

**PHYSICIAN ASSISTANT  
APPLICATION FOR REINSTATEMENT TO ACTIVE STATUS  
FOR THE BIENNIAL REGISTRATION PERIOD 2017- 2019  
NEVADA STATE BOARD OF MEDICAL EXAMINERS**

1105 Terminal Way, Suite 301 Reno, Nevada 89502  
Phone (775) 688-2559 Fax (775) 688-2321

Date Received by Board

License No. \_\_\_\_\_

File No. \_\_\_\_\_

For Board Use Only

Phone (775) 688-2559

For Board Use Only

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

\_\_\_\_\_ PHYSICIAN ASSISTANT REINSTATEMENT FEE: \$750.00

**You may pay by check, 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.**

**NAME:** \_\_\_\_\_

Make checks payable to:

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

**PLEASE NOTE:**

NAC 630.350 (3) