NEVADA STATE BOARD OF MEDICAL EXAMINERS

FEES FOR PERFUSIONIST LICENSURE

Applications which appear to have been altered in any form will not be accepted. Applications must be typed or legibly handwritten in ink (illegible or incomplete applications will be returned). Applications must be received on single-sided, white bond paper, 8 ½" x 11" in size. Your application is a public document.

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

Fees applicable if licensed between July 1, 2019 – June 30, 2020:

Application Fee	Registration Fee	Criminal Background Investigation Fee		
$300	$375.00	$75	=	$750.00

Fees applicable if licensed between July 1, 2020 – June 30, 2021:

Application Fee	Registration Fee	Criminal Background Investigation Fee		
$300	$187.50	$75	=	$562.50

The Application fee and Criminal Background Investigation fee will not be refunded. You may pay by cashier's check or money order, payable to "NEVADA STATE BOARD OF MEDICAL EXAMINERS," or by credit card. If paying by credit card, please complete the Credit Card Authorization form on the last page of this application. A two percent (2%) service fee will be assessed for payment by credit card.

The 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 **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, 21, 22, 23, 24, 25 and/or 26.

If, at the time you meet with the Board, the Board votes to deny or not accept your application for licensure, this denial or non-acceptance of your application may become 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.

Nevada Revised Statutes – Perfusionist Licensure

I. "Perfusion" means the performance of functions which are necessary to provide for the support, treatment, measurement or supplementation of a patient's cardiovascular, circulatory or respiratory system or other organs, or any combination of those activities, and to ensure the safe management of the patient's physiological functions by monitoring and analyzing the parameters of the patient's systems or organs under the order and supervision of a physician.

(a) The term includes, without limitation:

1. The use of extracorporeal circulation and any associated therapeutic and diagnostic technologies; and

2. The use of long-term cardiopulmonary support techniques.

(b) As used in this section, "extracorporeal circulation" means the diversion of a patient's blood through a heart-lung bypass machine or a similar device that assumes the functions of the patient's heart, lungs, kidney, liver or other organs.

II. "Perfusionist" means a person who is licensed to practice perfusion by the Board.

III. "Temporarily licensed perfusionist" means a person temporarily licensed to practice perfusion by the Board.

IV. To be eligible for licensing by the Board as a perfusionist, an applicant must:

(a) Be a natural person of good moral character;

(b) Submit a completed application as required by the Board;

(c) Submit any required fees;

(d) Have successfully completed a perfusion education program approved by the Board, which must:

(1) Have been approved by the Committee on Allied Health Education and Accreditation of the American Medical Association before June 1, 1994; or

(2) Be a program that has educational standards that are at least as stringent as those established by the Accreditation Committee-Perfusion Education and approved by the Commission of Accreditation of Allied Health Education Programs of the American Medical Association, or its successor;

(e) Pass an examination required by the Board; and

(f) Comply with any other requirements set by the Board.

V. The Board uses the certification examinations given by the American Board of Cardiovascular Perfusion, or its successor, in determining the qualifications for granting a license to practice perfusion.

VI. The Board shall waive the examination required pursuant to paragraph V, for an applicant who at the time of application:

(a) Is licensed as a perfusionist in another state, territory or possession of the United States, if the requirements for licensure are substantially similar to those required by the Board; or

(b) Holds a current certificate as a certified clinical perfusionist issued by the American Board of Cardiovascular Perfusion, or its successor, before October 1, 2009.

VII. The Board shall issue a license as a perfusionist to each applicant who proves to the satisfaction of the Board that the applicant is qualified for licensure. The license authorizes the applicant to represent himself as a licensed perfusionist and to practice perfusion in the State of Nevada subject to the conditions and limitations of this chapter.

(a) Each licensed perfusionist shall:

(1) Display his current license in a location which is accessible to the public;

(2) Keep a copy of his current license on file at any health care facility where he provides services; and

(3) Notify the Board of any change of address in accordance with NRS 630.254.

(b). As used in this section, "health care facility" means a medical facility or facility for the dependent licensed pursuant to chapter 449 of NRS.

VIII. Each perfusionist license issued by the Board expires on July 1 of every odd-numbered year and may be renewed if, before the license expires, the holder of the license submits to the Board:

(1) A completed application for renewal on a form prescribed by the Board;

(2) Proof of his completion of the requirements for continuing education prescribed by regulations adopted by the Board; and

(3) The applicable fee for renewal of the license prescribed by the Board.

(a) A license that expires pursuant to this section not more than 2 years before an application for renewal is made is automatically suspended and may be reinstated only if the applicant complies with the provisions required by the Board;

(b) If a license has been expired for more than 2 years, a person may not renew or reinstate the license but must apply for a new license and submit to the examination required by the Board.

(c) The Board shall send a notice of renewal to each licensee not later than 60 days before his license expires. The notice must include the amount of the fee for renewal of the license.

