**PHYSICIAN ASSISTANT**
**APPLICATION FOR REINSTATEMENT**
**FOR THE BIENNIAL REGISTRATION PERIOD 2009 - 2011**
**NEVADA STATE BOARD OF MEDICAL EXAMINERS**

Post Office Box 7238 Reno, Nevada 89510 Phone (775) 688-2559
Physical Address: 1105 Terminal Way, Suite 301 Reno, Nevada 89502

Date Received by Board

License No._____

File No._____
(For Board Use Only)

I hereby apply for reinstatement to active status and enclose the appropriate fee as indicated below:

_____PHYSICIAN ASSISTANT REINSTATEMENT FEE: $800.00

**NAME:** _____

Make checks payable to:
**NEVADA STATE BOARD OF MEDICAL EXAMINERS**
(Foreign checks must indicate "U.S. FUNDS")

## ***PLEASE NOTE:***

- **THIS *APPLICATION FOR REINSTATEMENT TO ACTIVE STATUS REGISTRATION* FORM IS THE FORM TO BE COMPLETED FOR REINSTATEMENT TO ACTIVE STATUS PHYSICIAN ASSISTANT LICENSURE IN THE STATE OF NEVADA.**
- **YOUR STATUS WILL NOT BE CHANGED AND/OR YOU WILL NOT BE REINSTATED UNLESS YOU ANSWER ALL QUESTIONS ON THIS *APPLICATION FOR REINSTATEMENT TO ACTIVE STATUS REGISTRATION* FORM. YOU MUST PROVIDE WRITTEN EXPLANATIONS FOR ALL QUESTIONS ANSWERED "YES."**
- **ALL INFORMATION YOU PROVIDE ON THIS *APPLICATION FOR REINSTATEMENT TO ACTIVE STATUS REGISTRATION* FORM IS PUBLIC INFORMATION.**

# PLEASE TYPE OR PRINT LEGIBLY

1. Active status registration requires the submission of proof of completion of 40 hours of AAPA OR AMA Category 1 continuing medical education (CME), which includes 2 hours of CME in medical ethics, 20 hours of CME in your scope of practice or specialty and 18 hours of CME in any other AMA Category 1 course - **completed during the preceding 24-month time period of the date of your submission of this form**. Submit your proof of completion of CME with your completed ***APPLICATION FOR REINSTATEMENT TO ACTIVE STATUS REGISTRATION*** form. (See last page of this form for CME statement.)
2. If your name and/or address has changed from that printed on the label on this form, clearly indicate the change in the space provided below. Also, please indicate your current telephone and fax numbers. [Please note: a notarized or certified copy of the document authorizing your name change (marriage license, divorce decree, etc.) must be included.]

Name_____

Street_____

City_____ County_____ State_____ Zip_____

Phone Number_____ Fax Number_____

E-mail address_____

3. List name(s) of your supervising physician(s) with their addresses and phone numbers for EACH and EVERY practice location:

Supervising Physician Name: Address(es) of Practice Location(s): Phone Number(s):

_____

_____

(If more space is needed, attach a separate sheet.)

