NEVADA STATE BOARD OF MEDICAL EXAMINERS
FEES FOR MEDICAL LICENSURE
BETWEEN JULY 1, 2009 AND JUNE 30, 2011

NOTE: APPLICATIONS WILL NOT BE PROCESSED WITHOUT RECEIPT OF BOTH THE APPLICATION AND REGISTRATION FEES IN THE FORM OF EITHER A CASHIER'S CHECK OR MONEY ORDER ONLY. **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 printed in black ink and received on single sided white bond paper, 8 ½" x 11" in size and must be typed or printed legibly.**

Applications not completed within six (6) months from date of receipt will be rejected per NAC 630.180 (2).
The Application fee and Criminal Background Check fee will not be refunded.

Active / Unrestricted $600 Application Fee plus Registration Fee $800 plus $75 Criminal Background Check Total = $ 1,475
Inactive Status $600 Application Fee plus Registration Fee $400 plus $75 Criminal Background Check Total = $ 1,075
Endorsement License $600 Application Fee plus Registration Fee $800 plus $75 Criminal Background Check Total = $ 1,475
Restricted License $400 Application Fee plus Registration Fee $400 plus $75 Criminal Background Check Total = $ 875
Authorized Facility License $400 Application Fee plus Registration Fee $400 plus $75 Criminal Background Check = $ 875

- To practice in a community without adequate medical care as determined by the Board
- To practice as a Psychiatrist in a Mental Health Center of the Division under the direct supervision of a licensed Psychiatrist or to practice in an institution of the Department of Corrections under the direct supervision of a physician who holds an unrestricted license.
- To practice in certain medical specialties for which there are critically unmet needs determined by the Governor
- To practice medicine in a medically underserved area of county

Locum Tenens $400 Application Fee plus Registration Fee $50 plus $75 Criminal Background Check Total = $ 525
A locum tenens license, to be effective not more than 3 months after issuance, to any physician who is licensed and in good standing in another state, who meets the requirements for licensure in this State and who is of good moral character and reputation. The purpose of this license is to enable an eligible physician to serve as a substitute for another physician who is licensed to practice medicine in this State and who is absent from his practice for reasons deemed sufficient by the Board. A license issued pursuant to the provisions of this paragraph is not renewable.

Temporary $400 Application Fee plus Registration Fee* $50 plus $75 Criminal Background Check Total = $ 525
A temporary license for a specified period if the physician is licensed and in good standing in another state and meets the requirements for licensure in this State, and if the Board determines that it is necessary in order to provide medical services for a community without adequate medical care. A temporary license issued pursuant to the provisions of this paragraph is not renewable.

Per Nevada Revised Statute 630.175, "an applicant for a license or a licensee shall report to the Board within 30 days any fact which would render any statement to the Board by the applicant or licensee false, misleading, inaccurate or incomplete".

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.**

** You **will** be required to personally appear before the Board for acceptance of your application for licensure if you are applying for a license by endorsement.

** You **may** be required to personally appear before the Board for acceptance of your application for licensure if you have in any way ever been involved in any malpractice awards, judgments, or settlements in any amount.

** You **may** be required to personally appear before the Board for acceptance of your application for licensure if you have answered in the affirmative ("Yes") to questions 8, 9, 10, 11, 12, 12a 13, 13a 14, 19, 27, 28, 29, 30, 31, 32 and 33.

If, at the time you meet with the Board, the Board votes to not accept your application for licensure, this non-acceptance of your application becomes a reportable action to the Healthcare Integrity and Protection Data Bank, Federation of State Medical Boards of the United States, Inc. and American Medical Association, among other entities.

