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

Department of Health and Human Services
Division of Public Health
Investigations - Healthcare Professionals and Occupations

Mandatory Report from a Licensed Facility/Organization Reporting a Licensed Health Professional

We are a: ☐ Health Care Facility ☐ Professional Association ☐ Peer Review Organization

Licensed Health Facilities Reporting Licensed Health Professionals for adverse action to the Division of Public Health - Investigations Unit.

State of Nebraska
Department of Health and Human Services, Division of Public Health
Office of Professional & Occupational Investigations
P.O. Box 94722, Lincoln, Nebraska 68509
Phone: 402-471-0175
Fax: 402-742-8335
Email: DHHS.InvestigationsPOL@nebraska.gov

Identifying Information for Professional I am Reporting

Prefix	First Name	Last Name	Middle Initial	Suffix

Primary Phone	Alt Phone	Fax

Email Address

Physical Address:

Address Line 1	Address Line 2

City	State	Zip Code

Is Mailing Address the same as Physical Address? ☐ Yes ☐ No

Mailing Address:

Address Line 1	Address Line 2

PO Box	City	State	Zip Code

List the profession and license number for each Nebraska license, certificate, or registration held

Profession	License Number

Reporting Party Information

Business Name*			
Contact/Owner Prefix	Contact/Owner First Name*	Contact/Owner Last Name*	Contact/Owner Suffix
Primary Phone	Alt Phone	Fax	
Email Address			

Physical Address

Address Line 1	Address Line 2	
City	State	Zip Code

Is Mailing Address the same as Physical Address? ☐ Yes ☐ No

Mailing Address

Address Line 1		Address Line 2	
PO Box	City	State	Zip Code

Relationship to Health Care Professional

Preferred Method of Contact

Do you wish to remain anonymous? ☐ Yes ☐ No

Health Care Facility Only

☐ Made a payment due to adverse judgment, settlement, or award of a professional liability claim against the health care facility or health care professional.

☐ Took action adversely affecting the privileges, membership, or employment of a health care professional due to alleged:

- ☐ Incompetence
- ☐ Negligence
- ☐ Unethical or unprofessional conduct
- ☐ Physical, mental or chemical impairment

Peer Review Organization or Professional Association Only:

☐ Took action adversely affecting the privileges, membership, or employment of a health care professional due to alleged:

- ☐ Incompetence
- ☐ Professional Negligence
- ☐ Unprofessional conduct
- ☐ Physical, mental or chemical impairment

Reporting an adverse action	
Date action was taken	Effective Date
Duration of the effect of the action:	
Type of adverse action taken	
Patient or client giving rise to the action taken	
Name:	Date of Birth:
Address:	
Date of act, omission, or conduct	
Where did it occur?	
Malpractice Payment	
Name of Patient or Client	
Address	
Name of Court	
Address	
Date of Judgment, Settlement, or Award	Date of Payment
Amount of Payment	
List all persons present at time of incident that would have first-hand knowledge of the incident	
Name	
Title	Phone
Address	
Name	
Title	Phone
Address	

Name	
Title	Phone
Address	

Reason for Complaint*

Please describe the complaint and include as much detail as possible. Include where and when the complaint occurred and whom the complaint is against. Attach any additional documentation.

The statements I have made are true and correct to the best of my knowledge.

Please sign your name below.*

Date Signed*