

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

**MINIMAL 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 Minimal 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):	<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 #	
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://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?	<input type="checkbox"/>	<input type="checkbox"/>			

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

- The court record, which includes charges and disposition;
- Arrest records;
- 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;
- All addiction/mental health evaluations and proof of any treatment obtained; and
- 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.

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 QUESTIONS:

QUESTIONS		
<p>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:</p>		
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 administer Minimal sedation?	<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 during dental school or postgraduate training?	<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 dentistry as a Dentist?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you practiced as a Dentist: <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"/>
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 dentistry? (Refer to the Practice Act and Regulations for Dentistry and Dental Hygiene.)	<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 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?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the operating room permit an operating team of at least two individuals to freely move about the patient?	<input type="checkbox"/>	<input type="checkbox"/>
Suction Equipment	Yes	No
1. Does suction equipment permit aspiration of the oral and pharyngeal cavities?	<input type="checkbox"/>	<input type="checkbox"/>
Oxygen Delivery System	Yes	No
1. Does oxygen delivery system have full-face masks and connectors?	<input type="checkbox"/>	<input type="checkbox"/>
2. Is it capable of delivering 100% oxygen to the patient under positive pressure?	<input type="checkbox"/>	<input type="checkbox"/>
3. Is there a backup oxygen delivery system available?	<input type="checkbox"/>	<input type="checkbox"/>
Recovery Area (Recovery area can be the operating room)	Yes	No
1. Does recovery area have oxygen available?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does recovery area have suction available?	<input type="checkbox"/>	<input type="checkbox"/>
3. Does recovery area have lighting?	<input type="checkbox"/>	<input type="checkbox"/>
4. Does recovery area have available electrical outlets?	<input type="checkbox"/>	<input type="checkbox"/>
5. Can the patient be observed by a member of the staff at all times during the recovery period?	<input type="checkbox"/>	<input type="checkbox"/>
Ancillary Equipment	Yes	No
1. Are there oral pharyngeal airway(s)?	<input type="checkbox"/>	<input type="checkbox"/>
2. Is there a sphygmomanometer?	<input type="checkbox"/>	<input type="checkbox"/>
3. Is there a stethoscope?	<input type="checkbox"/>	<input type="checkbox"/>
RECORDS – ARE THE FOLLOWING RECORDS MAINTAINED?	Yes	No
1. A medical history of the patient prior to the administration of minimal sedation and physical evaluation records?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the record include the name and dosage of the medication administered?	<input type="checkbox"/>	<input type="checkbox"/>
3. Does the record include a listing of the name(s) of those assisting the dentist?	<input type="checkbox"/>	<input type="checkbox"/>
4. Does the record include verification that the dentist and any person who assists the dentist in the administration of minimal sedation has a current certification in basic life-support and if providing minimal sedation for persons under twelve (12) years of age and under, has current certification in pediatric advanced life-support?	<input type="checkbox"/>	<input type="checkbox"/>
ADDITIONAL LOCATIONS	Yes	No
I have provided the Department with the proper application for any additional location(s) that I will be administering minimal sedation at.	<input type="checkbox"/>	<input type="checkbox"/>
I attest that the above answers apply to the additional location(s) that I have identified to the Department.	<input type="checkbox"/>	<input type="checkbox"/>

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 minimal sedation 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 administered minimal sedation in Nebraska and what is the business name, location and telephone number of the practice:	# of days: _____ Name of Business: _____ City: _____

Continuing Education Attestation:

- I have obtained the required 6 hours of continuing education related to the management and administration of sedation within the 2 years prior to signing the reinstatement form.

Citizenship 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 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.

NOTE: You may still be eligible for a credential 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.

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: _____