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 Licensed Health Professional Self-Reporting

Licensed Health Professionals reporting 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
1033 O Street, Suite 500, Lincoln, Nebraska 68508
Phone: 402-471-0175
Fax: 402-471-6238
Email: DHHS.InvestigationsPOL@nebraska.gov

Indicate the type of situation you are reporting.*

- ☐ Loss or voluntary limitation of privileges
- ☐ Resignation from staff
- ☐ Loss of employment
- ☐ Membership lost
- ☐ Professional liability
- ☐ Credential denied or disciplined
- ☐ Court conviction

Self Reporter's Information

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

Preferred Method of Contact

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

Profession	License Number

Patient or client name associated with this report.

Prefix	First Name	Last Name	Middle Initial	Suffix

Address Line 1	Address Line 2

City	State	Zip Code

Date of Birth

Facility, Board, Association, Jurisdiction, or Hospital associated with this report.

Business Name*

Contact/Owner Prefix	Contact/Owner First Name*	Contact/Owner Last Name*	Contact/Owner Suffix

Address Line 1	Address Line 2

City	State	Zip Code

Loss or voluntary limitation of privileges or resignation from staff or loss of employment report.

☐ 1. I lost my privileges in a hospital or other health care facility due to alleged:
- ☐ Incompetence
- ☐ Negligence
- ☐ Unethical or unprofessional conduct
- ☐ Physical, mental or chemical impairment
- ☐ Other_____

☐ 2. I voluntarily limited my privileges or resigned from the staff of a health care facility while under formal or informal investigations or evaluation by the facility or a committee of the facility for issues of:
- ☐ Clinical incompetence
- ☐ Unprofessional conduct
- ☐ Physical, mental or chemical impairment
- ☐ Other_____

☐ 3. I lost my employment due to alleged:
- ☐ Incompetence
- ☐ Negligence
- ☐ Unethical or unprofessional conduct
- ☐ Physical, mental or chemical impairment
- ☐ Other_____

Date the above action occurred	Date of incident that led to 1, 2, or 3 above

Name of person investigating or acting on privileges or employment		
Name of facility		
Address Line 1	Address Line 2	
City	State	Zip Code
Primary Phone		
Facility Name incident occurred, if different		
Facility Address incident occurred, if different		
Professional Liability Report ☐ 1. I had a professional liability claim that resulted in an adverse judgment, settlement, or award, including settlements made prior to suit: OR ☐ 2. My professional liability insurance coverage has been canceled, limited, or otherwise modified due to a professional liability claim, OR ☐ 3. I have refused professional liability insurance coverage on an initial or renewal basis due to a professional liability claim.		
Case Number		
Date(s) on which the act(s) or omission(s) which gave rise to the action or claim occurred		
Date of judgment, settlement, or award		
Date of payment	Amount	
Name of court or adjudicative body		
Address Line 1	Address Line 2	
City	State	Zip Code
Name of insurer, employer, other person, or entity making payment of the claim		
Address Line 1	Address Line 2	
City	State	Zip Code
Name of patient, client, or other person to whom or for whose behalf payment was made		
Address Line 1	Address Line 2	
City	State	Zip Code

Name of location or where act(s) or omission(s) occurred		
Address Line 1	Address Line 2	
City	State	Zip Code

Credential denied or disciplined, membership lost, or court conviction report.

☐ 1. I was denied a credential or other form of authorization to practice by a state, territory, or other jurisdiction, including any military or federal jurisdiction, due to alleged:

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

☐ 2. I had disciplinary action taken against a credential or other form of permit by another state, territory, or jurisdiction, including any federal or military jurisdiction, or I had a settlement of such action, or I voluntarily surrendered or had a limitation placed on my credential or other form of permit.

☐ 3. I lost my privileges in a hospital or other health care facility due to alleged:

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

Name of board, association, organization, or jurisdiction taking action		
Address Line 1	Address Line 2	
City	State	Zip Code
Date action taken	Date action effective	
Duration of action		

☐ 4. I was convicted of a misdemeanor or felony in Nebraska or another state, territory, or jurisdiction, including any federal or military jurisdiction. (Do not report speeding or parking tickets.) Include copy of conviction.

Name of court or adjudicative body		
City	State	Zip Code
Date of conviction	Case number	
Under appeal? To (Court)		
Name of crime for which convicted		

Reason for Self-Report*
Please describe the events leading to the actions noted above. Give as much detail as possible. 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*