

# NEVADA STATE BOARD OF MEDICAL EXAMINERS

## *SPECIAL EVENT MEDICAL LICENSURE*

ONLY original applications for licensure sent from The Nevada State Board of Medical Examiners or downloaded online applications will be accepted. Any applications which appear to have been altered in any form will not be accepted. Applications must be typed or legibly handwritten (illegible or incomplete applications will be returned). Applications must be received on single sided white bond paper, 8 ½” x 11” in size.

Applications not completed within six (6) months from date of receipt will be rejected per NAC 630.180(2).

### **SPECIAL EVENT LICENSURE FEES:**

<b>Special Event Medical License Application Fee .....</b>	<b>\$400</b>
<b>Criminal Background Investigation .....</b>	<b><u>\$ 75</u></b>
<b>TOTAL FEES .....</b>	<b>\$475</b>

**You may pay by cashier’s check or money order, payable to “NEVADA STATE BOARD OF MEDICAL EXAMINERS,” or by credit card. If paying by credit card, please complete the Credit Card Authorization form on the last page of this application. A two percent (2%) service fee will be assessed for payment by credit card.**

The Application fee and Criminal Background Investigation fee will not be refunded.

Per Nevada Revised Statute 630.161, “The Board shall not issue a license to practice medicine to an applicant who has been licensed to practice any type of medicine in another jurisdiction and whose license was revoked for gross medical negligence by that jurisdiction”.

The Board’s staff conducts an investigation into your background during the application process. If staff becomes aware of circumstances warranting a personal appearance at a Board meeting prior to acceptance of your application for licensure, your application must be completed 45 days prior to any regularly scheduled Board meeting in order for your appearance to be scheduled for that meeting for consideration of acceptance of your application. Under Nevada law, a public body cannot hold a meeting to consider the character, alleged misconduct, professional competence, or physical or mental health of any person unless it has given written notice to that person of the time and place of the meeting. The written notice must be sent by certified mail to the last known address of that person at least 21 working days before the meeting. A public body must receive proof of service of the notice before such a meeting may be held.

## SPECIAL EVENT LICENSE APPLICATION CHECKLIST

### TO BE RETURNED DIRECTLY TO BOARD OFFICE BY APPLICANT

_____ a	<p><b>APPLICATION:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Fully completed, signed and notarized application, including pages 1 – 5, Applicant Responsibility statement, and Criminal Background Investigation Report authorization form;</li> <li><input type="checkbox"/> Recent passport quality photograph (at least 2"x 2") attached to application, signed in ink on lower front edge;</li> <li><input type="checkbox"/> Appropriate explanations and copies of all pertinent documentation must be attached for affirmative responses to questions numbered 8, 9, 10, 11, and 12;</li> <li><input type="checkbox"/> Release form, signed and notarized (Form A);</li> </ul> <p>Malpractice - Provide signed and dated <u>explanations</u> for malpractice cases that occurred within the past 10 years answering who, what, where, when, why and settlement amount, if applicable. If you have a pending case or cases, you may be asked to request a status letter from your attorney to be sent directly to the Board.</p> <p><i>The Board reserves the right to require you to provide copies of legal documentation including but not limited to Arrest reports, Judgments of Conviction, Complaints, Settlements and/or Dismissals for malpractice cases, and Investigation documentation by any entity in question #12.</i></p>
_____ b.	<p><b>FEES:</b></p> <ul style="list-style-type: none"> <li>• Proper application AND criminal background investigation fees – <u>only</u> in the form of a cashier's check or money order made payable to Nevada State Board of Medical Examiners (NSBME) or by credit card as instructed. Credit cards will only be accepted by receipt of the signed credit card authorization form.</li> </ul> <p>Note: Application and criminal background investigation fees are <u>non-refundable</u>;</p>
_____ c.	<p><b>IDENTITY:</b></p> <ul style="list-style-type: none"> <li>• U.S. born citizens – photocopy of a certified Birth Certificate that bears an original seal of the issuing agency;</li> <li>• Foreign-born citizens – photocopy of Original Certificate of Naturalization or current U.S. Passport;</li> <li>• Non U.S. citizens - Copy of both sides of Alien Registration card or Employment Authorization card or Visa;</li> </ul>
_____ d.	<p><b>FOREIGN MEDICAL GRADUATES:</b></p> <ul style="list-style-type: none"> <li>• Copy of ECFMG certification report (per NRS 630.195);</li> </ul>
_____ e.	<p><b>ACADEMIC CREDENTIALS:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Copy of ABMS Board certification certificate; ABMS Board re-certification certificate; or ABMS SubBoard certification or recertification certificate(s);</li> </ul> <p><i>or if not ABMS Board certified, in the alternative you must provide copies of the following items:</i></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Copy of Medical school diploma or transcripts showing proof of Medical Doctor (MD) degree (per NRS 630.160 (2)(b)(1)(2));</li> <li><input type="checkbox"/> Copy of ACGME Postgraduate training certificate(s) of completion (per NRS 630.160(2)(d)(1)(I));</li> </ul>
_____ f.	<p><b>SAFE INJECTION PRACTICE REVIEW:</b> Review guidelines of the Centers for Disease Control and Prevention concerning the transmission of infectious agents through safe injection practices; (you will be required to attest within the application that you have reviewed these guidelines.)</p> <p style="text-align: center;"><a href="http://www.cdc.gov/hicpac/2007IP/2007isolationPrecautions.html">http://www.cdc.gov/hicpac/2007IP/2007isolationPrecautions.html</a> - or - <a href="http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf">http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf</a></p>
_____ g.	<p><b>FINGERPRINTING:</b> Fingerprint cards will be mailed to the applicant once application fees have been received. <i>(The Board fingerprint cards contain the necessary Board account numbers required for processing.);</i></p>
_____ h	<p><b>EXAMINATION REGARDING NEVADA LAW GOVERNING YOUR MEDICAL PRACTICE:</b></p> <p>Jurisprudence examination familiarizing you with the Medical Practice Act (Nevada Revised Statutes, Chapters 630 and 629 and Nevada Administrative Code, Chapter 630) will be mailed to you upon acknowledgement of receipt of your application and appropriate fees. You must answer correctly at least 75% of the questions.</p>

