AGENDA ITEM 24(d)

Uniform Application for Licensure

Application ID:

FID:

License Requested: MD

License Type: Permanent Medical License

Submitted to: Nevada State Board of Medical Examiners

Submission Date: 1/29/2021 7:31 AM

Practitioner Name

Bellak, Jason Michael

Alternate Name(s): Bellak, Jason M

Contact Information

Address

Public Access	Board Contact	Type	Address
No	Yes		
Yes	No	Business	1810 E. Memorial Rd. Oklahoma City, OK 73131 UNITED STATES

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Phone

Public Access	Board Contact	Type	Phone Number	Phone Extension
Yes	No	Business	(405) 607-4333	
No	Yes	Mobile		

Email

Public Access	Board Contact	Email
No	Yes	

Identification

USMLE Number	SSN	Birth Date	Birth Place	Gender	NPI	Practitioner Type	US Citizen
		'1972	NV UNITED STATES	M		MD	Yes

Medical School

Medical School Name	Address	Start Date	End Date	Graduation Date	Degree Code
University of Nevada School of Medicine	1664 North Virginia Street Reno, NV 895570046 UNITED STATES	08/15/1996	05/15/2000	05/15/2000	MD

Fifth Pathway

None Reported

ECFMG

Certificate Number	Issue Date
None Reported	

Postgraduate Training

Hospital Name:	Mayo Clinic College of Medicine and Science (Arizona) Program Scottsdale, AZ UNITED STATES	Program Code:	ACGME 1400321512
		Attendance Dates:	
Institution:	Mayo Clinic College of Medicine and Science	Start Date:	07/01/2000
Training Specialty:	Internal Medicine	End Date:	06/27/2003
		Program Type:	Residency
Training Status:	Completed		
Clinical %:	100	Administrative %:	0

Hospital Name:	University of Wisconsin Hospitals and Clinics Program Madison, WI UNITED STATES	Program Code:	ACGME 0205621028
		Attendance Dates:	
Institution:	University of Wisconsin Hospitals and Clinics	Start Date:	07/01/2003
Training Specialty:	Allergy & Immunology	End Date:	06/09/2004
		Program Type:	Fellowship
Training Status:	Completed		
Clinical %:	100	Administrative %:	0

Hospital Name:	University of Wisconsin Hospitals and Clinics Program Madison, WI UNITED STATES	Program Code:	ACGME 0205621028
		Attendance Dates:	
Institution:	University of Wisconsin Hospitals and Clinics	Start Date:	07/01/2004
Training Specialty:	Allergy & Immunology	End Date:	06/30/2005
		Program Type:	Fellowship
Training Status:	Completed		
Clinical %:	100	Administrative %:	0

Hospital Name:	University of Wisconsin Hospitals and Clinics Program Madison, WI UNITED STATES	Program Code:	ACGME 0205621028
		Attendance Dates:	
Institution:	University of Wisconsin Hospitals and Clinics	Start Date:	07/01/2011
Training Specialty:	Allergy & Immunology	End Date:	06/30/2012
		Program Type:	Fellowship
Training Status:	Completed		
Clinical %:	100	Administrative %:	0

Examination History

Exam	State	Last Attempt	Pass/Fail	Number Of Attempts
USMLE Step 1 Examination		06/09/1998	Pass	1
USMLE Step 2 CK Examination		02/14/2000	Pass	1
USMLE Step 3 Examination		09/21/2001	Pass	1

State Licensure History

MD, DO, PA License History

License Entity	Licensing State	License Number	Issue Date	Expiration Date	License Type	License Status
Arizona Medical Board	AZ	29914	12/12/2001	08/07/2022		Active
Oklahoma State Board of Medical Licensure & Supervision	OK	31873	11/05/2015	11/01/2021	Full	Active
Wisconsin Medical Examining Board	WI	48534-20	08/23/2005	10/31/2021		Active

Physician Reported License History

Practitioner License Type	Licensing State	License Number	Issue Date	Expiration Date	Type	License Status
None Reported						

Chronology of Activity Type

Practice/Emp/ Desc: University of Nevada School of Medicine
Chronology Type: Medical Education
Address: Reno, NV US
Attendance Dates:
Position/Dept:
From: 08/15/1996 to 05/15/2000
Clinical %:
Admin %:
Employment: **Staff Privileges:** **Affiliation:**