IX. The Board may issue a temporary license to practice perfusion in this State to a person who has not yet completed the examination required by the Board but who has:

(1) Has completed an approved perfusion education program;

(2) Files an application; and

(3) Pays the required fee.

(a) A perfusionist shall supervise and direct a temporarily licensed perfusionist at all times during which the temporarily licensed perfusionist performs perfusion.

(b) A temporary license is valid for 1 year after the date it is issued and may be extended subject to regulation by the Board. The application for renewal must be signed by a supervising licensed perfusionist.

(c) If a temporarily licensed perfusionist fails any portion of the examination, he shall immediately surrender the temporary license to the Board.

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

NRS 630.301 Criminal offenses; disciplinary action taken by other jurisdiction; 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. Any disciplinary action, including, without limitation, the revocation, suspension, modification or limitation of a license to practice any type of medicine, taken by another state, the Federal Government, a foreign country or 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 the 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 the 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 code of ethics adopted by the Board by regulation based on a national code of ethics.

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.

11. Conviction of:

(a) Murder, voluntary manslaughter or mayhem;

(b) Any felony involving the use of a firearm or other deadly weapon;

(c) Assault with intent to kill or to commit sexual assault or mayhem;

(d) Sexual assault, statutory sexual seduction, incest, lewdness, indecent exposure or any other sexually related crime;

(e) Abuse or neglect of a child or contributory delinquency;

(f) A violation of any federal or state law regulating the possession, distribution or use of any controlled substance or any dangerous drug as defined in chapter 454 of NRS; or

(g) Any offense involving moral turpitude.

(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; 2005, 2522; 2007, 3045; 2011, 847)

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 the licensee's medical education.

2. Nothing in this section prohibits a physician from forming an association or other business relationship with an optometrist pursuant to the provisions of NRS 636.373.

(Added to NRS by 1983, 301; A 1985, 2237; 1987, 198; 1989, 1114; 1991, 2437; 1993, 2302, 2596; 1995, 714, 2562)

THE FOLLOWING CONSTITUTE GROUNDS FOR DENIAL OF LICENSURE, AS SET OUT IN NRS 630.301 THROUGH NRS 630.3065 (cont.):

NRS 630.306 Inability to practice medicine; deceptive conduct; violation of regulation governing practice of medicine or adopted by State Board of Pharmacy; unlawful distribution of controlled substance; injection of silicone; practice beyond scope of license; practicing experimental medicine without consent of patient or patient's family; lack of skill or diligence; habitual intoxication or dependency on controlled substances; filing of false report; failure to report certain changes of information or disciplinary or criminal action in another jurisdiction; failure to be found competent after examination; certain operation of a medical facility; prohibited administration of anesthesia or sedation; engaging in unsafe or unprofessional conduct; knowingly or willfully procuring or administering certain controlled substances or dangerous drugs; failure to supervise medical assistant adequately; allowing person not enrolled in accredited medical school to perform certain activities; failure to obtain required training regarding controlled substances.

1. The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure:

(a) 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.

(b) Engaging in any conduct:

(1) Which is intended to deceive;

(2) Which the Board has determined is a violation of the standards of practice established by regulation of the Board; or

(3) Which is in violation of a regulation adopted by the State Board of Pharmacy.

(c) Administering, dispensing or prescribing any controlled substance, or any dangerous drug as defined in chapter 454 of NRS, to or for himself or herself or to others except as authorized by law.

(d) 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.

(e) 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 or she is not competent to perform or which are beyond the scope of his or her training.

(f) Performing, without first obtaining the informed consent of the patient or the patient's family, any procedure or prescribing any therapy which by the current standards of the practice of medicine is experimental.

(g) 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.

(h) Habitual intoxication from alcohol or dependency on controlled substances.

(i) 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.

(j) Failing to comply with the requirements of NRS 630.254.

(k) Failure by a licensee or applicant to report in writing, within 30 days, any disciplinary action taken against the licensee or applicant by another state, the Federal Government or a foreign country, including, without limitation, the revocation, suspension or surrender of a license to practice medicine in another jurisdiction.

(l) Failure by a licensee or applicant to report in writing, within 30 days, any criminal action taken or conviction obtained against the licensee or applicant, other than a minor traffic violation, in this State or any other state or by the Federal Government, a branch of the Armed Forces of the United States or any local or federal jurisdiction of a foreign country.

(m) Failure to be found competent to practice medicine as a result of an examination to determine medical competency pursuant to NRS 630.318.

(n) Operation of a medical facility at any time during which:

(1) The license of the facility is suspended or revoked; or

(2) An act or omission occurs which results in the suspension or revocation of the license pursuant to NRS 449.160.

➦ This paragraph applies to an owner or other principal responsible for the operation of the facility.

(o) Failure to comply with the requirements of NRS 630.373.

(p) Engaging in any act that is unsafe or unprofessional conduct in accordance with regulations adopted by the Board.