**SPECIAL EVENT LICENSE  
APPLICATION CHECKLIST**

**DIRECT SOURCE VERIFICATIONS  
TO BE SOLICITED BY APPLICANT FOR DIRECT RETURN  
BY THE VERIFYING INSTITUTION TO BOARD OFFICE**

*Verifying agencies may charge a fee. Do not provide pre-stamped or pre-addressed envelopes for direct source verifications.*

_____ a.	HOSPITAL VERIFICATION: Verification from hospital or surgery center (Form B) to be completed and returned directly to the Board office by the institution where the Special Event will be taking place, <u>if applicable</u> .
_____ b.	LICENSE VERIFICATION: Verification of state license (Form C) where applicant is currently licensed in good standing and where he/she is practicing clinical medicine.
_____ c.	MALPRACTICE CARRIER VERIFICATION: Verification from malpractice insurance carriers (Form D) only if requested by the Board.

**THE FOLLOWING MAY CONSTITUTE GROUNDS FOR DENIAL OF LICENSURE, AS SET OUT IN NRS 630.301 THROUGH NRS 630.3065:**

**NRS 630.301 Criminal offenses; revocation, suspension or other modification of previous license; surrender of previous license while under investigation; malpractice; engaging in sexual activity with patient; disruptive behavior; violating or exploiting trust of patient for financial or personal gain; failure to offer appropriate care with intent to positively influence financial well-being; engaging in disreputable conduct; engaging in sexual contact with surrogate of patient or relatives of patient.** The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure:

1. Conviction of a felony relating to the practice of medicine or the ability to practice medicine. A plea of nolo contendere is a conviction for the purposes of this subsection.
  2. Conviction of violating any of the provisions of NRS 616D.200, 616D.220, 616D.240, 616D.300, 616D.310, or 616D.350 to 616D.440, inclusive.
  3. The revocation, suspension, modification or limitation of the license to practice any type of medicine by any other jurisdiction or the surrender of the license or discontinuing the practice of medicine while under investigation by any licensing authority, a medical facility, a branch of the Armed Services of the United States, an insurance company, an agency of the Federal Government or an employer.
  4. Malpractice, which may be evidenced by claims settled against a practitioner, but only if such malpractice is established by a preponderance of the evidence.
  5. The engaging by a practitioner in any sexual activity with a patient who is currently being treated by the practitioner.
  6. Disruptive behavior with physicians, hospital personnel, patients, members of the families of patients or any other persons if the behavior interferes with patient care or has an adverse impact on the quality of care rendered to a patient.
  7. The engaging in conduct that violates the trust of a patient and exploits the relationship between the physician and the patient for financial or other personal gain.
  8. The failure to offer appropriate procedures or studies, to protest inappropriate denials by organizations for managed care, to provide necessary services or to refer a patient to an appropriate provider, when such a failure occurs with the intent of positively influencing the financial well-being of the practitioner or an insurer.
  9. The engaging in conduct that brings the medical profession into disrepute, including, without limitation, conduct that violates any provision of a national code of ethics adopted by the Board by regulation.
  10. The engaging in sexual contact with the surrogate of a patient or other key persons related to a patient, including, without limitation, a spouse, parent or legal guardian, which exploits the relationship between the physician and the patient in a sexual manner.
- (Added to NRS by 1977, 824; A 1981, 590; 1983, 305; 1985, 2236; 1987, 197; 1991, 1070; 1993, 782; 1997, 684; 2001, 766; 2003, 2707, 3433; 2003, 20th Special Session, 264, 265)

