State of Nebraska
Department of Health and Human Services Division of Public Health
Licensure Unit Attn: Vonda Apking
PO Box 94986, 301 Centennial Mall South
Lincoln, NE 68509-4986 * 402-471-2118

Application For Locum Tenens Permit
To Practice Dentistry In The State Of Nebraska
By A Dentist Licensed In Another State.

I hereby apply for a Certificate of Practice for temporary dental practice rights in the State of Nebraska for a period of time not to exceed 90 days in the twelve-month period commencing on the date of original issuance and submit the following statement concerning my qualifications therefore:

*Please note: A Locum Tenens is granted for the period specified on the application and for the dentist requesting such certificate. A new application must be submitted to this office for each term of service requested, but may not exceed 90 days in a 12-month period.

Name _____
(Print name in full, USE ONLY LEGAL NAME)

Permanent Address _____

_____

Phone number (optional): (_____)_____ Email(optional)_____

Date of Birth _____ Place of Birth _____

Social Security Number _____-_____-_____

EDUCATION:

Degree Issued By_____
Name of Univ./College

Degree issued on _____Circle one: DDS DMD
Date

EXAMINATION:

	YES	NO
Were you required to take a practical examination for the purpose of licensure?	_____	_____

Please indicate which examination and indicate the year the examination was taken:

- ❑ Western Regional Examining Boards (WREB) Year taken: _____
- ❑ Central Regional Dental Testing Services (CRDTS) Year taken: _____
- ❑ Southern Regional Testing Agency (SRTA) Year taken: _____
- ❑ North East Regional Board (NERB) Year taken: _____
- ❑ ADEX Examination Year taken: _____
- ❑ State Examination State: _____ Year taken: _____

PRACTICE

a. Total years of active practice in dentistry _____

b. List states where licensed to practice and effective date (list all states where you are licensed whether license is current or not)

State	License #	Issuance date	Current?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

A certification of licensure must be sent directly to our office from **at least one state** where you hold an active license to practice dentistry. The certification should include the name and address of the agency that issued the applicant's license to practice dentistry in another jurisdiction. It should also show the license number, issue date, expiration date, and any disciplinary information.

REGULATORY INFORMATION

If you answer YES to any of the following questions, explain the circumstances and outcomes on the back of this application. **You must sign and date any additional pages that you attach to the application. Please read the information at the end of this section regarding the malpractice and misdemeanor/felony conviction information that is required.**

	YES	NO
1. Has any state or territory ever taken any of the following actions against your license? Denied Suspended Revoked Limited	_____	_____
2. Has any licensing or disciplinary authority ever taken any of the following actions against your license? Limited Suspended Restricted Revoked	_____	_____
3. Has any licensing or disciplinary authority placed your license on probation?	_____	_____
4. Have you ever voluntarily surrendered a license issued to you by a licensing or disciplinary authority?	_____	_____
5. Have you ever voluntarily limited in any way a license Issued to you by a licensing or disciplinary authority?	_____	_____
6. Have you ever been requested to appear before any licensing agency?	_____	_____
7. Have you ever been notified of any charges or complaints filed against you by any licensing or disciplinary authority or criminal prosecution authority?	_____	_____
8. Have you ever been addicted to, dependent upon or chronically impaired by alcohol, narcotics, barbiturates, or other drugs which may cause physical and/or psychological dependence?	_____	_____

	YES	NO
9. During the past ten years, have you voluntarily entered or been involuntarily admitted to an institution or health care facility for treatment of a mental or emotional disorder/condition?	_____	_____
10. During the last ten years, have you been diagnosed with or treated for bipolar disorder, schizophrenia, or any psychotic disorder?	_____	_____
11. Have you ever been convicted of a felony?*	_____	_____
12. Have you ever been convicted of a misdemeanor?*	_____	_____
13. Have you ever been denied a Federal Drug Enforcement Administration (DEA) Registration or state controlled substances registration?	_____	_____
14. Have you ever been called before any licensing agency or lawful authority concerned with DEA controlled substances?	_____	_____
15. Have you ever surrendered your state or Federal controlled substances registration?	_____	_____
16. Have you ever had your state or federal controlled substances registration restricted in any way?	_____	_____
17. Have you ever been notified of any malpractice claim against you?**	_____	_____

All applicants must complete the following:

Effective July 1, 2004, the Department is authorized to assess an administrative penalty in the amount of $10 per day, not to exceed a total of $1,000 when evidence exists that a person has practiced medicine and surgery prior to being issued a license or permit.

1. Have you practiced dentistry in Nebraska prior to issuance of a Nebraska Permit or License?
   YES NO (Circle one)

   If yes, how many days have you practiced dentistry in Nebraska since July 1, 2004?

   _____
   Total Number of days

REQUEST FOR LOCUM TENENS ASSIGNMENT

Actual dates that you will be practice in Nebraska:

Start Date: _____

End Date: _____

REASON for temporary dental practice: _____

Date of last application for a Nebraska Locum Tenens Permit if any: _____

ALL APPLICANTS MUST SIGN AND DATE APPLICATION

I, _____, being first duly sworn say that I am the person
(Print Name)

referred to on this application, that I am of good moral character and that the statements on the application are true and complete.

_____
(Signature of Applicant)

_____
(Month-Day-Year)

*** Required Misdemeanor/Felony Conviction Information**
If you have had any misdemeanor or felony convictions you must submit:

1. Official Court Record, which includes charges and disposition;
2. Arrest records;
3. A letter from the applicant explaining the nature of the conviction;
4. All addiction/mental health evaluations and proof of treatment, if the conviction involved a drug and/or alcohol related offense and if treatment was obtained and/or required; and
5. A letter from the probation officer addressing probationary conditions and current status, if the applicant is currently on probation.

**** Required Malpractice Information**
Regarding your malpractice, claim(s), **please include the following information. Sign and date your explanation.**

A. State the **total number of claims ever filed a**gainst you; and
B. Submit a **detailed explanation** (see below) of each claim ever filed against you. Do not send copies of forms completed for insurance companies or other entities.
C. For any malpractice claims that are **currently pending**, submit copies of the court documents that outline the statement of charges (often called the "Complaint") and a letter from the attorney stating the current status of the claim.

Include the following information regarding each claim:
1. Name, sex and age of patient;
2. Date of occurrence;
3. Initial event (procedure/diagnosis);
4. Subsequent event that precipitated the claim – include the time sequence in relation to the initial event;
5. Damages – a description of damages or alleged damages resulting from the initial and subsequent events;
6. Date of filing of malpractice claim in court (if applicable);
7. Outcome of claim – include the court disposition, whether or not the case was settled, and the amount of any **monetary settlement or judgement made on your behalf.** If no money was paid on your behalf, you must indicate this**.**
8. Date of final outcome of claim.

NOTE: If you have had malpractice claims or Misdemeanor/Felony convictions your file may need to be reviewed by the Board of Dentistry at the next Board of Dentistry Meeting. Contact our office for the meeting dates.