APPLICATION CHECKLIST

TO BE RETURNED DIRECTLY TO BOARD OFFICE BY APPLICANT:

_____a. Properly completed, signed and notarized application, including pages 1 – 6 and Responsibility Statement;

_____b. Recent photo (at least 2"x 2") attached to application, signed in ink on lower edge of photograph;

_____c. Complete mailing addresses of all hospital staff memberships;

_____d. Month and year for all internships, residencies and fellowships;

_____e. Appropriate explanations and copies of all pertinent documentation must be attached for affirmative responses to questions numbered 8, 9, 10, 11, 12, 12a, 13, 13a, 14, 19, 27, 28, 29, 30, 31, 32 and 33;

(Examples: If you have ever been a defendant in a legal action involving professional liability (malpractice), whether or not you have ever had a settlement paid on your behalf, you should answer affirmatively to question #12 and submit the appropriate documentation, including copies of the Complaint, Settlement and Dismissal. If the case is pending, a letter from your attorney providing the status of the case.)

If you have ever had any actions, restrictions or limitation or imposed on you , or have been placed on probation while participating in any type of training program, you should answer affirmatively to question #19 and submit the appropriate documentation.

If you have ever been notified that you were under investigation by any medical licensing board, hospital, medical society, governmental entity or other agency, whether or not you were charged with or convicted of any violation of a statute, rule or regulation governing your practice as a physician, you should answer affirmatively to question #31 and submit the appropriate documentation.)

_____f. U.S. born citizens – certified copy of Birth Certificate that bears an original seal of of the issuing agency (notarized copies are not acceptable);

_____g. Foreign-born citizens - Original Certificate of Naturalization or current U.S. Passport;

_____h. Non U.S. citizens - Copy of both sides of Alien Registration card or Employment Authorization card or Visa;

_____i. Release form, signed and notarized (Form A);

_____j. Proper application AND registration fees - payable by cashier's check or money order only (please note, application fees are not refunded);

_____k. Self-query responses from the National Practitioner Data Bank (NPDB) AND the Healthcare Integrity and Protection Data Bank (HIPDB), see enclosed instruction sheet. The NPDB and HIPDB will send their reports directly to the applicant and the applicant will forward both reports to the board office.

_____l. FORM C: ONLY if applying for a license by endorsement – completed, notarized and returned to the Board office with completed application for licensure.

____m. Form B must be returned to the Board office with completed application for licensure.

____n. Copy of ABMS Board certification certificate, copy of ABMS Board re-certification certificate

____o. 4 hours bio-terrorism AMA Category 1 CME relating to the medical consequences of an act of terrorism that involves the use of a weapon of mass destruction (NRS 630.253 2.(b))

* Licenses will be issued in the applicant's name as it is indicated on the submitted documented proof of such name (i.e. U.S. Birth Certificate, Certificate of Naturalization, Alien Registration card, Employment Authorization card, and/or legal documentation reflecting name change).

APPLICATION CHECKLIST

TO BE SOLICITED BY APPLICANT FOR DIRECT RETURN
BY THE VERIFYING INSTITUTION TO BOARD OFFICE:
(Verifying agencies may charge a fee)

_____a. Certificate of Medical Education (Form 1) to be completed by medical school(s) and forwarded directly to the Board office;

_____b. Official transcripts from all schools where professional medical instruction was received (if transcripts are not in English, an original, certified and official English translation is required);

_____c. Certificate of Completion of Progressive Postgraduate Training (Form 2) sent to ALL institutions where any training occurred (internship, residency, fellowship and research fellowship);

_____d. Certification of National Board, FLEX, USMLE and SPEX scores request form or instructions enclosed OR state written examination certification Form 4 if applicable. For LMCC, call (613) 521-6012;

On June 17, 2009
NAC 630.080 is hereby amended to read as follows:
NAC 630.080 Examinations (NRS 630.130, 630.160, 630.180, 630.318)

1. For the purposes of paragraph (e) of subsection 2 of NRS 630.160, an applicant for a license to practice medicine must pass:

3. For the purposes of subparagraph (3) of paragraph © of subsection 2 of NRS 630.160, a person must pass Steps I, II and III of the United States Medical Licensing Examination within 7 years after the date on which the person first passes any step of the United States Medical Licensing Examination and a person is limited to a combined maximum of 9 attempts to pass steps I, II and no more than three attempts at step III of the United States Medical Licensing Examination.

