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, NE 68509-4986
Telephone #: 402-471-2299

(Print or type the application and mail to the address on the left)

Effective: 08/14/2011
Revised: 12/09/2020

APPLICATION MUST BE PRINTED ONE-SIDED ONLY AND MUST BE ACTUAL SIZE.

APPLICATION FOR REINSTATEMENT TO PRACTICE RESPIRATORY CARE
(Non-disciplinary Revocation, Expired, Inactive, Lapsed or Voluntary Surrender unrelated to Discipline)

SECTION A - Fee

Reinstatement Application fee:
The Respiratory Care reinstatement application fee is $153.00. If your license is reinstated within 180 days prior to the expiration date of June 1st of even-numbered years, the reinstatement application fee is prorated and will be $64.50. **Make check payable to "Licensure Unit" and mail with your application.**
All respiratory care licenses expire June 1 of even-numbered years.

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Even Year	$64.50	$64.50	$64.50	$64.50	$64.50	$153	$153	$153	$153	$153	$153	$153
Odd Year	$153	$153	$153	$153	$153	$153	$153	$153	$153	$153	$153	$64.50

SECTION B – Personal Information: All applicants must complete this section.

1	Legal Name	Last:	First:	Middle:
	Maiden Name	Name:	License Number:	

If your NAME has changed as it appears on your expired, inactive or lapsed license, you must submit one of the following documents: Marriage license, divorce decree or court order of legal name change.

2	Present Address	Street/Box/Route:		
		City:	State:	Zip:
3	Other Info	Other names you are known as:	Phone # :	
		Email Address:	Fax#: Optional	

Additional Information requested

4	Check the Appropriate Box(s):	☐ Social Security Number (SSN);	SSN#:
		☐ Alien Registration Number ("A#"); or	A#:
		☐ Form I-94 (Arrival-Departure Record) number	I-94#:

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.

THIS BOX IS FOR OFFICIAL USE ONLY		
BACKGROUND CHECK		
BOARD REVIEW		
REINSTATEMENT # AND DATE		

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.

Please answer each of the following questions with regard to the time period since your license was last **renewed**. Answer each of the following questions by placing a check mark 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. (Continue on reverse side or use additional sheet if space is inadequate.)

#	Question	Yes	No	Type of Crime or Licensure Action	Date of Action	Name of Court/Entity Taking Action
1	Have you ever been convicted in any jurisdiction of a misdemeanor or felony?	☐	☐			

If you answered YES to the question above, you must submit the following documents with your application:

- A copy of the Court Record(s), which includes charges and proof of completion:
- Written explanation of the events leading to the conviction(s) (what, when, where, 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(s) involved a drug and/or alcohol related offense and if treatment was obtained and/or required;
- A letter from the probation officer addressing probationary conditions and current status, if you are currently on probation.

The following questions relate to credential(s) that you hold or have held in health services, health related services or environmental services in Nebraska or another jurisdiction

#	Question	Yes	No	State(s)/Jurisdiction(s)	Type of credential
2	Are you or have you been credentialed in any state or jurisdiction? ***(Current and expired credentials must be listed.)***	☐	☐	If yes, what States(s)/Jurisdiction(s) are you credentialed in?	What type of credential do you hold?

#	Question	Yes	No	Type of Credential	Date of Action	Name of Entity taking action
3	Has your credential(s) ever been denied, refused renewal, limited, suspended, revoked or had disciplinary measures taken against it?	☐	☐			

If you answered YES to questions 2 and/or 3 above, you must request a certification of your credentials(s) (current or expired) to be sent to Nebraska. Submit Attachment A (Certification in Another Jurisdiction) to the appropriate licensing agency(s).

Section C – Practice Prior to Reinstatement: An individual who practices prior to reinstatement 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	Have you practiced respiratory care in Nebraska since your license was placed on expired, inactive, non-disciplinary revocation, lapsed or following voluntary surrender unrelated to discipline?	☐ Yes ☐ No
2	If yes, what are the actual number of days you practiced in Nebraska and what is the business name, location (address) and telephone number of the practice.	Number of days: _________
		Name of Business:
		Location/Address of Business
		Phone Number of Business:

Section D - Continuing Competency Requirements – Respiratory Care

You must have completed twenty (20) hours of acceptable continuing education hours within the preceding 24 months of your application for reinstatement of your license.