**NRS 630.304 Misrepresentation in obtaining or renewing license; false advertising; practicing under another name; signing blank prescription forms; influencing patient to engage in sexual activity; discouraging second opinion; terminating care without adequate notice.** The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure:

1. Obtaining, maintaining or renewing or attempting to obtain, maintain or renew a license to practice medicine by bribery, fraud or misrepresentation or by any false, misleading, inaccurate or incomplete statement.
  2. Advertising the practice of medicine in a false, deceptive or misleading manner.
  3. Practicing or attempting to practice medicine under another name.
  4. Signing a blank prescription form.
  5. Influencing a patient in order to engage in sexual activity with the patient or with others.
  6. Attempting directly or indirectly, by way of intimidation, coercion or deception, to obtain or retain a patient or to discourage the use of a second opinion.
  7. Terminating the medical care of a patient without adequate notice or without making other arrangements for the continued care of the patient.
- (Added to NRS by 1983, 301; A 1985, 2236; 1987, 198)

**NRS 630.305 Accepting compensation to influence evaluation or treatment; inappropriate division of fees; inappropriate referral to health facility, laboratory or commercial establishment; charging for services not rendered; aiding practice by unlicensed person; delegating responsibility to unqualified person; failing to disclose conflict of interest; failing to initiate performance of community service; exception.**

1. The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure:
    - (a) Directly or indirectly receiving from any person, corporation or other business organization any fee, commission, rebate or other form of compensation which is intended or tends to influence the physician's objective evaluation or treatment of a patient.
    - (b) Dividing a fee between licensees except where the patient is informed of the division of fees and the division of fees is made in proportion to the services personally performed and the responsibility assumed by each licensee.
    - (c) Referring, in violation of NRS 439B.425, a patient to a health facility, medical laboratory or commercial establishment in which the licensee has a financial interest.
    - (d) Charging for visits to the physician's office which did not occur or for services which were not rendered or documented in the records of the patient.
    - (e) Aiding, assisting, employing or advising, directly or indirectly, any unlicensed person to engage in the practice of medicine contrary to the provisions of this chapter or the regulations of the Board.
    - (f) Delegating responsibility for the care of a patient to a person if the licensee knows, or has reason to know, that the person is not qualified to undertake that responsibility.
    - (g) Failing to disclose to a patient any financial or other conflict of interest.
    - (h) Failing to initiate the performance of community service within 1 year after the date the community service is required to begin, if the community service was imposed as a requirement of the licensee's receiving loans or scholarships from the Federal Government or a state or local government for his medical education.
  2. Nothing in this section prohibits a physician from forming an association or other business relationship with an optometrist pursuant to the provisions of NRS 636.373.
- (Added to NRS by 1983, 301; A 1985, 2237; 1987, 198; 1989, 1114; 1991, 2437; 1993, 2302, 2596; 1995, 714, 2562)

**THE FOLLOWING MAY CONSTITUTE GROUNDS FOR DENIAL OF LICENSURE, AS SET OUT IN NRS 630.301 THROUGH NRS 630.3065:**

**Cont.**

**NRS 630.306 Inability to practice medicine; deceptive conduct; violation of statute or regulation governing practice of medicine; unlawful distribution of controlled substance; injection of silicone; practice beyond scope of license; practicing experimental medicine without consent of patient; lack of skill or diligence; filing of false report; habitual intoxication; failure to report modification of license in another jurisdiction.** The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure:

1. Inability to practice medicine with reasonable skill and safety because of illness, a mental or physical condition or the use of alcohol, drugs, narcotics or any other substance.
2. Engaging in any conduct:
  - (a) Which is intended to deceive;
  - (b) Which the Board has determined is a violation of the standards of practice established by regulation of the Board; or
  - (c) Which is in violation of a regulation adopted by the State Board of Pharmacy.
3. Administering, dispensing or prescribing any controlled substance, or any dangerous drug as defined in chapter 454 of NRS, to or for himself or to others except as authorized by law.
4. Performing, assisting or advising the injection of any substance containing liquid silicone into the human body, except for the use of silicone oil to repair a retinal detachment.
5. Practicing or offering to practice beyond the scope permitted by law or performing services which the licensee knows or has reason to know that he is not competent to perform.
6. Performing, without first obtaining the informed consent of the patient or his family, any procedure or prescribing any therapy which by the current standards of the practice of medicine are experimental.
7. Continual failure to exercise the skill or diligence or use the methods ordinarily exercised under the same circumstances by physicians in good standing practicing in the same specialty or field.
8. Making or filing a report which the licensee or applicant knows to be false or failing to file a record or report as required by law or regulation.
9. Failing to comply with the requirements of NRS 630.254.
10. Habitual intoxication from alcohol or dependency on controlled substances.
11. Failure by a licensee or applicant to report, within 30 days, the revocation, suspension or surrender of his license to practice medicine in another jurisdiction.
12. Failure to be found competent to practice medicine as a result of an examination to determine medical competency pursuant to NRS 630.318. (Added to NRS by 1983, 302; A 1985, 2238; 1987, 199, 800, 1554, 1575)