_____e. Verification of board certification, if applying via state written exam/board certification;

_____f. License verification (Form 3) from all states where applicant is currently licensed or has ever been licensed;

_____g. Status report from the Educational Commission for Foreign Medical Graduates (ECFMG), use enclosed request form.

_____h. Form 5 to be completed by appropriate entity and returned directly by the verifying institution to the Board office.

_____i. Form 6 to be completed by appropriate entity and returned directly by the verifying institution to the Board office and must include the loss history report.

_____j FBI Criminal history background report – returned directly by the verifying institution to the Board office.
(Once application fees have been received, fingerprint cards and instructions will be mailed to the applicant

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, Ste 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.

o o o o o

I have read this responsibility statement and understand that I alone am accountable for completing my application for medical licensure in Nevada.

Print your name_____

Sign your name_____

Date_____

INSTRUCTIONS FOR REQUESTING EXAM SCORES, "BOARD ACTION HISTORY REPORT" AND NPDB/HIPDB "SELF QUERY"

NATIONAL PRACTITIONER DATA BANK AND HEALTHCARE INTEGRITY AND PROTECTION DATA BANK'S "PRACTITIONER REQUEST" FOR INFORMATION DISCLOSURE (SELF-QUERY):

The request form for the NPDB and HIPDB is available on the NPDB/HIPDB website at www.npdb-hipdb.hrsa.gov/welcomesq.html
Once you reach the web site, you will be in the "self query service" module of the NPDB/HIPDB web site. You will need to click on "Perform a "self-query" in the center of the page, then click on "Individual Self-Query" and follow the instructions provided. If you require additional information, please call the NPDB/HIPDB at (800) 767-6732.

NOTE: Once you have received the NPDB and HIPDB self-query responses, forward **both** of them to the Board office.

FLEX, SPEX and USMLE AND BOARD ACTION HISTORY REPORT (EBAHR) FROM THE FEDERATION OF STATE MEDICAL BOARDS OF THE UNITED STATES

The Federation of State Medical Boards of the United States, Inc.'s EBAHR will certify a complete history of your scores for a designated examination(s). The Federation maintains scores for FLEX, SPEX, and the USMLE Steps 1, 2, and 3.
The request form for the EBAHR is available on the FSMB web site at www.fsmb.org.
Once you reach the FSMB web site, click on "Transcripts Requests", then "EBHAR Form" and follow the instructions for requesting the scores.

NATIONAL BOARD SCORES:

The request form for the National Board of Medical Examiners is available on the NBME web site at http.// www.nbme.org/pdf/endorse.pdf. If you are unsuccessful in downloading or printing this form, or do not have access to a computer, please send to the NBME a signed, written request for your scores which includes the state to which you are applying, your name (please print), USMLE ID# or NBME ID# or SSN, date of birth, current address, phone number and e-mail address (if applicable). Include $50 for one endorsement and $5 for each additional endorsement requested at the same time. Make your check payable to NBME and mail to:

NBME
PO Box 48014
Newark, NJ 07101-4814.

For additional information, please call the NBME Examinee Records office at (215) 590-9592.

LMCC EXAMINATION TRANSCRIPT OF SCORES

Navigate to this website: www.mcc.ca
Click on **English; go** to **Licentiate** on the menu line; then go to **Certified Transcript of Examinations**.
Then click on **Service Request Form**.
Print the Service Request Form and complete it. Mail it along with your check to the address on the top of the form. Or, if you are paying by credit card, you can fax the form to the fax number located on the form itself and also on the instruction page.