In order for a learning experience to be accepted for renewal of a license, the learning experience must relate to the theory or clinical application of theory pertaining to the practice of respiratory care and it may focus on research, treatment, documentation, management or education. Acceptable continuing education activities are:

1. Programs at State and National association meetings which relate to the theory or clinical application of theory pertaining to the practice of respiratory care;
2. Formal education courses/presentations in which:
   a. Courses or presentations are formally organized and planned instructional experiences;
   b. Courses have a date, location, course title, number of contact hours, signed certificate of attendance, and are open to all licensees;
   c. The objectives relate to the theory or clinical application of theory pertaining to the practice of respiratory care; and
   d. The instructor has specialized experience or training to meet the objectives of the course.
3. University or college sponsored courses relating to the theory or clinical application of theory pertaining to the practice of respiratory care;
4. Home study where the content of home study activity relates to the theory or clinical application of theory pertaining to the practice of respiratory care whether the subject is research, treatment, documentation, education, or management, e.g. videotapes, internet courses, and/or correspondence courses. The program must have a testing mechanism scored by the named study provider.
5. Management courses which relate to the theory or clinical application of theory pertaining to the practice of respiratory care. A respiratory care practitioner may complete a **maximum of four hours** of continuing education utilizing management courses.
6. Nationally recognized specialty certification examinations. A licensee will earn contact hours for successful completion of nationally recognized specialty certification examinations related to an area of specialty practice in the field of respiratory care each 24 month renewal period. A licensee's documentation must include a copy of the certification that shows the date of the examination. Continuing education hours will be awarded as follows:
   a. Certified Pulmonary Function Technologist (CPFT), ten hours;
   b. Registered Polysomnographic Technologist (RPSGT), ten hours;
   c. Neonatal Pediatric Specialist (NPS), ten hours;
   d. Registered Pulmonary Function Technologist (RPFT), ten hours; and
   e. Registered Respiratory Therapist (written and clinical simulation examinations, 15 hours.
7. Basic cardiac life support or advanced cardiac life support for adults and pediatric or neonatal courses.
   a. Maximum of one hour credit for the Basic Cardiac Life Support course;
   b. Maximum of 12 hours credit for initial ACLS certification course or six hours credit for re-certification;
   c. Maximum of 8 hours credit for initial Neonatal Advanced Life Support certification course or four hours credit for recertification.
   d. Maximum of 12 hours credit for Pediatric Advanced Life Support certification course or six hours credit for recertification.
8. One hour credit will be awarded for each hour of scientific presentation by a licensee acting as an essayist or lecturer to licensed respiratory care practitioners if the program relates to the theory or clinical application of theory pertaining to respiratory care. A licensee may receive continuing education credit for only the initial presentation during a renewal period, with a maximum of four hours of continuing education for presentations.
9. In-services that meet the requirements for formal education as outlined in item #2 above that cover:
   a. Therapeutic respiratory care procedures; or
   b. Respiratory care equipment.
10. One hour of credit will be awarded for each hour of attendance. Credit will not be awarded for breaks, lunch, or dinner.

NAME: ______________________________

Section D - Continuing Competency Requirements – Respiratory Care continued Continuing Competency Hours		
1	Have you met the continuing competency requirements of completion of 20 hours of acceptable continuing education within the preceding 24 months of your application for reinstatement of your license?	☐ Yes ☐ No
2	**CONTINUING COMPETENCY WAIVER:** If you **have not** completed the continuing competency requirement and wish to apply for a waiver of the continuing competency requirement of twenty (20) hours of continuing education, please submit the documentation required for the waiver you check below.	
	I AM REQUESTING A WAIVER of continuing education hours. Check applicable reason(s) for waiver below	☐ Yes ☐ No Number of hours: _______
	I have served full-time duty in the active military service of the United States, or a National Guard call to active service for more than 30 consecutive days, or active service as a commissioned officer of the Public Health Service or the National Oceanic and Atmospheric Administration during part of the 24 months immediately preceding this licensure reinstatement application and request both my continuing education requirements and renewal fee be waived. (**You MUST provide official documentation of Armed Forces Service, such as Active Duty Orders to claim this exemption.**)	☐ Yes ☐ No
	I was first licensed within the twenty-four months immediately preceding the date of my application for reinstatement.	☐ Yes ☐ No
	I have suffered a serious or disabling illness or physical disability during the preceding twenty-four (24) months of this reinstatement application, which prevented completion of the continuing competency requirements. (Submit a statement from a treating physician(s) stating that you were injured or ill; the duration of the illness or injury and of the recovery period; and that you were unable to obtain or complete continuing education hours during that period.)	☐ Yes ☐ No
	I had other circumstances beyond my control that prevented me from obtaining the required continuing competency requirements preceding this license reinstatement application. (You must submit documentation verifying such circumstances.)	☐ Yes ☐ No
	I was not able to complete my continuing education requirement due to circumstances beyond my control. (You must submit documentation to support this waiver request.)	☐ Yes ☐ No

