actively addicted to alcohol, any controlled substance, or any mind-altering substance?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
4. Within the past 5 years, has any licensing agency or credentialing organization initiated any inquiry into your physical, mental or emotional health?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have the mental and physical capacity to practice medicine and surgery as a Physician Assistant?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
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 while attending an approved physician assistant program?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you had hospital or institutional privileges denied, reduced, restricted, suspended, revoked, terminated or placed on probation?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you been notified that any action against your hospital or institutional privileges is pending or proposed?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you been allowed to withdraw your staff privileges from a hospital or institution?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you been subject to staff disciplinary action or non-renewal of an employment contract?	<input type="checkbox"/>	<input type="checkbox"/>
SECTION IV	Yes	No
1. Have you been convicted of a felony?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you been convicted of a misdemeanor?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you been notified of any charges, complaints or other actions filed against you by any criminal prosecution authority?	<input type="checkbox"/>	<input type="checkbox"/>
SECTION V	Yes	No
1. Have you been denied a Federal Drug Enforcement Administration (DEA) Registration or state controlled substances registration?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you been called before any licensing agency or lawful authority concerned with DEA controlled substances?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you surrendered your state or federal controlled substances registration?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you had your state or federal controlled substances registration restricted or disciplined in any way?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
2. Are you aware of any professional liability claims currently pending against you?	<input type="checkbox"/>	<input type="checkbox"/>
SECTION VII	Yes	No
1. Have you committed any immoral or dishonorable acts that would evidence unfitness to practice medicine and surgery as a Physician Assistant?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you practiced as a Physician Assistant: <ul style="list-style-type: none"> • Fraudulently? • Beyond your authorized scope? • With gross incompetence or gross negligence? • In a pattern of incompetent or negligent conduct? 	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you permitted, aided, or abetted the practice of any profession by a person not credentialed to do so?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you used untruthful, deceptive, or misleading advertising?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you been convicted of fraudulent or misleading advertising, or of violating the Uniform Deceptive Trade Practices Act?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you unlawfully distributed intoxication liquors, controlled substances, or drugs?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you violated: <ul style="list-style-type: none"> • The Uniform Credentialing Act? • Mandatory Reporting Regulations? • The Uniform Controlled Substances Act? 	<input type="checkbox"/>	<input type="checkbox"/>

SECTION VI – CON'T	Yes	No
8. Have you invaded a field of practice for which you are not credentialed?	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you committed any acts of unprofessional conduct relating to medicine and surgery? (Refer to the Practice Act and Regulations for Medicine and Surgery.)	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you been denied the right to take a Credentialing Examination?	<input type="checkbox"/>	<input type="checkbox"/>

SECTION E: 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 practiced as a physician assistant in Nebraska since I last held an active credential?	<input type="checkbox"/> Yes <input type="checkbox"/> 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: _____

Attestation: For the purpose of complying with Neb. Rev. Stat. §§4-108 through 4-114 and 38-129 (check only **ONE** of the boxes below): **I attest that:**

- I am a citizen of the United States.
- OR**
- I am a qualified alien under the Federal Immigration and Nationality Act (i.e.: permanent resident (green) card, I-94 document, asylum, etc.) **YOU MUST SUBMIT A COPY OF THIS DOCUMENT WITH YOUR RENEWAL**
- I am a nonimmigrant lawfully present in the United States. (i.e.: permanent resident (green) card, I-94 document, asylum, etc.) **YOU MUST SUBMIT A COPY OF THIS DOCUMENT WITH YOUR RENEWAL**
- 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. **YOU MUST SUBMIT A COPY OF THIS DOCUMENT WITH YOUR RENEWAL**
- NOTE:** You may still be eligible for a certificate if you provide a photocopy of your unexpired Employment Authorization Document (EAD) and evidence of meeting section 202(c)(2)(B)(i) through (ix) of the Federal REAL ID Act of 2005. (i.e.: DACA, pending asylum, pending refugee, etc.)

Signature and Application Attestation: I attest that:

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

Print Name: _____

Original Signature: _____

Date: _____

Email (Optional): _____