ECFMG VERIFICATIONS

International medical graduates must contact the ECFMG for certification status to be sent to the Nevada State Board of Medical Examiners. You can contact ECFMG's Applicant Information Services at (215) 386-5900.
The request form can be found on ECFMG's website at www.ecfmg.org

THE FOLLOWING 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)

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)

7/1/2009 - 6/30/2011 PHYSICIAN APPLICATION FOR LICENSURE NEVADA STATE BOARD OF MEDICAL EXAMINERS

Date Received by Board

License No._____

File No._____

(For Board Use Only)

Post Office Box 7238 Reno, Nevada 89510 Phone (775) 688-2559

1. Present Legal Name _____
Last First Middle Maiden

List any other name(s) ever used _____

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 address_____

5. Date of Birth _____ Place of Birth _____ Gender____F____M
(Month / Day / Year) (City, State, Country)

6. Citizenship: U.S. Citizen _____ Alien Registration # _____ Employment Authorization # _____ Applying for Visa_____
Submit a certified copy of birth certificate or original Certificate of Naturalization or current U.S. passport or copy 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.

7. Social Security Number _____ Color of Eyes _____ Color of Hair _____ Height _____ Weight _____
NRS 630.165(3) An application submitted pursuant to subsection 1 or 2 must include the social security number of the applicant;
NRS 630.165(5) The applicant bears the burden of proving and documenting his qualifications for licensure.

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.

"Medical condition" includes physiological, mental or psychological condition or disorder.

"Chemical substances" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction.

FOR ALL "YES" RESPONSES TO THE FOLLOWING QUESTIONS, YOU MUST SUBMIT YOUR WRITTEN EXPLANATION(S) ON A SEPARATE SHEET ATTACHED TO YOUR COMPLETED *APPLICATION FOR LICENSURE* FORM.

8. Do you currently have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety?
_____Yes _____No

9. If you currently have a medical condition which in any way impairs or limits your ability to practice medicine, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? _____Yes _____No

10. If you currently use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety?
_____Yes _____No

11. Have you failed to initiate the performance of public service within one year after the date the public service is required to begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local government for your medical education?
_____Yes _____No

12. Have you EVER been named as a defendant, or been requested to respond as a defendant or potential defendant, to a legal action involving professional liability? (malpractice?) (Including any military tort claims if applicable))? (IF ANSWER IS "YES", YOU MUST COMPLETE FORM B AND FORM 6 – see Application Checklist.) _____Yes _____No

12a. Have you 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

13. Have you been arrested, investigated for, charged with, convicted of, or pled guilty or nolo contendere to any criminal offense 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, sealing of a record, or expungement. (If "Yes," attach explanation on separate sheet.) _____Yes _____No

13a. Have you been arrested, investigated for, charged with, convicted of, or pled guilty or nolo contendere to any criminal offense other than a criminal offense listed in question #13? *Please note that you MUST disclose ANY investigation or arrest, including those where the final disposition was dismissal, sealing of a record, or expungement. (If "Yes," attach explanation on separate sheet.) _____Yes _____No

14. Have you previously applied for medical licensure in Nevada (including a residency program)? _____Yes _____No

15. List names and addresses of all medical schools attended. **HAVE EACH MEDICAL SCHOOL SUBMIT AN OFFICIAL TRANSCRIPT DIRECTLY TO THE BOARD.**

Name	City/State	Place Where Instruction Received	Dates of Attendance From (Mo./Yr.) To (Mo./Yr.)

(All information must begin on the application, if more space is needed, please attach separate sheet.)

16. Doctor of Medicine Degree granted by:

Medical School Name	City/State	Exact Date of Issuance

17. List all ACGME* approved graduate medical education you have received as an Intern, Resident or Fellowship in the United States or Canada.
*Accreditation Council for Graduate Medical Education

Postgraduate Year	Hospital/ Institution	City/State	Specify (I =Internship or R = Residency) (F = Fellowship)	Type of Specialty	Dates of Attendance From (Mo./Yr.) To (Mo./Yr.)

(All information must begin on the application, if more space is needed, please attach separate sheet.)