(q) Knowingly or willfully procuring or administering a controlled substance or a dangerous drug as defined in chapter 454 of NRS that is not approved by the United States Food and Drug Administration, unless the unapproved controlled substance or dangerous drug:

(1) Was procured through a retail pharmacy licensed pursuant to chapter 639 of NRS;

(2) Was procured through a Canadian pharmacy which is licensed pursuant to chapter 639 of NRS and which has been recommended by the State Board of Pharmacy pursuant to subsection 4 of NRS 639.2328;

(3) Is marijuana being used for medical purposes in accordance with chapter 453A of NRS; or

(4) Is an investigational drug or biological product prescribed to a patient pursuant to NRS 630.3735 or 633.6945.

(r) Failure to supervise adequately a medical assistant pursuant to the regulations of the Board.

(s) Failure to comply with the provisions of NRS 630.3745.

(t) Failure to obtain any training required by the Board pursuant to NRS 630.2535.

2. As used in this section, "investigational drug or biological product" has the meaning ascribed to it in NRS 454.351.

(Added to NRS by 1983, 302; A 1985, 2238; 1987, 199, 800, 1554, 1575; 2007, 3046; 2009, 533, 879, 2961, 2962; 2011, 257, 2612; 2015, 116, 492, 985, 1536)

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; failure to comply with certain requirements relating to controlled substances. 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 knowingly 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 within 30 days after the date the licensee knows or has reason to know of the violation.

7. Failure to comply with the requirements of NRS 453.163 or 453.164.

(Added to NRS by 1985, 2223; A 1987, 199; 2001, 767; 2002 Special Session, 19; 2003, 3433; 2009, 2963; 2015, 493, 1170)

NRS 630.3065 Knowing or willful disclosure of privileged communication; knowing or willful failure to comply with law, subpoena or order; knowing or willful failure to perform legal obligation. The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure:

1. Knowingly or willfully disclosing a communication privileged pursuant to a statute or court order.

2. Knowingly or willfully failing 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. Knowingly or willfully failing 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; 2015, 494)

PERFUSIONIST

APPLICATION CHECKLIST

TO BE RETURNED DIRECTLY TO BOARD OFFICE BY APPLICANT

_____	a.	APPLICATION: ☐ Properly completed, signed and notarized application, including Applicant Responsibility statement; ☐ Recent passport quality photograph (at least 2"x 2") attached to application; ☐ Appropriate explanations and copies of all pertinent documentation must be attached for affirmative responses to questions numbered 8, 9, 10, 11, 12, 12a, 13, 14, 21, 22, 23, 24, 25, and 26; ☐ Release form - signed and notarized (Form A);
_____	b.	FEES: • Proper application, registration, AND criminal background investigation fees – cashier's check or money order made payable to Nevada State Board of Medical Examiners (NSBME) or by credit card as instructed. Credit cards will only be accepted by receipt of the signed credit card authorization form. Note: Application and criminal background investigation fees are non-refundable;
_____	c.	IDENTITY (Identity documents will be returned to you via secured mail.): 1. U.S. born citizens: Original or Certified Birth Certificate that bears an original seal or stamp of the issuing agency (notarized copies are not acceptable). 2. Foreign-born citizens: Original Certificate of Naturalization or current U.S. Passport. 3a. Non-U.S. citizens (with legal status): Copy of both sides of Alien Registration or Employment Authorization card, or Visa; and Copy of foreign passport. 3b. Non-U.S. citizens (otherwise): Individual Taxpayer Identification Number (ITIN) and original ITIN assignment letter from the IRS Supporting documentation of identity also required, e.g., Passport, or USCIS, US Military, or US State I.D.
_____	d.	SELF-QUERY VERIFICATION: • Self-query response from the National Practitioner Data Bank (NPDB); The NPDB will send the report directly to you and you will forward the final report to the Board office; The request form for the National Practitioner Data Bank (NPDB) is available at http://www.npdb.hrsa.gov. Click on 'Self-Query' for Healthcare Professionals on the right side of the page and follow the instructions provided. If you require additional information, please call the NPDB at (800) 767-6732. Once you have received the final report or self-query response from the NPDB, forward a copy of this report to the Board office.
_____	e.	SUPPLEMENTARY FORM: • FORM B: ONLY if you have answered affirmatively to either of the two malpractice questions on the application; Also include: o Copy of the legal Complaint o Copy of the Settlement and/or filed Dismissal
_____	f.	EDUCATION: ☐ Copy of high school transcripts or diploma; ☐ Copy of transcripts or diplomas for degrees other than Perfusionist degree – an Associates, Bachelors or Masters Degree that you would like added to your educational profile on the Board's website;
_____	g.	NOTIFICATION OF PRACTICE LOCATION: • Notification of Practice Location form signed and dated;
_____	h.	NOTIFICATION OF SUPERVISING PERFUSIONIST(S) (required for Temporary Perfusionist only): • Notification of Nevada Licensed Supervising Perfusionist(s) form signed and dated;
_____	i.	FINGERPRINTING: • Once the application and criminal background investigation fee have been received, a fingerprint card and instructions will be mailed to you. The fingerprint card you receive from the Board contains the necessary account numbers required for processing. The completed card must be returned to the Board as well as the signed Civil Applicant Waiver (included in your application package) prior to licensure. Note: Receipt of the Criminal history background results will not delay licensure.