Practice/Emp/ Desc: not applicable
Chronology Type: Vacation
Address:
Attendance Dates:
Position/Dept:
From: 06/01/2000 to 07/01/2000
Clinical %: 0
Admin %: 0
Employment: **Staff Privileges:** **Affiliation:**

Practice/Emp/ Desc: Mayo Clinic College of Medicine and Science (Arizona) Program
Chronology Type: Accredited Training
Address: Scottsdale, AZ US
Attendance Dates:
Position/Dept:
From: 07/01/2000 to 06/27/2003
Clinical %: 100
Admin %: 0
Employment: **Staff Privileges:** **Affiliation:**

Practice/Emp/ Desc: University of Wisconsin Hospitals and Clinics Program
Chronology Type: Accredited Training

Address: Madison, WI
US

Attendance Dates:

Position/Dept:

From: 07/01/2003 to 06/09/2004

Clinical %: 100

Admin %: 0

Employment: Staff Privileges: Affiliation:

Practice/Emp/ Desc: University of Wisconsin Hospitals and Clinics Program

Chronology Type: Accredited Training

Address: Madison, WI
US

Attendance Dates:

Position/Dept:

From: 07/01/2004 to 06/30/2005

Clinical %: 100

Admin %: 0

Employment: Staff Privileges: Affiliation:

Practice/Emp/ Desc:

Chronology Type: Seeking Employment

Address:

Attendance Dates:

Position/Dept:

From: 07/01/2005 to 08/01/2006

Clinical %: 0

Admin %: 0

Employment: Staff Privileges: Affiliation:

Practice/Emp/ Desc: Moundview Memorial Hospital and Clinics

Chronology Type: Work

Address: 402 W Lake St
Friendship, WI 53934
US

Attendance Dates:

Position/Dept: Physician - Family Clinic and Specialty Clinic

From: 09/01/2006 to 07/01/2011

Clinical %: 90

Admin %: 10

Employment: Staff Privileges: Affiliation:

Practice/Emp/ Desc: University of Wisconsin Hospitals and Clinics Program

Chronology Type: Accredited Training

Address: Madison, WI
US

Attendance Dates:

Position/Dept:

From: 07/01/2011 to 06/30/2012

Clinical %: 100

Admin %: 0

Employment: Staff Privileges: Affiliation:

Practice/Emp/ Desc: Moundview Memorial Hospital and Clinics

Chronology Type: Work

Address: 402 W Lake St
Friendship, WI 53934
US

Attendance Dates:

	Position/Dept:	Physician - Family Clinic and Specialty Clinic	**From:**	07/01/2012	to 04/30/2016
	Clinical %:	90			
	Admin %:	10			
	Employment: •	**Staff Privileges:** •	**Affiliation:** •		
Practice/Emp/ Desc:	**Oklahoma Institute of Allergy Asthma and Immunology**		**Chronology Type:**	Work	
	Address:	1810 E. Memorial Rd. Oklahoma City, OK 73131 US	**Attendance Dates:**		
	Position/Dept:	Physician - Allergy and Immunology	**From:**	05/01/2016	to In Progress
	Clinical %:	95			
	Admin %:	5			
	Employment: •	**Staff Privileges:** •	**Affiliation:** •		

Malpractice

None Reported

ADDENDUM 3 – ADDITIONAL PHYSICIAN INFORMATION

CITIZENSHIP AND IDENTIFICATION

U.S. Citizen: Yes ☒ No ☐ Social Security Number: [redacted]

Non U.S. Citizen: Yes ☐ No ☐ Social Security Number: _____ or

Individual Taxpayer Identification Number (ITIN): _____

Permanente Resident Alien Registration #_____

Employment Authorization #_____

Visa Type: _____ Visa #: _____ Applying for Visa: Yes ☐ No ☐

Color of Eyes: _____ Color of Hair: _____ Height _____ Weight: _____

EXAMINATION SCORES

List all licensure examinations you have taken, whether U.S. or International, on the Examination History tab of the online Uniform Application. Also list below the score you received on each exam taken. INCLUDE ALL INFORMATION PERTAINING TO ANY AND ALL FAILED ATTEMPTS.