18. List all non-ACGME approved Fellowship training programs attended in the United States or Canada.

Institution	City/State	Type of Fellowship	Dates of Attendance From (Mo./Yr.) To (Mo./Yr.)

(All information must begin on the application, if more space is needed, please attach separate sheet.)

19. Have you **EVER** been the subject of an investigation (including matters that resulted in no adverse action or outcome to you) have you resigned, been dismissed, or have any actions, restrictions, limitations, probations, terminations or any other disciplinary actions ever been imposed on you while participating in any type of training program? (If "Yes," attach explanation on separate sheet.) _____Yes _____No

20. If you graduated from a medical school located outside the United States of America or Canada, list your ECFMG#:_____

21. For each of the following licensing examinations, list the location, parts and dates taken, and scores obtained, (also include any failed examinations). **FOR EACH EXAM TAKEN, HAVE CERTIFICATE OF SCORES SUBMITTED FROM THE TESTING ENTITY DIRECTLY TO THE BOARD OFFICE.**

21a. NATIONAL BOARDS: (ALSO INCLUDE ALL INFORMATION PERTAINING TO ANY AND ALL FAILED EXAMINATIONS.)

Location	Part Taken	Date (Mo/Yr)	Results (Two Digit Scores)

21b. FLEX (Federation Licensing Examination): (ALSO INCLUDE ALL INFORMATION PERTAINING TO ANY AND ALL FAILED EXAMINATIONS.)

Location	Part Taken	Date (Mo/Yr)	Results (Two Digit Scores) (FLEX weighted average)

21c. USMLE (United States Medical Licensing Examination): (ALSO INCLUDE ALL INFORMATION PERTAINING TO ANY AND ALL FAILED EXAMINATIONS.)

Location	Part Taken	Date (Mo/Yr)	Results (Two Digit Scores)

21d. LMCC (Licentiate of the Medical Council of Canada): (ALSO INCLUDE ALL INFORMATION PERTAINING TO ANY AND ALL FAILED EXAMINATIONS.)

Location	Part Taken	Date (Mo/Yr)	Results (Scores)

21e. State Written Examination:

Location	Part Taken	Date (Mo/Yr)	Results (Scores)

21f. SPEX (Special Purpose Examination):

Location	Date (Mo/Yr)	Results (Scores)

22. State your scope of practice/specialty(ies):_____

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

Specialty Board	Certification #	Dates of Certification/Recertification (Mo/Yr)

24. Account for, **in chronological order**, all activities since graduation from medical school. **ALL PERIODS OF TIME MUST BE ACCOUNTED FOR. (Curriculum Vitae is unacceptable)**

Activities	Location (City/State/Country)	From (Mo./Yr.)	To (Mo./Yr.)

(All information must begin on the application, if more space is needed, please attach separate sheet.)

25. List below the requested information for all hospitals or surgery centers in which you **ARE, OR HAVE EVER BEEN** a staff member at any level during the last ten years. If none, please indicate. Do not list internship, residency or fellowship affiliation.

Hospital	Complete Mailing Address	Dates of Appointment From (Mo./Yr.)	To (Mo./Yr.)

(All information must begin on the application, if more space is needed, please attach separate sheet.)

26. List any and all licenses (including training licenses and permits) **YOU HOLD OR HAVE HELD** to practice medicine in any state, territory or country.

State/Territory Country	License #	Exact Date of Issuance	Dates of Practice From (Mo./Yr.)	To (Mo./Yr.)

(All information must begin on the application, if more space is needed, please attach separate sheet.)

27. Have you EVER been denied a license, permission to practice medicine or any other healing art, or permission to take an examination to practice medicine or any other healing art in any state, country or U.S. territory? (If "Yes," attach explanation on separate sheet.) _____Yes _____No

28. Have you EVER had a medical license or license to practice any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory? (If "Yes," attach explanation on separate sheet.) _____Yes _____No

29. Have you EVER voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory? (If "Yes," attach explanation on separate sheet.) _____Yes _____No

30. Have you EVER been denied membership, asked to resign, or expelled from a medical society or other professional medical organization? (If "Yes," attach explanation on separate sheet.) _____Yes _____No

31. 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? (If "Yes," attach explanation on separate sheet.) _____Yes _____No

32. Have you EVER surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? _____Yes _____No
(If "Yes," attach explanation on separate sheet.)