**4. Indicate below your primary and secondary scopes of practice using the following codes:**

## SCOPES OF PRACTICE CODES

| | | | | | |
|---|---|---|---|---|---|
| 1 | ADDICTION MEDICINE | 41 | NEOPLASTIC DISEASES | 81 | PEDIATRIC, RHEUMATOLOGY |
| 2 | ADOLESCENT MEDICINE | 42 | NEPHROLOGY | 82 | PEDIATRIC, SURGERY |
| 3 | AEROSPACE MEDICINE | 43 | NEUROLOGY | 83 | PEDIATRIC, UROLOGY |
| 4 | ALLERGY | 44 | NEURO-OPHTHALMOLOGY | 84 | PEDIATRICS |
| 5 | ALLERGY/IMMUNOLOGY | 45 | NEUROPATHOLOGY | 85 | PHYSICAL MEDICINE/REHABILITATION |
| 6 | AMBULATORY MEDICINE | 46 | NEURORADIOLOGY | 86 | PREVENTIVE MEDICINE |
| 7 | ANESTHESIOLOGY | 47 | NON-CONVENTIONAL MEDICINE | 87 | PSYCHIATRY |
| 8 | BLOODBANKING | 48 | NUCLEAR MEDICINE | 88 | PSYCHOANALYSIS |
| 9 | BRONCO-ESOPHAGOLOGY | 49 | NUTRITION | 89 | PUBLIC HEALTH |
| 10 | CARDIOVASCULAR DISEASES | 50 | OBSTETRICS | 90 | PSYCHOMATIC MEDICINE |
| 11 | CATSCAN/ULTRASOUND | 51 | OBSTETRICS/GYNECOLOGY | 91 | PULMONARY DISEASES |
| 12 | CHILD NEUROLOGY | 52 | OCCUPATIONAL MEDICINE | 92 | RADIOLOGY |
| 13 | CHILD PSYCHIATRY | 53 | ONCOLOGY | 93 | RADIOLOGY, DIAGNOSTIC |
| 14 | CLINICAL PHARMACOLOGY | 54 | ONCOLOGY, GYNECOLOGICAL | 94 | RADIOLOGY, INTERVENTIONAL |
| 15 | CRITICAL CARE | 55 | ONCOLOGY, HEMATOLOGY | 95 | RADIOLOGY, NUCLEAR |
| 16 | DERMATOLOGY | 56 | ONCOLOGY, RADIATION | 96 | RADIOLOGY, THERAPEUTIC |
| 17 | DERMATOPATHOLOGY | 57 | ONCOLOGY, SURGICAL | 97 | RADIOLOGY, VASCULAR |
| 18 | EMERGENCY MEDICINE | 58 | OPHTHALMOLOGY | 98 | RHEUMATOLOGY |
| 19 | ENDOCRINOLOGY | 59 | OTOLARYNGOLOGY | 99 | RHINOLOGY |
| 20 | FAMILY PRACTICE | 60 | OTOLOGY | 100 | SLEEP DISORDERS |
| 21 | GASTROENTEROLOGY | 61 | PAIN MANAGEMENT | 101 | SPORTS MEDICINE |
| 22 | GENERAL PRACTICE | 62 | PATHOLOGY | 102 | SURGERY, ABDOMINAL |
| 23 | GERIATRIC PSYCHIATRY | 63 | PATHOLOGY, ANATOMIC | 103 | SURGERY, CARDIOTHORACIC |
| 24 | GERIATRICS | 64 | PATHOLOGY, CLINICAL | 104 | SURGERY, CARDIOVASCULAR |
| 25 | GYNECOLOGY | 65 | PATHOLOGY, FORENSIC | 105 | SURGERY, COLON/RECTAL |
| 26 | HAIR TRANSPLANTATION | 66 | PEDIATRIC, ALLERGY | 106 | SURGERY, GENERAL |
| 27 | HEMATOLOGY | 67 | PEDIATRIC, CARDIOLOGY | 107 | SURGERY, HAND |
| 28 | HOMEOPATHY | 68 | PEDIATRIC, CRITICAL CARE | 108 | SURGERY, HEAD/NECK |
| 29 | HYPNOSIS | 69 | PEDIATRIC, EMERGENCY MEDICINE | 109 | SURGERY, MAXILLOFACIAL |
| 30 | IMMUNOLOGY | 70 | PEDIATRIC, ENDOCRINOLOGY | 110 | SURGERY, NEUROLOGICAL |
| 31 | INFECTIOUS DISEASES | 71 | PEDIATRIC, GASTROENTEROLOGY | 111 | SURGERY, ORTHOPEDIC |
| 32 | INFERTILITY | 72 | PEDIATRIC, HEMATOLOGY/ONCOLOGY | 112 | SURGERY, PLASTIC |
| 33 | INTERNAL MEDICINE | 73 | PEDIATRIC, INFECTIOUS DISEASES | 113 | SURGERY, THORACIC |
| 34 | LARYNGOLOGY | 74 | PEDIATRIC, INTENSIVIST | 114 | SURGERY, TRANSPLANT |
| 35 | LEGAL MEDICINE | 75 | PEDIATRIC, NEPHROLOGY | 115 | SURGERY, TRAUMATIC |
| 36 | MATERNAL/FETAL MEDICINE | 76 | PEDIATRIC, NEUROLOGY | 116 | SURGERY, UROLOGIC |
| 37 | MEDICAL ACUPUNCTURE | 77 | PEDIATRIC, OPHTHALMOLOGY | 117 | SURGERY, VASCULAR |
| 38 | MEDICAL ETHICS | 78 | PEDIATRIC, PHYSIATRY | 118 | TOXICOLOGY |
| 39 | MEDICAL GENETICS | 79 | PEDIATRIC, PULMONARY | 119 | URGENT CARE |
| 40 | NEO/PERINATAL MEDICINE | 80 | PEDIATRIC, RADIOLOGY | 120 | UROLOGY |

**Primary Scope of Practice** _____ **Code** **Secondary Scope of Practice** _____ **Code**

## All of the following questions refer to the time period July 1, 2007 or since your last renewal, through the present date only.

