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 license to practice perfusion. Our records indicate that your license was revoked (non-disciplinary), lapsed, expired or placed on inactive status.

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**

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Please be advised that should you reinstate your license at this time, the expiration date will be October 1, 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 continuing competency, on or before the expiration date.

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

Sincerely,

Jan Harris | *Health Licensing Specialist*
PUBLIC HEALTH

Nebraska Department of Health and Human Services
POB 94986 Lincoln, NE 68509
OFFICE: 402-471-2118 | FAX: 402-742-8355

DHHS.ne.gov | **Facebook** | **Twitter** | **LinkedIn**

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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

PERFUSIONIST APPLICATION FOR REINSTATEMENT OF A LICENSE TO PRACTICE
(Revoked {Non-Disciplinary}, Lapsed, Expired or Placed on Inactive Status)

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

Name: _____

Address: _____

_____

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

1	Phone #: (optional)	Fax #: (optional)	E-Mail Address: (optional)
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 #
	NOTE: If you have both a SSN and an A# or I-94 number, 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.**		

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 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?	☐	☐			

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				
	Are you licensed in any other state?	☐	☐	If yes, what State(s) are you licensed in? State	License #	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 CONTINUING COMPETENCY:

CONTINUING COMPETENCY REQUIREMENTS		
In order to meet the continuing competency requirement for your license, **you must have completed the following within the 24 month period immediately preceding your application for reinstatement**: **1.** Perform a minimum of 80 clinical activities, as defined by ABCP, of which no more than 30 clinical activities may be documented intraoperative pump standbys that must be documentable in an audit; **and** 2. Earn 30 continuing education units (CEUs), as approved by the ABCP, of which 10 CEUs must be earned in Category 1.		
All applicants for reinstatement must answer the following question by placing a (✓) in the appropriate box (yes or no):	**Yes**	**No**
Have you met the continuing competency requirements as outlined above?	☐	☐

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:

☐	**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.
☐	**Initial License:** I was first licensed within the 24 months immediately preceding my date of application for active status.

SECTION D QUESTIONS:

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. Have you had any disciplinary or adverse action imposed against a professional license or permit in any state or jurisdiction?	☐	☐

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. Are you currently, or have you been, addicted to, dependent upon or chronically impaired by alcohol, narcotics, barbiturates, or other drugs which may cause physical and/or psychological dependence?	☐	☐
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?	☐	☐
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 podiatry 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 podiatry 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 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 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	Have you practiced perfusion in Nebraska since you last held an active credential?	☐ 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:

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.

☐ 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:

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

Print Name: _____

Signature: _____ Date: _____

Email (Optional): _____