33. List all hospitals where you have had staff privileges denied, suspended, limited, revoked or not renewed by the hospital. List any and all resignations from any medical staff in lieu of disciplinary or administrative action. (Please Note: Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance).

Hospital	Mailing Address	Type of Action	Dates of Action From (Mo./Yr.) To (Mo./Yr.)

(All information must begin on the application, if more space is needed, please attach separate sheet.)

CHILD SUPPORT STATEMENT

The law of the state of Nevada requires that all applicants for issuance of a license be required to provide the following information concerning the support of a child. You are advised that this questions is part of your application, your response is given under oath, and any response hereto which is false, fraudulent, misleading, inaccurate or incomplete, may result in your application being denied. You must mark one of the following responses, and failure to mark one of the responses may result in denial of your application.

Please place a check mark next to one of the following statements:

_____ (a) I am not subject to a court order for the support of a child;

_____ (b) 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; **OR**

_____ (c) 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.

I, _____ 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.

_____ _____
(signature of applicant) (date)

(NOTARY SEAL)

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: _____

_____

Signature of Notary: _____

APPLICANT PHOTOGRAPH:

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

PHOTOGRAPH MUST HAVE BEEN TAKEN WITHIN THE LAST SIXTY (60) DAYS AND BE AT LEAST 2" x 2" IN SIZE.

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

PROOF PHOTOS, NEGATIVES AND DIGITAL PHOTOS ARE NOT ACCEPTABLE.

CENTER AND ATTACH PHOTOGRAPH HERE.

I hereby certify that the attached photograph is a true likeness of myself taken within the last sixty (60) days.

_____ _____

(signature of applicant) (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: _____

(NOTARY SEAL)

State of _____ County of _____

Subscribed and sworn to before me this

_____ day of _____, 2_____.

Notary Public for State of: _____

My Commission Expires: _____

Residing at: _____
City State

_____
Signature of Notary

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

LIST OF MALPRACTICE INSURANCE CARRIERS

If you answered affirmatively to question #12 on the Application for Licensure, list all malpractice carriers, past and present.

Name of Insured: _____

Insurance Company: _____
Address: _____
_____
_____
Phone Number: _____
Fax Number: _____
Policy Number: _____
Dates: _____

Insurance Company: _____
Address: _____
_____
_____
Phone Number: _____
Fax Number: _____
Policy Number: _____
Dates: _____

Insurance Company: _____
Address: _____
_____
_____
Phone Number: _____
Fax Number: _____
Policy Number: _____
Dates: _____

Insurance Company: _____
Address: _____
_____
_____
Phone Number: _____
Fax Number: _____
Policy Number: _____
Dates: _____

(If more space is needed, please copy this page or attach a separate sheet.)

FORM C

REQUEST FOR LICENSURE BY ENDORSEMENT

(ENDORSEMENT IS NOT THE SAME AS RECIPROCITY)

State your Name, and fill in the State, territory, or District of Columbia in which licensed:

I, _____, being first duly sworn, do hereby swear or affirm under the penalties of perjury that the statements contained herein are true and correct to the best of my knowledge.

That I am now, and have been continuously licensed to practice medicine by the licensing agency of

_____, since _____.
(state, territory, or District of Columbia) (month / day / year)

That I have never had a license to practice any type of medicine in any jurisdiction, country, state, territory, or District of Columbia, revoked for gross medical negligence.

That I am the person named in the license to practice medicine in _____,
(state, territory, or District of Columbia)
and that said license to practice medicine was obtained by me without fraud or misrepresentation or any mistake of which I am aware, and that all information contained in this application for licensure by endorsement, and any accompanying materials are complete and correct.