**NRS 630.3062 Failure to maintain proper medical records; altering medical records; making false report; failure to file or obstructing required report; failure to allow inspection and copying of medical records; failure to report other person in violation of chapter or regulations.** The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure:

1. Failure to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of a patient.
2. Altering medical records of a patient.
3. Making or filing a report which the licensee knows to be false, failing to file a record or report as required by law or willfully obstructing or inducing another to obstruct such filing.
4. Failure to make the medical records of a patient available for inspection and copying as provided in NRS 629.061.
5. Failure to comply with the requirements of NRS 630.3068.
6. Failure to report any person the licensee knows, or has reason to know, is in violation of the provisions of this chapter or the regulations of the Board. (Added to NRS by 1985, 2223; A 1987, 199; 2001, 767; 2002 Special Session, 19; 2003, 3433)

**NRS 630.3065 Willful disclosure of privileged communication; willful failure to comply with statute or regulation governing practice of medicine.** The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure:

1. Willful disclosure of a communication privileged pursuant to a statute or court order.
2. Willful failure to comply with:
  - (a) A regulation, subpoena or order of the Board or a committee designated by the Board to investigate a complaint against a physician;
  - (b) A court order relating to this chapter; or
  - (c) A provision of this chapter.
3. Willful failure to perform a statutory or other legal obligation imposed upon a licensed physician, including a violation of the provisions of NRS 439B.410. (Added to NRS by 1983, 302; A 1985, 2238; 1987, 200; 1989, 1663; 1993, 2302)

## NEVADA REVISED STATUTES – SPECIAL EVENT LICENSURE

1. Except as otherwise provided in NRS 630.161, the Board may issue a special event license to a licensed physician of another state to conduct demonstrations of medical techniques and procedures at a special event in this State.

2. A licensed physician of another state who applies for a special event license pursuant to this section:

(a) Must be in good standing in that state; and

(b) Is not required to take or pass a written examination concerning his qualifications to practice medicine but must satisfy the requirements for a special event license.

3. A physician who holds a special event license issued pursuant to this section may perform medical techniques and procedures pursuant to the license for demonstration purposes only.

4. A special event license issued pursuant to the provisions of this section is valid for a short period, as determined by the Board, and is not renewable.

5. For the purposes of this section, “special event” means a scheduled activity or event at which a physician appears as a clinician for teaching or demonstrating certain methods of technical procedures if:

(a) The persons attending the scheduled activity or event are:

(1) Members of a medical society or other medical organization;

(2) Persons who are attending a medical convention;

(3) Students or faculty members of a medical school; or

(4) Licensed physicians; and

(b) The scheduled activity or event is being held before any combination of the persons described in paragraph (a) and is being held at:

(1) A meeting or other gathering of a medical society or other medical organization;

(2) A medical convention;

(3) A medical school; or

(4) A licensed hospital.

**ATTENTION APPLICANT**  
**RESPONSIBILITY STATEMENT**

**Please sign and return this statement with your application for licensure to:**  
**The Nevada State Board of Medical Examiners,**  
**P.O. Box 7238, Reno, NV 89510**  
**or**  
**1105 Terminal Way, Suite 301, Reno, NV 89502**  
**(775) 688-2559**

Because you are applying for the privilege of practicing medicine in Nevada, you should know that our state has some of the most stringent licensing requirements and comprehensive investigation programs in the United States.

Our licensing specialists are likely to discover if data you have submitted on your application is erroneous or incomplete, or that you have omitted vital information.

Explaining and documenting a problem to your licensing specialist will be much less painful than discussing your honesty before the entire Board of Medical Examiners. This includes a sanction or disciplinary action you may have experienced during medical school or your postgraduate training, or any conflict you may have had with the legal system — **even if the charge(s) has been expunged, lessened, or dismissed and no matter how long ago it occurred, the FBI will have your fingerprints on file. This will be discovered.**

ONLY YOU — NOT A LAWYER, DOCTOR, SPOUSE, OR CREDENTIALING COMPANY — ARE RESPONSIBLE FOR READING AND ANSWERING EVERY QUESTION ACCURATELY AND COMPLETELY.