PERFUSIONIST
APPLICATION CHECKLIST

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

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

_____	a.	PERFUSIONIST SCHOOL: ☐ Verification of completion of accredited perfusionist program (Form 1); ☐ Official transcripts from perfusionist program. If trained on the job (grandfathered into your position as a perfusionist), please provide copies of supporting documentation or certificates which so indicate. If no such document(s) exist, provide a notarized statement indicating your training experience (who, what, where, when, why);
_____	b.	EXAMINATION: • Current certification by the American Board of Cardiovascular Perfusion (Form 2);
_____	c.	STATE LICENSE VERIFICATIONS: • Verification of licensure/certification from ALL states where applicant is currently licensed/certified or has ever been licensed/certified (Form 3) [does not include training licenses or temporary permits];
_____	d.	MALPRACTICE INSURANCE CARRIER VERIFICATIONS: • Malpractice insurance carrier verification (Form 4) to be completed by appropriate entity and returned directly by the verifying institution to the Board office and must include the loss history report for any and all malpractice cases that occurred within the past 10 years with a liability, settlement or claim paid on your behalf (see Disclaimer below).

Disclaimer: Per Nevada Revised Statute 630.173(2), the Board has the right to consider information for any malpractice history or derogatory hospital privilege history that is more than 10 years old.

APPLICATION GUIDE

Identity - 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 other legal documentation reflecting name change).

Malpractice - If you have ever been named in a legal action involving professional liability (malpractice), whether or not you have ever had a professional liability, settlement, claim paid on your behalf, or paid such a claim yourself, provide signed and dated explanations for all malpractice cases throughout your career. Provide copies of legal documentation for malpractice cases that occurred within the past 10 years unless otherwise instructed, which includes copies of Complaints, Settlements and/or Dismissals. If you have a pending case or cases, request a letter from your attorney to be sent directly to the Board describing the current status of the case(s). In summary:

- Provide descriptive explanations for any and all malpractice cases (who, what, where, when and why);
- Complete Form B listing all malpractice insurance carriers;
- Provide copies of legal documentation for cases that occurred within the past 10 years:
    - Complaint
    - Settlement
    - and/or Dismissal.
- Request malpractice carrier verifications (Form 4) from all malpractice insurance carriers within the past 10 years if you have been named in a malpractice case where there was a liability, settlement or claim paid on your behalf;
- For any pending case(s), request a status letter to be sent directly to the Board from your attorney.

Investigation - 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 violations of a statute, rule or regulation governing your practice as a physician assistant, you should answer affirmatively to question #24 and submit the appropriate documentation. Provide signed and dated explanations and copies of any related documentation you received regarding any investigation unless otherwise instructed.

Arrest - If you have ever been arrested, read question #13 carefully. You will be expected to provide a signed and dated explanation addressed to the Nevada State Board of Medical Examiners for any arrest(s) no matter how long ago it may have occurred, whether it was expunged or not. Provide a copy of the arrest report, proof of completion of probation and/or time served, community service, fines paid and any other documentation applicable to the incident(s).

Release for Communication with a Person other than the Applicant: If you wish to authorize the Board to communicate about the status of your application for licensure with someone other than yourself, provide a brief signed written release of authorization indicating the specific name of the person thus providing the Board with authority to tender information related to your application status.

Disclaimer: Per Nevada Revised Statute 630.173(2), the Board has the right to consider information that is more than 10 years old regarding malpractice, investigations by another licensing board, complaints or disciplinary actions from a hospital, clinic or medical facility if the Board receives the information from the applicant or any other source from which the Board is verifying the information provided by 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
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 your 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.

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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 _____

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.

Nevada Department of *Public Safety*

CIVIL APPLICANT WAIVER

NOTICE OF NONCRIMINAL JUSTICE APPLICANT'S RIGHTS

As an applicant who is subject pursuant to NRS 630.342, and who is the subject of a national fingerprint-based criminal history record check for a noncriminal justice purpose (such as an application for employment or a license, an immigration or naturalization matter, security clearance, or adoption), you have certain rights which are discussed below. All notices must be provided to you in writing. These obligations are pursuant to the Privacy Act of 1974, Title 5, United States Code (U.S.C.) Section 552a, and Title 28 Code of Federal Regulations (CFR), 50.12, among other authorities.

1. You must be notified by Nevada State Board of Medical Examiners that your fingerprints will be used to check the criminal history records of the FBI and the State of Nevada.