SECTION E - YOU MUST COMPLETE THE FOLLOWING QUESTIONS/INFORMATION: Please answer each of the following questions with regard to the time period since your license was last **renewed**. If you answer YES to any of the following questions, you must provide an explanation.			
1	Have you committed any immoral or dishonorable acts that would evidence unfitness to practice your profession?		☐ Yes ☐ No
2	Have you abused or become dependent on or actively addicted to alcohol, any controlled substance, or any mind-altering substance?		☐ Yes ☐ No
3	Have you practiced your profession:	• Fraudulently? • Beyond its authorized scope? • With gross incompetence or gross negligence? • In a pattern of incompetent or negligent conduct?	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
4	Have you practiced your profession while your ability to do so was impaired by alcohol, controlled substances, drugs, mind-altering substances, physical disability, mental disability, or emotional disability?		☐ Yes ☐ No
5	Have you permitted, aided, or abetted the practice of any profession by a person not credentialed to do so?		☐ Yes ☐ No
6	Have you been denied the right to take a Credentialing Examination?		☐ Yes ☐ No
7	Have you used untruthful, deceptive, or misleading advertising?		☐ Yes ☐ No
8	Have you been convicted of fraudulent or misleading advertising, or of violating the Uniform Deceptive Trade Practices Act?		☐ Yes ☐ No
9	Have you unlawfully distributed intoxicating liquors, controlled substances, or drugs?		☐ Yes ☐ No
10	Have you invaded a field of practice for which you are not credentialed?		☐ Yes ☐ No
11	Have you violated:	• The Uniform Credentialing Act? • Mandatory Reporting Regulations? • The Uniform Controlled Substances Act?	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
12	Have you committed any acts of unprofessional conduct relating to the practice of respiratory care? (Refer to the practice act and regulations for respiratory care)		☐ Yes ☐ No

Name: ________________________

SECTION F – Attestation

Attestation: For the purpose of complying with Neb. Rev. Stat. §§4-108 through 4-114 and 38-129 (*check **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.)

☐ I am a nonimmigrant lawfully present in the United States. (i.e.: permanent resident (green) card, I-94 document, asylum, etc.)

☐ 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.
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.)

Application Attestation: I 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: ______________________

NOTE:
The applicant must submit the following documentation:

1. Other Credentialing Info: If you are or have been credentialed to provide health services, health-related services, or environmental services in other jurisdiction(s), you must have the other jurisdiction(s) submit to the Department a certification/verification of your credential;
2. Conviction Information: If you have been convicted of a felony or misdemeanor, you must submit:
   (a) A copy of the court record, which includes charges and disposition;
   (b) Explanation from the applicant 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;
   (c) If treatment was obtained and/or required, all addiction/mental health evaluations and proof of treatment (if the conviction involved a drug and/or alcohol related offense); and
   (d) If you are currently on probation, a letter from the probation officer addressing probationary conditions and current status.

On the application you are required to list all misdemeanor/felony convictions, regardless of when they occurred. If you are not sure if a ticket or arrest resulted in a misdemeanor or felony conviction, we suggest that you contact the court in the county where you were ticketed or arrested. The following provides just a small **sampling** of some of the misdemeanor convictions; this is not an exclusive list and is only intended as examples of convictions:

☐ MIP	☐ Driving under Suspension / Revocation
☐ DUI / DWI	☐ License Vehicle without Liability Insurance
☐ Controlled Substance	☐ Fail to Appear in Court
☐ Open Container	☐ False Information or Reporting
☐ Tobacco Use by Minor	☐ Leave the Scene of an Accident
☐ Shoplifting / Theft / Burglary	☐ Operator not Carrying License
☐ Unauthorized use of a Financial Transaction	☐ Unlawful Display of Plates/Renewal tabs
☐ Disturbing the Peace	☐ Park Rule Violation / Curfew Violation
☐ Assault	☐ Dog at Large / Fail to Vaccinate Animal
☐ Disorderly Conduct	☐ Littering
☐ Disorderly House	☐ Bad Check
☐ Reckless Driving	☐ Fireworks