If you have *any* questions about your application, ASK YOUR LICENSING SPECIALIST. Our licensing specialists are here to help you.

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I have read this cover sheet and understand that I alone am responsible for completing my application for medical licensure in Nevada.

*Print* your name \_\_\_\_\_

*Sign* your name \_\_\_\_\_

Date \_\_\_\_\_

## SPECIAL EVENT MEDICAL LICENSE APPLICATION

### 1. PERSONAL INFORMATION

NOTE: All information requested is MANDATORY and MUST be provided except for the e-mail address which should be provided if you have one.

1. Present Legal Name \_\_\_\_\_  
Last First Middle Maiden  
List any other name(s) ever used \_\_\_\_\_ Gender:  Male  Female

2. Mailing Address \_\_\_\_\_  
Street City County State Zip

3. Home Address \_\_\_\_\_  
Street City County State Zip

4. Telephone Number (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ Fax Number (\_\_\_\_) \_\_\_\_\_  
Office Home  
Cellular Number (Optional) \_\_\_\_\_ Email \_\_\_\_\_

5. Date of Birth \_\_\_\_\_ Place of Birth \_\_\_\_\_  
City State Country

6. Citizenship: U.S. Citizen (Circle one): YES NO Alien Registration # \_\_\_\_\_  
Employment Authorization # \_\_\_\_\_

*Submit a photocopy of your birth certificate, photocopy of Certificate of Naturalization or of U.S. passport, or photocopy of the front and back of your alien registration card, Employment Authorization or Visa. Please note: Copy of document authorizing a name change (marriage license, divorce decree, etc) must be included, if applicable.*

7. Social Security Number \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Color of Eyes \_\_\_\_\_ Color of Hair \_\_\_\_\_

Pursuant to NRS 630.165(3), an application must include the social security number of the applicant;  
Pursuant to NRS 630.165(5), the applicant bears the burden of proving and documenting his qualifications for licensure.

### 2. QUESTIONS

For the purposes of the following questions, these phrases or words have these meanings:

“Ability to practice medicine” is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments;
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks such as physician examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

“Criminal offense” includes a felony, gross misdemeanor, and misdemeanor, and includes any violation of federal, state, or local law (including a violation of the Uniform Code of Military Justice). Minor traffic offenses are not included.

**For all YES responses to the following questions, you must submit your written explanations on a separate sheet attached to this form.**

8. Have you ever previously applied for a medical license in Nevada (including a residency program)? \_\_\_\_\_Yes \_\_\_\_\_No
9. Have you EVER been arrested, investigated for, charged with, convicted of, or pled guilty or nolo contendere to any offense or violation of any federal (including the Uniform Code of Military Justice), state or local law, or the laws of any foreign country, which is a misdemeanor, gross misdemeanor, felony, violation of the Uniform Code of Military Justice, or synonymous thereto in a foreign jurisdiction, excluding any minor traffic offense (driving or being in control of a motor vehicle while under the influence of a chemical substance, including alcohol, is not considered a minor traffic offense), or for any offense which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? \*Please note that you MUST disclose ANY investigation or arrest, including those where the final disposition was dismissal, or expungement. \_\_\_\_\_Yes \_\_\_\_\_No
10. Have you EVER been named as a defendant, or been requested to respond as a defendant, to a legal action involving professional liability, or malpractice, including any military tort claims if applicable? \_\_\_\_\_Yes \_\_\_\_\_No
11. Have you EVER had a professional liability, malpractice, claim paid on your behalf, or paid such a claim yourself including any military tort claims if applicable? \_\_\_\_\_Yes \_\_\_\_\_No
12. Have you EVER been: a) asked to respond to an investigation; b) notified that you were under investigation for; c) investigated for; d) charged with; or e) convicted of any violation of a statute, rule or regulation governing your practice as a physician by any medical licensing board, hospital, medical society, governmental entity or agency other than the Nevada State Board of Medical Examiners? \_\_\_\_\_Yes \_\_\_\_\_No

**3. ACADEMIC CREDENTIALS**

13. Doctor of Medicine Degree granted by:

Medical School Name	City/State	Exact Date of Issuance
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14. List all Accreditation Council for Graduate Medical Education (ACGME) approved graduate medical education you have received as an Intern, Resident or Fellowship in the United States or Canada.

Postgraduate Year (e.g. PGY1, PGY2, etc.)	Hospital/City/State Institution	Specify <small>I = Internship R = Residency F = Fellowship</small>	Type of Specialty	Dates of Attendance From (Mo./Yr.) To (Mo./Yr.)
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(All information must begin on the application. If more space is needed, please attach separate sheet.)