2. Authority: The FBI's acquisition, preservation, and exchange of fingerprints and associated information is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include Federal statutes, State statutes pursuant to Pub. L. 92-544, Presidential Executive Orders, and federal regulations. Providing your fingerprints and associated information is voluntary; however, failure to do so may affect completion or approval of your application.

3. Principal Purpose: Certain determinations, such as employment, licensing, and security clearances, may be predicated on fingerprint-based background checks. Your fingerprints and associated information/biometrics may be provided to the employing, investigating, or otherwise responsible agency, and/or the FBI for the purpose of comparing your fingerprints to other fingerprints in the FBI's Next Generation Identification (NGI) system or its successor systems (including civil, criminal, and latent fingerprint repositories) or other available records of the employing, investigating, or otherwise responsible agency. The FBI may retain your fingerprints and associated information/biometrics in NGI after the completion of this application and, while retained, your fingerprints may continue to be compared against other fingerprints submitted to or retained by NGI.

4. Routine Uses: During the processing of this application and for as long thereafter as your fingerprints and associated information/biometrics are retained in NGI, your information may be disclosed pursuant to your consent, and may be disclosed without your consent as permitted by the Privacy Act of 1974 and all applicable Routine Uses as may be published at any time in the Federal Register, including the Routine Uses for the NGI system and the FBI's Blanket Routine Uses. Routine uses include, but are not limited to, disclosures to: employing, governmental or authorized non-governmental agencies responsible for employment, contracting, licensing, security clearances, and other suitability determinations; local, state, tribal, or federal law enforcement agencies; criminal justice agencies; and agencies responsible for national security or public safety.

5. If you have a criminal history record, you should be afforded a reasonable amount to time to correct or complete the record (or decline to do so) before the officials deny you the employment, license, or other benefit based on information in the FBI criminal history record. The procedures for obtaining a change, correction, or update of your FBI criminal history record as set forth at, 28 CFR 16.34 provides for the proper procedure to do so.

6. If agency policy permits, the officials may provide you with a copy of your FBI criminal history record for review and possible challenge. If agency policy does not permit it to provide you a copy of the record, you may obtain a copy of the record by submitting fingerprints and a fee to the FBI. Information regarding this process may be obtained at https://www.fbi.gov/services/cjis/identity-history-summary-checks and https://www.edo.cjis.gov .

Applicant: Initial: _____ Date:_____

7. If you decide to challenge the accuracy or completeness of your FBI criminal history record, you should send your challenge to the agency that contributed the questioned information to the FBI. Alternatively, you may send your challenge directly to the FBI by submitting a request via https://www.edo.cjis.gov . The FBI will then forward your challenge to the agency that contributed the questioned information and request the agency to verify or correct the challenged entry. Upon receipt of an official communication from that agency, the FBI will make any necessary changes/corrections to your record in accordance with the information supplied by that agency. (See 28 CFR 16.30 through 16.34.)

8. You have the right to expect that officials receiving the results of the fingerprint-based criminal history record check will use it only for authorized purposes and will not retain or disseminate it in violation of federal or state statute, regulation or executive order, or rule, procedure or standard established by the National Crime Prevention and Privacy Compact Council.

9. I hereby authorize Nevada State Board of Medical Examiners to submit a set of my fingerprints to the Nevada Department Public Safety, Records Bureau for the purpose of accessing and reviewing State of Nevada and FBI criminal history records that may pertain to me.

10. I hereby release from liability and promise to hold harmless under any and all causes of legal action, the State of Nevada, its officer(s), agent(s) and/or employee(s) who conducted my criminal history records search and provided information to the submitting agency for any statement(s), omission(s), or infringement(s) upon my current legal rights. I further release and promise to hold harmless and covenant not to sue any persons, firms, institutions or agencies providing such information to the State of Nevada on the basis of their disclosures. I have signed this release voluntarily and of my own free will.

A reproduction of this authorization for release of information by photocopy, facsimile or similar process, shall for all purposes be as valid as the original. In consideration for processing my application I, the undersigned, whose name and signature voluntarily appears below; do hereby and irrevocably agree to the above.

Applicant's Name: _____
PLEASE PRINT Last Name First Name Middle

Applicant's Signature: _____

Date: _____

Agency Account #: 881183

Agency Representative: _____
PLEASE PRINT Daniels Lynnette

Agency Representative Signature: L. Daniels

Date: 10.22.2020

PERFUSIONIST
APPLICATION FOR LICENSURE
NEVADA STATE BOARD OF
MEDICAL EXAMINERS
9600 Gateway Drive, Reno, NV 89521
Phone (775) 688-2559

Date Received by Board

License No._____

File No._____

(For Board Use Only)

Identity:

1. Present Legal Name _____
Last First Middle Maiden

List any other name ever used _____

Address:
The **Public Access Address** will be available to the public on the Board's website, and will also be your contact address once licensed. It can be changed if the Licensee completes the Notification of Address Change form available on the Board's website: www.medboard.nv.gov.
The **Mailing Address** that you choose will be used for communication only during the application process. It can be one and the same.

