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

Nebraska Department of Health and Human Services

Mandatory Report of Licensed Health Professionals from Licensed Facilities

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

STATE OF NEBRASKA *Name and address change eff 7/1/07 per LB296*
DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF PUBLIC HEALTH
Office of PROFESSIONAL & OCCUPATIONAL INVESTIGATIONS
1033 O Street, Suite 500 Lincoln, Nebraska 68508
402-471-0175

PROFESSIONAL I AM REPORTING

Name	First:	Middle/MI:	Last:	Maiden:	Date of Birth:
Work Address:	Street:				
	City:		State:		Zip:
Home Address:	Street:				
	City:		State:		Zip:
Telephone	Home:		Work:		

LIST THE FIELD AND NUMBER FOR EACH NEBRASKA LICENSE, CERTIFICATE, OR REGISTRATION HELD

License Field	License Number

REPORTING PARTY

Name:

Title:

Organization:

Address:

Telephone Number:	Fax Number:

Email Address:

Relationship to Health Care Professional:

We are a:

☐ Health Care Facility ☐ Peer Review Organization ☐ Professional Association

We have (Health Care Facility Only):

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

☐ Taken actions 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

We have (Peer Review Organizations or Professional Associations Only):

☐ Taken an action adversely affecting the privileges or membership 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:	Address:

Detailed description of act, omission, or conduct surrounding the reason of action taken:

Date of act, omission, or conduct:	Where did it occur?

List persons present at the end of the next page.

MALPRACTICE PAYMENT

Name of patient or client:	Address:
Name of Court:	Address
Date of judgement, settlement, or award:	Date of payment:

Amount of payment:

Description of the facts surrounding the reason of payment for the act or omission:

Date of occurrence:

Where did it occur?

How did the act or omission occur?

Describe the nature of any injury, illness, damage, or other loss upon which the claim was based:

PERSONS PRESENT AT TIME OF ACT OR OMISSION OR WITH FIRST HAND KNOWLEDGE

Name	Title
Address	Telephone
Name	Title
Address	Telephone
Name	Title
Address	Telephone