15. If you graduated from a medical school located outside the United States of America or Canada, list your Educational Commission for Foreign Medical Graduates (ECFMG) #: \_\_\_\_\_

16. State your scope of practice specialty(ies): \_\_\_\_\_

17. List any and all certifications and re-certifications by a board or sub-board recognized by the **AMERICAN BOARD OF MEDICAL SPECIALTIES (ABMS)**.

Specialty Board	Certification #	Dates of Certification / Recertification	(Mo./Yr)
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#### 4. EVENT INFORMATION

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18. Sponsor of Event and intended audience:

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19. Provide the name of the Nevada facility, school or hospital in which you **are to perform the requested procedure(s)** (if applicable).

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Date of Procedure	Facility / Hospital	Complete Mailing Address	(Month / Day(s) / Year)
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20. Description of your role or function at the Special Event:

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21. For all medical records that may be created in Nevada related to this special event medical license, please explain the arrangements you have made regarding the maintenance of those records and where they will be maintained per NRS 629.051 and NRS 629.061. (Please identify the Nevada Licensee, if applicable.)

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22. Applicant's current Malpractice Insurer (if applicable):

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(Please attached proof of current malpractice insurance coverage, when applicable)

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#### 5. STATE LICENSE INFORMATION

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23. List the state in which you currently reside, practice clinical medicine and hold unrestricted medical licensure in good standing in:

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State/Territory	License #	<u>Exact</u> Date of Issuance	From (Mo./Yr.) To (Mo./Yr.)
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#### 6. CHILD SUPPORT

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**PLEASE PLACE AN "X" NEXT TO THE STATEMENT THAT APPLIES TO YOU:**

- I am not subject to a court order for the support of a child.
- I am subject to a court order for the support of one or more children and am in compliance with the order or am in compliance with a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.
- I am subject to a court order for the support of one or more children and am **NOT** in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

**7. SAFE INJECTION PRACTICE ATTESTATION**

**ATTESTATION TO KNOWLEDGE OF AND COMPLIANCE WITH THE GUIDELINES OF  
THE CENTERS FOR DISEASE CONTROL AND PREVENTION  
FOR APPLICANT PHYSICIANS**

I hereby attest to knowledge of and compliance with the guidelines of the Centers for Disease Control and Prevention concerning the prevention of transmission of infectious agents through safe and appropriate injection practices. I also attest that any person who is currently, or will be under my control as their supervising physician in the future, and who is not licensed pursuant to chapter 630 of the Nevada Revised Statutes and whose duties involve injection practices, has knowledge of and is in compliance with the guidelines of the Centers for Disease Control and Prevention concerning the prevention of transmission of infectious agents through safe and appropriate injection practices.

Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

**8. AFFIDAVIT**

I, \_\_\_\_\_  
(Print your full name)

being duly sworn, depose and say: That the answers to the foregoing questions and statements made in the above application as well as any and all further explanations contained on any separate attached pages are true and correct, that I am the person named in the credentials to be submitted, and that the same were procured in the regular course of instruction and examination without fraud or misrepresentation. I understand that if any of my responses on this application are false, fraudulent, misleading, inaccurate, or incomplete, my application for licensure will be denied.

I am responsible to keep the Board informed of any circumstance or event that would require a change to my initial responses provided to the Board in my application for licensure, and which occur prior to my being granted licensure to practice medicine in the state of Nevada.

\_\_\_\_\_  
Signature of applicant Date

(NOTARY SEAL)

State of \_\_\_\_\_, County of \_\_\_\_\_

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

By: \_\_\_\_\_

Notary Public for the State of \_\_\_\_\_

My Commission Expires: \_\_\_\_\_

Residing at: \_\_\_\_\_

Signature of Notary: \_\_\_\_\_

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**9. APPLICANT PHOTOGRAPH**

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**APPLICANT PHOTOGRAPH:**

ATTACH A FINISHED PHOTOGRAPH OF PASSPORT QUALITY OF YOUR HEAD AND SHOULDERS ONLY.

PHOTOGRAPH MUST HAVE BEEN TAKEN WITHIN THE LAST SIX MONTHS AND BE AT LEAST 2" x 2" IN SIZE.

***CENTER AND ATTACH PHOTOGRAPH HERE.***

SIGN THE PHOTOGRAPH IN INK ACROSS THE LOWER PORTION OF ITS FRONT SIDE.

I hereby certify that the attached photograph is a true likeness of me taken within the last six months.

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Signature of applicant

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Date

# FORM A

## RELEASE

I hereby authorize all hospitals, medical institutions or organizations, my references, personal physicians, employers (past and present) business and professional associates (past and present) and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Nevada State Board of Medical Examiners any information, files or records required by the Nevada State Board of Medical Examiners for its evaluation of my professional, ethical and physical and mental qualifications for licensure in the state of Nevada.