Examination Name	Score Received
ABAI	539 (PASSED)
ABIM MOC	533 (PASSED)
ABIM	Score? (PASSED)
USMLE STEP 1	230 (PASSED)
USMLE STEP 2	231 (PASSED)
USMLE STEP 3	220 (PASSED)

Examination Name	Score Received

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SPECIALTY CERTIFICATION

Scope of Practice/Specialty(ies): Allergy and Immunology ; Internal Medicine

List any and all certifications and re-certifications by a board or sub-board recognized by the **American Board of Medical Specialties.** INCLUDE ALL INFORMATION PERTAINING TO ANY AND ALL FAILED ATTEMPTS.

Board / Specialty Board	If you are Lifetime Board Certified, indicate "Lifetime"	Certification #	Dates of Certification/ Recertification (MM/YY)
ABAI		7342	10/12 - 12/22
ABIM		222905	8/03, 10/13 - 12/23

If you hold "lifetime or historical" ABMS Board certification, please provide a notarized statement agreeing to maintain Board certification for the duration of your licensure in the state of Nevada.

ADDENDUM 4 – ATTESTATION 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.

"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 THIS ADDENDUM.

1. Do you currently have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? If "Yes," attach an explanation on a separate sheet. — Yes ☐ No ☒

2. 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, the manner in which you have chosen to practice, or by any other reasonable accommodation? If "Yes," attach an explanation on a separate sheet. — Yes ☐ No ☒

3. 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? If "Yes," attach an explanation on a separate sheet. — Yes ☐ No ☒ N/A

4. 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? If "Yes," attach an explanation on a separate sheet. — Yes ☐ No ☒

5a. 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? If "Yes," please describe in the space provided on the Malpractice Liability Claims Information page within the online Uniform Application. Also complete addendum 5. — Yes ☐ No ☒

5b. 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? If "Yes," please describe in the space provided on the Malpractice Liability Claims Information page within the online Uniform Application. Also complete addenda 5 and 6. — Yes ☐ No ☒

6. 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. If "Yes," attach an explanation on a separate sheet. — Yes ☒ No ☐

7. Have you previously applied for medical licensure in Nevada (including in a Residency program)? If "Yes," attach an explanation on a separate sheet. — Yes ☐ No ☒

8. 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 an explanation on a separate sheet. Yes ☒ No ☐

9. 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 an explanation on a separate sheet. Yes ☐ No ☒

10. 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 an explanation on a separate sheet. Yes ☒ No ☐

11. 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 an explanation on a separate sheet. Yes ☐ No ☒

12. Have you EVER been denied membership, asked to resign, or expelled from a medical society or other professional medical organization? If "Yes," attach an explanation on a separate sheet. Yes ☐ No ☒

13. 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 <u>other than</u> the Nevada State Board of Medical Examiners? If "Yes," attach an explanation on a separate sheet. Yes ☒ No ☐

14. Have you EVER surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? If "Yes," attach an explanation on a separate sheet. Yes ☒ No ☐

15. List all hospitals where you have had staff privileges denied, suspended, limited, revoked or not renewed by the hospital. List any (all) resignations from any medical staff in lieu of disciplinary or administrative action.

(<u>Please Note</u>: 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 MM/YY to MM/YY)
N/A			

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 question 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.

ATTESTATION REGARDING THE REPORTING OF THE ABUSE OR NEGLECT OF A CHILD

Yes ☒ No ☐ I attest and affirm that I am aware and understand the reporting requirements found in Nevada Revised Statute 432B.220 regarding the abuse or neglect of a child.
http://www.leg.state.nv.us/NRS/NRS-432B.html#NRS432BSec220

SAFE INJECTION PRACTICE ATTESTATION

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

Yes ☒ No ☐ 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.
http://www.cdc.gov/injectionsafety/IP07_standardPrecaution.html

MILITARY SERVICE ATTESTATION

1-Have you ever served in the United States Military (to include National Guard or Reserves)? ____Yes X No
If your answer is "No", you do not have to complete the remaining questions for the Military Service Attestation.

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2-If yes, which branch of service did you serve?