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 SEAL)

By: _____

Notary Public for State of: _____

My Commission Expires: _____

Residing at: _____
City State

_____
Signature of Notary

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

Applicant: ***Each medical school where instruction was received must complete this form. If more than one school was attended, photocopies of this blank form may be made and used.***

FORM 1

NEVADA STATE BOARD OF MEDICAL EXAMINERS
VERIFICATION OF MEDICAL EDUCATION

This certifies that _____
(name of applicant)

was enrolled in _____
(name of Medical School) (Location – City/State)

To be completed by program only.

The undersigned further certifies that the records of this institution show that the applicant attended

this institution from _____ to _____.
(month / year) (month / year)

Please check one: _____ The applicant was granted a medical degree by

_____ The applicant withdrew from

the above named Medical School on _____.
(month / day / year)

ADVANCED CREDITS – Credits Granted Upon Admission

_____ _____ _____
(name of Medical or Professional School) (total credits) (dates attended)

Signed and the institutional seal affixed this

_____ day of _____, 2_____.

Affix Seal Here

By: _____
(typed name and title of President, Registrar or Dean)

_____
(signature of President, Registrar or Dean)

Completed form is to be returned by the verifying institution directly to:

Nevada State Board of Medical Examiners
PO Box 7238
Reno, NV 89510 ***or***
1105 Terminal Way #301
Reno, NV 89502
(775) 688 – 2559

Applicant: ***Each institution where internship, residency and/or fellowship training was received must complete this form. If more than one institution was attended, photocopies of this blank form may be made and used.***

FORM 2

NEVADA STATE BOARD OF MEDICAL EXAMINERS
VERIFICATION OF POSTGRADUATE TRAINING

Institution: _____ Affiliated University: _____

Address: _____

Name of Physician: _____

DOB: _____ SS#: _____ Medical School: _____

The following information to be completed by program only.

IMPORTANT - Program Participation: *Report incomplete postgraduate years (PGY) separately from those that were successfully completed. If the postgraduate year is currently in progress, report the expected completion in the "To" field. Report internships, residencies and fellowships separately.*

PG/Year:_____ DEPARTMENT / SPECIALTY: _____

_____ Internship
_____ Residency **From:** _____/_____/_____ **To:** _____/_____/_____
_____ Fellowship
_____ Research **Successfully completed?: _____ Yes _____ No _____ In Progress**

PG/Year:_____ DEPARTMENT / SPECIALTY: _____

_____ Internship
_____ Residency **From:** _____/_____/_____ **To:** _____/_____/_____
_____ Fellowship
_____ Research **Successfully completed?: _____ Yes _____ No _____ In Progress**

PG/Year:_____ DEPARTMENT / SPECIALTY: _____

_____ Internship
_____ Residency **From:** _____/_____/_____ **To:** _____/_____/_____
_____ Fellowship
_____ Research **Successfully completed?: _____ Yes _____ No _____ In Progress**

Circle the correct response to the question below:

1.Is this training approved by the Accreditation Council for Graduate Medical Education (ACGME)? **Yes** **No**

Circle the correct response to the questions below: ("Yes" responses require written explanation.)

2. Did this individual ever take a leave of absence or break from their training? If yes, please explain. **Yes** **No**
3. Was this individual disciplined and/or placed under investigation or on probation? **Yes** **No**

Please explain below any "Yes" response(s) to the above two questions. If necessary, you may continue your explanation on a separate sheet of paper.

_____

_____

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct.