3. Citizenship/non-citizenship information: You must submit a copy of at least one of the following documents:

   If you are a U.S. Citizen, provide one of the following documents as proof of U.S. Citizenship:
   A U.S. Passport (unexpired or expired);
   A birth certificate issued by a state, county, municipal authority or outlying possession of the United States bearing an official seal;
   An American Indian Card (I-872);
   A Certificate of Naturalization (N-550 or N-570);
   A Certificate of Citizenship (N-560 or N-561);
   Certification of Report of Birth (DS-1350);
   A Consular Report of Birth Abroad of a Citizen of the United States of America (FS-240);
   Certification of Birth Abroad (FS-545 or DS-1350);
   A United States Citizen Identification Card (I-197 or I-179);
   A Northern Mariana Card (I-873).

If you are NOT a U.S. Citizen, you must submit a copy of one of the following:
If you are a Qualified Alien under the Federal Immigration and Nationality Act:
Green Card, otherwise known as a Permanent Resident Card (Form I-551), both front and back of the card;
An unexpired foreign passport with an unexpired Temporary I-551 stamp bearing the same name as the passport; or
Form I-94 (Arrival-Departure Record) AND an unexpired foreign passport with a valid unexpired US visa.
If you are not a U.S. Citizen nor a Qualified Alien under the Federal Immigration and Nationality Act and are lawfully present in the United States, you may still be eligible for a license if you provide a photocopy of your unexpired Employment Authorization Document (EAD) and evidence of one of the following documents under the Federal REAL ID Act:
Employment Authorization Card
AND
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.

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

If an applicant has practiced while his/her credential was revoked, expired, inactive, or voluntarily surrendered, the Department may, with the recommendation of the Board, take one or more of the following actions:

1. Assess an administrative penalty, in which case a separate notice of opportunity for hearing will be sent to the applicant;
2. Deny the application to reinstate the credential;
3. Reinstate the credential to active status and impose limitation(s) or other disciplinary actions on the credential; and/or
4. Reinstate the credential.

If an applicant has committed any other violation of the statutes and regulations governing the credential, the Department may:

1. Deny the application for reinstatement of the credential;
2. Reinstate the credential to active status and impose limitation(s) or other disciplinary actions on the credential; and/or
3. Reinstate the credential.

The Department will act within 150 days on all completed applications. The Department’s decision may be appealed to the Director by any party to the decision. The appeal must be in accordance with the Administrative Procedure Act.

Attachment A

STATE OF NEBRASKA
DEPARTMENT OF HEALTH & HUMAN SERVICES
DIVISION OF PUBLIC HEALTH
LICENSURE UNIT
RESPIRATORY CARE

CERTIFICATION OF CREDENTIAL IN ANOTHER JURISDICTION

All applicants applying for reinstatement of his/her Nebraska Respiratory Care credential who are or have been credentialed to provide health services, health-related services, or environmental services in other jurisdiction(s) (state) must have those jurisdiction(s) (state) complete and submit this form directly to our office. Section A must be filled out by the applicant and forwarded to the appropriate jurisdiction(s) to complete Sections B, C and D.

SECTION A – This section must be completed					
Applicant's Name:					
Credential Type:		Credential Number:		Credential Status:	❒ Active ❒ Inactive ❒ Other ________________
Date of Issue:		Date of Expiration:			

SECTION B – This section must be completed only if it is a certification of a Respiratory Care Credential.

Credential was issued on the basis of:

❒ NBRC Examination Date of Examination: ________________________________ Score: _______________

❒ State Examination Date of Examination: ________________________________ Score:_______________

❒ Other. Please explain:____

Graduation from an accredited Respiratory Care Program

Name of Respiratory Care School: ____ Date of graduation: _________________

SECTION C – This section must be completed

Based on the records of this Department, the applicant's credential:

❒ Is in good standing, and so far as our records are concerned, the applicant is entitled to endorsement
❒ Has been disciplined.
Please explain any disciplinary action: ____
Submit supporting document of disciplinary action.

Does the applicant have any pending complaints:

❒ No
❒ Yes. If yes, please explain: ____

____

SECTION D – This section must be completed

SIGNATURE:	**AGENCY SEAL**
DATE:	
NAME (PRINT)	
TITLE:	
LICENSING AGENCY NAME AND ADDRESS:	

RETURN THIS FORM TO:
Licensure Unit
ATTN: Respiratory Care
P.O. Box 94986
Lincoln NE 68509-4986