2. Public Address _____
Street City County State Zip

☐ Please check if you choose to have your Mailing Address the same as the Public Address you have entered above.

3. Mailing Address _____
Street City County State Zip

4. Telephone Numbers (_____)_____ (_____)_____ (_____)_____ (_____)_____
Office Fax Home Cellular (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 # _____ Visa _____

Non U.S. Citizen (without the foregoing): Individual Taxpayer Identification Number (ITIN) _____

Submit a Certified 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 card or Visa. Non Citizens (without the foregoing) submit an Original ITIN assignment letter from the IRS. Please note: Copy of the document authorizing your name change (marriage license, divorce decree, etc.) must be included.

7. Social Security Number _____ Color of Eyes _____ Color of Hair _____ Height _____ Weight _____
NRS 630.197(1)(a) An applicant for the issuance of a license to practice medicine shall include the social security number of the applicant in the application submitted to the Board; however, AB275 (2019) provides that an applicant who does not have a social security number must provide an Individual Taxpayer Identification Number (ITIN) when completing an application for licensure.
NRS 630.165(5) The applicant bears the burden of proving and documenting his qualifications for licensure.

Questions:

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

"Ability to practice as a Perfusionist" 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 SIGNED 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 as a perfusionist with reasonable skill and safety? (If "Yes," attach explanation on separate sheet.) _____Yes _____No

9. If you currently have a medical condition which in any way impairs or limits your ability to practice as a perfusionist, 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 explanation on separate sheet.) _____Yes _____No _____N/A

10. If you currently use chemical substances, does your use in any way impair or limit your ability to practice as a perfusionist with reasonable skill and safety? _____Yes _____No _____N/A
(If "Yes," attach explanation on separate sheet.)

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
(If "Yes," attach explanation on separate sheet.)

Malpractice Questions:

12. 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 ANSWER IS "YES", YOU MUST COMPLETE FORM B – see Application Checklist.)

_____Yes _____No

12a. Have you EVER had a professional liability, malpractice, claim paid on your behalf, or paid such a claim yourself including any military tort claims if applicable?

_____Yes _____No

Malpractice Explanation(s):

List of all claims or suits for medical malpractice made against you. A claim is any formal or informal demand for payment to any person or organization. If you have not answered "yes" to questions #12 and/or #12a and do not have any such claims or suits, this section will be left blank. If you have more than 1 claim, make a copy or copies of this page and submit all explanations with your application for licensure.

Name of patient involved:

In which state did the action take place?

Case number (if applicable):

Which court?
(If settled before initiation of civil action, state here.)

Current status of claim:

☐ Open ☐ Closed (settled or judgment) ☐ Dismissed (no money paid out) ☐ Other

Date claim was closed/settled or dismissed: _____
Month/Year

Amount of judgment or settlement $

Month and year of event precipitating claim:

Month and year of lawsuit or court filing:

Insurance carrier at time:

What is/or was your status? ☐ Primary defendant ☐ Co-defendant ☐ Other

Please provide specifics in reference to the adverse event including the allegations and your role in the event:

Arrest Question:

13. 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 explanation on separate sheet.) _____Yes _____No

Nevada License History:

14. Have you previously applied for perfusionist licensure in Nevada?
(If "Yes," attach explanation on separate sheet.) _____Yes _____No

Perfusionist Education:

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

15. List all schools attended (including high school), type of degree received and dates of attendance.

Name	City/State	Type of Degree Received	Dates of Attendance From (Mo./Yr.) To (Mo./Yr.)

16. Perfusionist Certificate / Degree granted by:

Perfusionist School	City / State	Exact Date of Issuance

Activities:

17. Account for, in chronological order, all activities since graduation from Perfusionist School. Activities include working as a Perfusionist and also non-medical activities (seeking employment, moving, job search, applying for a license, vacation etc.) **ALL PERIODS OF TIME MUST BE ACCOUNTED FOR.**

Activities	City / State (and Country if other than U.S.)	From (Mo./Yr.)	To (Mo./Yr.)

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

State licenses and Hospital affiliations:

18. List any and all licenses (including training licenses and permits) YOU HOLD OR HAVE HELD to practice as a perfusionist in any state, territory or country.

State/Territory	License #	Date of Issuance (Mo./Yr.)	Date of Expiration (Mo./Yr.)

19. List below the requested information for all hospitals or surgery centers in which you **ARE employed, OR HAVE EVER BEEN** a staff member at any level during the last ten years. If none, please indicate.

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.)

Examination:

20. Are you currently certified by the American Board of Cardiovascular Perfusion? _____Yes _____No

If "Yes:" certification number _____ certification expires _____

If "No:" date scheduled to sit for the examination _____

Disciplinary Questions:

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

22. Have you ever had a perfusionist 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
(If "Yes," attach explanation on separate sheet.)

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

24. Have you ever failed the ABCP examination, or any state or other jurisdiction examination for certification as a perfusionist? _____Yes _____No
(If "Yes," attach explanation on separate sheet.)