- ☐ Air Force
- ☐ Army
- ☐ Navy
- ☐ Marine Corp
- ☐ Coast Guard

3-Military occupation specialty or specialties?

- ☐ Administration or Personnel
- ☐ Aviation
- ☐ Civil Engineering
- ☐ Communications
- ☐ Infantry or Armor
- ☐ Legal or Chaplin Corps
- ☐ Logistics or Supply
- ☐ Maintenance
- ☐ Medical Services
- ☐ Security Forces or Military Police
- ☐ Other

4&5-Dates of service in the Military:

4-From: ____/____/____ (DD / MM / YYYY) **5-To:** ____/____/____ (DD / MM / YYYY)

6-Are you still serving? __Yes ___No

7-Have you ever served on active duty in the Armed Forces of the United States? ____Yes X No

8-Have you ever been assigned to duty for a minimum of 6 continuous years in the National Guard or a reserve component of the Armed Forces of the United States? ____Yes X No

9-Have you ever served the Commissioned Corps of the United States Public Health Service or the Commissioned Corps of the National Oceanic and Atmospheric Administration of the United States in the capacity of a commissioned officer while on active duty in defense of the United States? ____Yes X No

10-If the answer to question(s) 7, 8 and/or 9 is "yes," did you separate from such service under conditions other than dishonorable? ____Yes ____No

APPLICATION AFFIRMATION

I, JASON M. BELLAK, MD
(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 occurs prior to my being granted licensure to practice medicine in the state of Nevada.

Signature of applicant — 2/1/21 Date

State of Oklahoma County of Oklahoma

Subscribed and sworn to before me this 1st day of February, 2021.

(NOTARY SEAL) OLGA V. REED NOTARY PUBLIC STATE OF OKLAHOMA #18001218 EXP. 03/19/21

Notary Public for the State of Oklahoma

My Commission Expires: March 19, 2021

Residing at: Edmond OK
City State

Olga V. Reed
Signature of Notary

ADDENDUM 5 – LIST OF MALPRACTICE INSURANCE CARRIERS

If you have answered in the affirmative ("Yes") to questions 5a and/or 5b of Addendum 4 of the UA, list all malpractice carriers.

Name of Insured: JASON M. BELLAK, MD

Insurance Company: PLICO, Inc.
Address: P.O. Box 1838
Oklahoma City, OK 73101
Phone Number: 405-815-4808
Fax Number: 405-815-4900
Policy Number:
Dates: 01/01/2021 – 01/01/2022

Insurance Company: ProAssurance
Address: 1600 Aspen Commons Suite 980
Middleton, WI 53562
Phone Number: 608-831-8331
Fax Number: 608-831-0084
Policy Number:
Dates: 08/01/06 – 04/30/2016

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:

ADDENDUM 1 – RESPONSIBILITY STATEMENT

ATTENTION APPLICANT!

Please sign and return this statement with your application for licensure to:

The Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521

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.

Via FBI fingerprinting and other investigative modalities, our licensing specialists are likely to discover if data you have submitted on your application is erroneous or incomplete; therefore, you must answer all questions truthfully and completely. Specifically, this includes any sanctions or disciplinary actions you may have experienced during medical school or your postgraduate training, or any involvement you may have had with the legal system, either civil or criminal — criminal to include charges that may have ultimately been expunged, lessened, or dismissed, and no matter how long ago the event(s) occurred.

Explaining and documenting a problem to your licensing specialist will be much less painful than discussing your veracity before the entire Board of Medical Examiners due to inconsistencies between your application and incongruent input from outside sources.

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 JASON M. BELINK, MD

Sign your name _____

Date 01/30/21

Note: It is your responsibility to keep the Board informed of any circumstance or event that would require a change to your initial responses provided to the Board in your application for licensure, and which occurs prior to you being granted licensure to practice medicine in the state of Nevada.

Applicant's signature (must be signed in the presence of a notary)

BELLAK, JASON, M.

Applicant's printed last name, first name, middle initial, and suffix (e.g., Jr.)

02/01/2021

Date of signature (must correspond to date of notarization)

[Please note: The Notary Public seal should overlap the bottom of the photo to the left.]

NOTARY

GA V. REF