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 Reporting Another Licensed Health Professional

Licensed Health Professional Reporting Alleged Violations by Another Licensed Health Professional 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

Profession	License Number

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

Reporting Party Information

A. I am in the same profession and it is necessary for me to report:

- ☐ A pattern of negligent conduct
- ☐ Unprofessional conduct
- ☐ Other violations of laws or regulations governing the practice of the profession
- ☐ Gross incompetence
- ☐ Practicing while his/her ability to practice is impaired by:
  - ☐ Controlled Substance
  - ☐ Alcohol
  - ☐ Narcotic drugs
  - ☐ Physical disability
  - ☐ Mental disability
  - ☐ Emotional disability
  - ☐ Other_____

B. I am in a different profession and it is necessary for me to report:

- ☐ Gross incompetence
- ☐ Practicing while his/her ability to practice is impaired by:
  - ☐ Controlled Substance
  - ☐ Alcohol
  - ☐ Narcotic drugs
  - ☐ Physical disability
  - ☐ Mental disability
  - ☐ Emotional disability

Prefix	First Name	Last Name	Middle Initial	Suffix

Primary Phone	Alt Phone	Fax

Email Address

Physical Address

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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

Do you wish to remain anonymous? ☐ Yes ☐ No

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	
Name	
Title	Phone
Address	

Patient/Client Associated with Report				
Prefix	First Name	Last Name	Middle Initial	Suffix

Date of Birth	Primary Phone Number	Alternate Phone Number
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*