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

**"Ability to practice as a physician assistant"** 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 REGISTRATION RENEWAL* FORM.**

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

2. If you currently have a medical condition which in any way impairs or limits your ability to practice as a physician assistant, 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 _____N/A

3. If you currently use chemical substances, does your use in any way impair or limit your ability to practice as a physician assistant with reasonable skill and safety? _____Yes _____ No _____N/A

4. Have you been named as a defendant, or been requested to respond as a defendant or potential defendant, to a legal action involving professional liability (malpractice)? _____Yes _____No

5. 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

6. 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 or expungement. _____Yes _____No

7. 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 questions #6? *Please note that you MUST disclose ANY investigation or arrest, including those where the final disposition was dismissal or expungement. _____Yes _____No

8. Have you been denied a license or certificate to practice as a physician assistant, or in any other healing art, or permission to take an examination to practice as a physician assistant or in any other healing art(s) in any state, country or U.S. territory? _____Yes _____No

9.Have you had a physician assistant license or certificate, or license or certificate to practice in any other healing art, revoked, suspended, limited, or restricted in any state, country or U.S. territory? _____Yes _____No

10. Have you voluntarily surrendered a license or certificate to practice as a physician assistant, or in any other healing art, in any state, country or U.S. territory? _____Yes _____No

11. Have you been denied membership, been asked to resign or expelled from a medical society or other professional medical organization? _____Yes _____No

12. Have you 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 assistant by any medical licensing board, hospital, medical society, governmental entity or other agency other than the Nevada State Board of Medical Examiners? _____Yes _____No

13. Have you surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? _____Yes _____No

14. 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.

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

(If more space is needed, attach a separate sheet.)

## CHILD SUPPORT STATEMENT

**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.

## CONTINUING MEDICAL EDUCATION (CME) STATEMENT

I completed a minimum of 40 hours of continuing medical education (CME) as defined by the American Academy of Physician Assistants or American Medical Association, during the period July 1, 2007 through June 30, 2009.

- **ATTACH COPIES OF PROOF OF YOUR COMPLETION OF CONTINUING MEDICAL EDUCATION (CME) HOURS.**
- **YOUR COPIES OF PROOF OF CONTINUING MEDICAL EDUCATION (CME) COMPLETION WILL NOT BE RETURNED TO YOU.**

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

_____ (a) I completed a minimum of 40 hours of AAPA or AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics and 20 hours of which were in my scope of practice or specialty, during the past biennial period of July 1, 2007 through June 30, 2009;

_____ (b) I was initially licensed in Nevada during the time period January 1, 2008 through June 30, 2008, the second six months of the past biennial period, and completed a minimum of 30 hours of AAPA or AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics and 20 hours of which were in my scope of practice or specialty;

_____ (c) I was initially licensed in Nevada during the time period July 1, 2008 through December 31, 2008, the third six months of the past biennial period, and completed a minimum of 20 hours of AAPA or AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics and 18 hours of which were in my scope of practice or specialty;

_____ (d) I was initially licensed in Nevada during the time period January 1, 2009 through June 30, 2009, the fourth six months of the past biennial period, and completed a minimum of 10 hours of AAPA or AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics and 8 hours of which were in my scope of practice or specialty;

## CERTIFICATION STATEMENT

I am currently certified by the National Commission on Certification of Physician Assistants.

- **ATTACH COPY OF PROOF OF YOUR CURRENT CERTIFICATION.**
- **YOUR COPY OF PROOF OF CURRENT CERTIFICATION WILL NOT BE RETURNED TO YOU.**

## HOME ADDRESS & PHONE NUMBER *(REQUIRED)*

Street_____

City_____ County_____ State_____ Zip_____

Phone Number_____ Fax Number_____

**BY SIGNING ON THE SIGNATURE LINE BELOW:**

**I HEREBY SWEAR OR AFFIRM UNDER THE PENALTIES OF PERJURY THAT I UNDERSTAND HAVE ANSWERED THE QUESTIONS TRUE TO THE BEST OF MY KNOWLEDGE.** _____Yes _____No

**I UNDERSTAND THAT THIS *APPLICATION FOR REINSTATEMENT OF REGISTRATION OF LICENSE* WILL BE DENIED IF I HAVE NOT PLACED A CHECK MARK NEXT TO (a), (b), OR (c) UNDER THE CHILD SUPPORT STATEMENT SECTION; AND**

**I UNDERSTAND THAT THIS *APPLICATION FOR REINSTATEMENT O F REGISTRATION OF LICENSE* WILL BE DENIED IF I HAVE NOT ANSWERED ALL QUESTIONS THEREON AND/OR ATTACHED THERETO: (a) THE APPROPRIATE COPIES OF PROOF OF CONTINUING MEDICAL EDUCATION (CME); (b) THE APPROPRIATE PROOF OF CURRENT CERTIFICATION BY THE NATIONAL COMMISSION ON CERTIFICATION OF PHYSICIAN ASSISTANTS; (c) PAYMENT OF THE APPROPRIATE REGISTRATION RENEWAL FEE; AND (d) WRITTEN EXPLANATION (S) TO ANY "YES" ANSWER(S).**

_____ _____

**Date** **Signature (SIGNATURE STAMP UNACCEPTABLE)**