Name: _____ **Signature:** _____

This section MUST be signed by the Program Director ***(M.D. or D.O. only)***

Title: _____ **Date of Signature:** _____

Telephone: _____ **Fax:** _____ **E-mail:** _____

Completed form is to be returned by the verifying institution directly to:

Nevada State Board of Medical Examiners
PO Box 7238 **OR** **1105 Terminal Way, Ste 301**
Reno, NV 89510 **Reno, NV 89502**
(775) 688 – 2559

Applicant: ***Each state where licensure is or ever was held must complete this form. If more than one state, photocopies of this blank form may be made and used.***

FORM 3

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)

Date of Birth: ____________________
(month) (day) (year)

I am in the process of applying for medical licensure in the state of Nevada. I hereby authorize release of the following information directly to the Nevada State Board of Medical Examiners at the address below.

____
(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)

I certify that the records in this office indicate that there are not now nor have there ever been any charges filed against the holder of this license.

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

____
(signature of certifying individual)

____
(title of certifying individual)

____
(licensing agency name)

____
(date of signature)

Completed form is to be returned by the verifying institution directly to:

Nevada State Board of Medical Examiners
PO Box 7238 **OR** **1105 Terminal Way, Ste 301**
Reno, NV 89510 **Reno, NV 89502**
(775) 688 – 2559

Applicant: ***This form to be completed ONLY if applying via state written examination with current ABMS certification. This form is to be completed by the state-licensing agency where examination was taken.***

FORM 4

NEVADA STATE BOARD OF MEDICAL EXAMINERS
VERIFICATION OF STATE LICENSING EXAMINATION

I certify that _____ who
(name of applicant)

graduated from _____
(name and location of Medical School)

on _____ was granted license number _____ on _____
(date of graduation) (date of issuance)

on the basis of the licensing agency regular written examination of the state of _____.

I further certify that this physician passed the regular written examination given by this licensing agency on _____
(date)

and obtained a general average of _____ percent in the following subjects. A score of _____ is

considered a passing score.

Subjects of Examination	Percent	Subjects of Examination	Percent

I certify that this license is valid, current, has never been suspended or revoked, and will expire on _____;
(date)

OR this license was valid, was never suspended or revoked, and expired on _____.
(date)

NOTE: If any portion of the above certification is deleted or modified, please attach an explanation.

_____ _____
(type or print name and title of agency official) (name of state licensing agency)

_____ _____
(signature of agency official) (address)

_____ _____
(date) (phone number)

(affix licensing agency seal)

Completed form is to be returned by the verifying institution directly to:

Nevada State Board of Medical Examiners
PO Box 7238
Reno, NV 89510
(775) 688 – 2559

FORM 5

NEVADA STATE BOARD OF MEDICAL EXAMINERS
VERIFICATION OF HOSPITAL OR SURGERY CENTER PRIVILEGES

Hospital: _____
Attn: Medical Staff Office
Address: _____
_____

Name: _____
DOB: _____
Specialty: _____
Affiliation dates: _____

The above named physician submitted an application to obtain a medical license in Nevada. The applicant has indicated that he/she holds or has held staff privileges at your hospital. 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 are/were extended to the applicant? _____
_____

2. Dates of hospital privileges: From_____ To_____
   month / year month / year

3. Have staff privileges ever been limited, restricted, suspended or revoked? No_____ Yes_____
   If Yes, please explain: _____
_____

4. Is there any derogatory information on file? No _____ Yes_____ If Yes, please explain:
_____
_____

5. Do your records indicate applicant having privileges at any other hospitals in your area?
   No_____ Yes_____ If Yes, please attach list.

_____
Signature:
Hospital Chief-of-Staff or Administrator

_____
Typed Name, Title and Date

Phone #_____
Fax #_____
Email_____

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

Subscribed and sworn to before me this ____day of _____, 200__.
By: _____
Notary Public for State of: _____
My Commission Expires: _____

_____
Signature and Seal of Notary Public

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

If you answered affirmatively to question #12 on the Application for Licensure, submit this form to all malpractice carriers. If more than one malpractice carrier, photocopies of the blank form may be made and used.

FORM 6

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

Subscribed and sworn to before me this ____day of _____, 200__.

By: _____

Notary Public for State of: _____

My Commission Expires: _____

_____

Signature and Seal of Notary Public