DATED this \_\_\_\_\_ day of \_\_\_\_\_, 2\_\_\_\_\_.

Signature: \_\_\_\_\_

Typed or Printed Name: \_\_\_\_\_

State of \_\_\_\_\_ County of \_\_\_\_\_

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 2\_\_\_\_\_.

Notary Public for the State of \_\_\_\_\_

My Commission Expires: \_\_\_\_\_

Residing at: \_\_\_\_\_

City

State

\_\_\_\_\_  
Signature of Notary

(NOTARY SEAL)

A photocopy of this form will serve as an original.

### Please return completed form to:

Nevada State Board of Medical Examiners

PO Box 7238

Reno, NV 89510

*or*

1105 Terminal Way #301

Reno, NV 89502

# FORM B

## NEVADA STATE BOARD OF MEDICAL EXAMINERS VERIFICATION OF HOSPITAL / SURGERY CENTER PRIVILEGES FOR A SPECIAL EVENT LICENSE

Hospital: \_\_\_\_\_ Name: \_\_\_\_\_  
Attn: Medical Staff Office DOB: \_\_\_\_\_  
Address: \_\_\_\_\_ Specialty: \_\_\_\_\_  
Procedure Date: \_\_\_\_\_

The above named physician submitted an application to obtain a Special Event Medical license in Nevada. The applicant has indicated that he/she has been granted **one time procedure privileges** at your hospital / surgery center. In order that the processing of the application may be completed, we ask that you provide us with the information requested below.

1. What privileges will be extended to the special event license applicant?

\_\_\_\_\_  
\_\_\_\_\_

2. Name of the licensed **Nevada** physician who is receiving the assistance / training during the one time procedure: \_\_\_\_\_

3. Date of procedure: \_\_\_\_\_

4. Initials of patient receiving procedure: \_\_\_\_\_

5. Type of procedure: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Hospital Chief of Staff or Administrator: \_\_\_\_\_  
Signature

Hospital Chief of Staff or Administrator: \_\_\_\_\_  
Type or Print Name and Title

State of \_\_\_\_\_ County of \_\_\_\_\_

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 2\_\_\_\_\_.

Notary Public for the State of \_\_\_\_\_

My Commission Expires: \_\_\_\_\_

Residing at: \_\_\_\_\_

City State

\_\_\_\_\_  
Signature of Notary

(NOTARY SEAL)

**Please return completed form to:**  
Nevada State Board of Medical Examiners  
P.O. Box 7238, Reno, NV 89510 (Mailing Address)  
1105 Terminal Way, Suite 301  
Reno, NV 89502 (Physical Address)  
Phone: (775) 688-2559

Applicant: State where licensure is held must complete this form. *You may want to contact the state(s) where you were licensed since some states charge a fee for license verifications and some do not. The direct source verification of your license does not have to be completed on this form. It is a courtesy form which provides the Board's address.*

# FORM C

## NEVADA STATE BOARD OF MEDICAL EXAMINERS VERIFICATION OF STATE LICENSURE

### PART 1 – TO BE COMPLETED BY APPLICANT

Printed Name of Applicant: \_\_\_\_\_

Address:

\_\_\_\_\_

Street	Apt. or Suite #	City	State	Zip Code
--------	-----------------	------	-------	----------

Date of Birth: \_\_\_\_\_

Month	Day	Year
-------	-----	------

I am in the process of applying for a special event medical license in the state of Nevada. I hereby authorize release of the following information directly to the Nevada State Board of Medical Examiners at the above address.

\_\_\_\_\_  
Signature of Applicant

-----

### PART 2 – TO BE COMPLETED BY LICENSING AGENCY

I certify that \_\_\_\_\_ who  
Name of Applicant

graduated from \_\_\_\_\_  
Name and Location of Medical School

on \_\_\_\_\_ was granted license number \_\_\_\_\_ by the state of \_\_\_\_\_  
Date of Graduation

on \_\_\_\_\_ on the basis of \_\_\_\_\_  
Date of Issuance Examination: NB / FLEX / USMLE / LMCC / State Licensing Examination

I certify that the above license is:

_____	current, in good standing
_____	not current, due to non-payment of fees
_____	subject to pending disciplinary charges
_____	subject to restriction of licensure or practice
_____	other (please attach explanation)

**NOTE:** If any portion of this form is deleted or modified, please attach an explanation.

### PLEASE RETURN COMPLETED FORM TO:

Nevada State Board of Medical Examiners  
P.O. Box 7238  
Reno, NV 89510

\_\_\_\_\_  
Signature of Certifying Individual

\_\_\_\_\_  
Title of Certifying Individual

\_\_\_\_\_  
Licensing Agency Name

If you answered affirmatively to questions #10 and/or #11 on the Application for Special Event Licensure, you may, at the discretion of the Board, be asked to submit this form to all malpractice carriers verifying all coverage within the past 10 years. If more than one malpractice carrier, photocopies of the blank form may be made and used.