25. 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 perfusionist by any medical licensing board, hospital, medical society, governmental entity or other agency other than the Nevada State Board of Medical Examiners? _____Yes _____No
(If "Yes," attach explanation on separate sheet.)

26. 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.)

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

Attestations/Affirmations:

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

I attest and affirm that I am aware of and understand the reporting requirements found in Nevada Revised Statute 432B.220 regarding the abuse or neglect of a child. _____Yes _____No

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 PERFUSIONISTS

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 supervision 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. _____Yes _____No

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 _____No
If your answer is "No", you do not have to complete the remaining questions for the Military Service Attestation.

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: _____/ _____/ _____ **5-To:** _____/ _____/ _____
DD MM YYYY 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 _____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 _____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 _____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 _____N/A

APPLICANT PHOTOGRAPH

ATTACH A FINISHED PHOTOGRAPH OF PASSPORT QUALITY OF YOUR HEAD AND SHOULDERS ONLY. PHOTOGRAPH MUST HAVE BEEN TAKEN WITHIN THE LAST SIX MONTHS AND BE AT LEAST 2" x 2" IN SIZE.

CENTER AND ATTACH PHOTOGRAPH HERE.

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

_____ _____
Signature of applicant **Date**

APPLICATION AFFIRMATION

I, _____,
(Print your full name)

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

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

_____ _____
Signature of applicant **Date**

State of _____ County of _____

Subscribed and sworn to before me this _____ day of

_____, 2_____.

Notary Public for the State of _____

(NOTARY SEAL)

My Commission Expires: _____

Residing at: _____
City State

_____
Signature of Notary

END OF APPLICATION

PERFUSIONIST

Notification of Practice Location

Pursuant to Nevada Administrative Code Chapter 630, before providing perfusion services, a Perfusionist must notify the Board of the name and location of the primary location of practice.

Please type or print clearly.

I, _____, hereby notify the Nevada State Board of Medical Examiners that I will be working at:

_____

_____

_____

Practice Location(s) Telephone Number

You may use an extra page, if necessary.

_____

Print your name

_____

Signature

_____

Date

TEMPORARY PERFUSIONIST

Notification of Supervising Perfusionist(s)

Pursuant to Nevada Administrative Code Chapter 630.2696 (2), a perfusionist shall supervise and direct a temporarily licensed perfusionist at all times during which the temporarily licensed perfusionist performs perfusion.

Please type or print clearly.

I, _____, hereby notify the Nevada State Board of Medical Examiners that my Nevada licensed supervising perfusionist(s) is/are:

_____

_____

_____

Perfusionist's Name License number Telephone Number

You may use an extra page, if necessary.

_____

Print your name

_____

Signature

_____

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, 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 the State of _____

My Commission Expires: _____

Residing at: _____

City State

_____

Signature of Notary

A photocopy of this form will serve as an original (Board use only).

Please return completed form to:

Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89502

FORM B

LIST OF MALPRACTICE INSURANCE CARRIERS

If you answered affirmatively to questions #12 and/or #12a on the Application for Licensure, list all malpractice carriers.

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: ____________________

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 cardiovascular perfusion 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 cardiovascular perfusion 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 cardiovascular perfusion 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)

Notary Public for the State of _____

My Commission Expires: _____

Residing at: _____
City State

_____
Signature of Notary

Please return completed form to:

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

Applicant: *Each school where perfusionist education was received must complete this form. If more than one school, photocopies of this blank form may be made and used. The Board also requires transcripts from the perfusionist program(s) or school(s) to be sent directly from the school(s) to the Nevada State Board of Medical Examiners.*

FORM 1

NEVADA STATE BOARD OF MEDICAL EXAMINERS
PERFUSIONIST EDUCATION VERIFICATION

This certifies that _____
Name of Applicant

was enrolled in _____
Name of Perfusionist School (Location – City / State / Country)

The following information 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 _____
(date of enrollment for Perfusionist Degree) (ending date of attendance for Perfusionist Degree)

The applicant was granted:

- ☐ Perfusionist Certificate
- ☐ Perfusionist Degree
- ☐ Bachelor's Degree
- ☐ Combined Perfusionist / Bachelor's Degree
- ☐ Combined Perfusionist / Masters Degree
- ☐ Other (Please attach explanation.)

on the _____ day of _____, _____.
(day) (month) (year)

Signed and the institutional seal affixed this

_____ day of _____ , 2 _____

By: _____
Printed name of President, Registrar or Dean)

Title _____
Title of President, Registrar or Dean

Affix Seal Here

Signature _____
Signature of President, Registrar or Dean **

Telephone: _____

Fax: _____

Email: _____

** Signatures by personnel other than the President, Registrar or Dean must attach documentation granting authorization to sign in lieu of the President, Registrar or Dean.