# FORM D

## NEVADA STATE BOARD OF MEDICAL EXAMINERS MALPRACTICE INSURANCE CARRIER VERIFICATION

### Insurance Carrier Information:

Name of Insured Physician: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

.....  
(To be completed by verifying agency only)

Policy Number: \_\_\_\_\_

Policy Period From: \_\_\_\_\_ To: \_\_\_\_\_

\*\*\*\*Please provide a loss history report with this verification.

### Claims Experience:

Has this Physician had a settlement paid on his/her behalf? \_\_\_\_ No \_\_\_\_ Yes

If "yes", please provide the following information:

*Occurrence*

*Date*

*Status*

*Date Closed*

*Indemnity*

*Amount*





*Description of Claim:* \_\_\_\_\_

*Occurrence*

*Date*

*Status*

*Date Closed*

*Indemnity*

*Amount*





*Description of Claim:* \_\_\_\_\_

### Insurance Carrier Agent:

\_\_\_\_\_  
Print Name and Title

\_\_\_\_\_  
Telephone

\_\_\_\_\_  
Signature of Agent

### Please return completed form to:

Nevada State Board of Medical Examiners  
P.O. Box 7238, Reno, NV 89510 (Mailing Address)  
1105 Terminal Way #301  
Reno, NV 89502 (Physical Address)  
Phone: (775) 688-2559

#### RELEASE

I hereby authorize the above named institution to release any information, files, or records required by the Nevada State Board of Medical Examiners for licensure in the state of Nevada.

\_\_\_\_\_  
Medical Doctor (applicant) signature and date

State of \_\_\_\_\_ County of \_\_\_\_\_

Subscribed and sworn to before me this \_\_\_\_\_ day of

\_\_\_\_\_, 2 \_\_\_\_\_.

Notary Public for the State of \_\_\_\_\_

My Commission Expires: \_\_\_\_\_

Residing at: \_\_\_\_\_

City State

\_\_\_\_\_  
Signature of Notary

**PERMISSION TO SEEK CRIMINAL BACKGROUND INVESTIGATION REPORT  
AND TO OBTAIN AND USE A SET OF MY FINGERPRINTS IN THIS REGARD**

I understand that all applicants applying for licensure with the Nevada State Board of Medical Examiners, pursuant to the Nevada Revised Statutes, Chapter 630, must submit a full set of his/her fingerprints, along with an authorization for the Nevada State Board of Medical Examiners to forward his/her fingerprints to the Department of Public Safety Records and Technology Division and to the Federal Bureau of Investigation for a state and federal criminal background investigation and report.

**I herewith and hereby grant permission and fully authorize the Nevada State Board of Medical Examiners to submit a complete set of my fingerprints to the Department of Public Safety Records and Technology Division for submission to the Federal Bureau of Investigation for their reports.**

I UNDERSTAND THAT THE COSTS OF FINGERPRINTING, THE BACKGROUND CHECK AND THE REPORT SHALL BE AT MY OWN EXPENSE.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 2\_\_\_\_\_

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Print Name

-----

By signing my signature on the line below, I do hereby understand that I must timely submit my fingerprints to the Nevada State Board of Medical Examiners in order for the Board to submit a complete set of my fingerprints to the Department of Public Safety Records and Technology Division for submission to the Federal Bureau of Investigation for their reports. Failure to do so could result in disciplinary action up to and including immediate summary suspension of my license. NRS 630.167.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

***Return this form to:***

Nevada State Board of Medical Examiners  
1105 Terminal Way, Ste. 301, Reno, NV 89502

***or***

P.O. Box 7238  
Reno, NV 89510

# CREDIT CARD AUTHORIZATION FORM

**If you are using your credit card for payment of application fees,  
this authorization form must be submitted with the application.**

**Please type or print legibly.**

Method of Payment:     MasterCard     Visa     American Express     Discover

Name on Credit Card: \_\_\_\_\_

Business Name (if applicable): \_\_\_\_\_

Credit Card Billing Address:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Credit Card Number: \_\_\_\_\_

Expiration Date: \_\_\_\_ / \_\_\_\_  
                          (MM)    (YYYY)

I authorize the Nevada State Board of Medical Examiners to charge the above credit card for a one-time payment in the amount of \$ \_\_\_\_\_, and an additional 2% service fee.

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_                      Date: \_\_\_\_\_