Completed form is to be returned by the verifying institution directly to:
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521

Perfusionist School : *If you have questions, you may contact the Board at (775) 688-2559. The Board requires that this verification form be received by mail and NOT by facsimile.*

Applicant: ***This form is to be mailed to the ABCP for completion.***

FORM 2

NEVADA STATE BOARD OF MEDICAL EXAMINERS
ABCP CERTIFICATION

The American Board of
Cardiovascular Perfusion
2903 Arlington Loop
Hattiesburg, MS 39401
601-268-2221
Fax 601-268-2229
www.abcp.org

Part 1 – to be completed by applicant

I, ____ am in the process
(name of applicant)
of applying for perfusionist licensure in the state of Nevada and hereby authorize release of the following information directly to the Nevada State Board of Medical Examiners.

____
(signature of applicant)

- -

Part 2 – to be completed by ABCP and returned directly to the Nevada State Board of Medical Examiners

I, the undersigned, certify that ______________________________________
(name of applicant)
was granted initial certification by the American Board of Cardiovascular Perfusion

on: date issued ________________________________

certificate number ____________________________.

The above certificate is: ________ current, in good standing ________ not current.

Expiration date of current certification: ________________________.

Signed and the institutional seal affixed this

________ day of ______________________, 2________

(Affix seal here)

By: ______________________________________
(typed name and title of certifying agent)

____
(signature of certifying agent)

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

Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521
(775) 688 – 2559

Applicant: *Each state where licensure/certification* *__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/CERTIFICATION

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 perfusionist 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 above address.

____
(signature of applicant)

- -

PART 2 – TO BE COMPLETED BY LICENSING AGENCY and returned directly to the Nevada State Board of Medical Examiners

Name of Licensee: ____
Last First Middle

Issuing State Board: ____________________

License/Certificate Number: ____________________

Issue Date: ____________________ Expiration Date: ____________________

License was issued on the basis of ____
(examination: ABCP / State Licensing/Certifying examination)

I certify that the above license/certificate is:

- ____________ Current, in good standing
- ____________ Not current, due to non-payment of fees
- ____________ Subject to pending disciplinary charges
- ____________ Subject to restriction of licensure or practice
- ____________ Other (please attach explanation)

Note: Please attach any pertinent disciplinary documentation, if applicable.

I certify that to the best of my knowledge and belief the foregoing is a true, accurate, and complete statement of the record of the individual named on this form.

AFFIX BOARD SEAL HERE

Signature of certifying individual: ____________________

Print name: ____________________

Title: ____________________

Date: ____________________

Email: ____________________

Completed form or state license verification is to be mailed by the verifying institution directly to:

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

__State Licensing Board__: *If you have questions, you may contact the Nevada Board at (775) 688-2559.*

Applicant: *If you answered affirmatively to questions #12 and #12a on the Application for Licensure, complete both the top portion and release area of this form; have this form notarized, and submit this form to all malpractice carriers verifying coverage within the past 10 years. Copies of this form may be used if you have more than one malpractice carrier.*

FORM 4

MALPRACTICE CLAIM VERIFICATION REQUEST

Insurance Carrier Information:

Name of Insured Perfusionist**:** _____

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 Perfusionist had a settlement paid on his/her behalf? _____Yes _____No

If "yes", please provide the following information:

Occurrence Date	*Status*	*Date Closed*	*Indemnity Amount*
_____	_____	_____	_____

*Description of Claim:*_____

_____

Insurance Carrier Agent:

_____
Print Name and Title

_____
Signature of Agent

_____
Telephone

_____
Email address

Please mail completed form to:

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

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.

_____
Perfusionist (applicant) signature and date

Subscribed and sworn to before me this _____ day of

_____, 2_____,

Notary Public for the State of _____

My Commission Expires: _____

Residing at: _____
City State

_____
Signature and Seal of Notary Public

Malpractice Insurance Carrier: *If you have questions, you may contact the Nevada Board at (775) 688-2559.*

CREDIT CARD AUTHORIZATION FORM

If mailing or faxing this page separately from an application or order form, please mail to:
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521
or fax to: 775-688-2321

<u>Please type or print legibly.</u>

Method of Payment: MasterCard / Visa / American Express / Discover

Name on Credit Card: _____

Business Name (if applicable): _____

Credit Card Billing Address:

_____

_____

_____

Phone Number: _____

Name of Applicant (if applying for licensure): _____

Credit Card Number: _____

Expiration Date: _____ / _____ Credit Card Verification Code (CVC): _____
(MM) (YYYY) *(Three or four digit code found on the front or back of the card)*

For security of your financial information, please do not email this form to the Board; emailed forms will not be accepted.

I authorize the Nevada State Board of Medical Examiners to charge the above credit card for a

One-time payment in the amount of $_____.

Printed Name: _____

Authorized Signature: _____Date:_____

Email Address for receipt: _____

Disclosure: By continuing, you will be charged a non-refundable card payment-processing fee of 2.5% for debit and credit cards by our payment processor. If you do not wish to pay the fee, you can select another payment option.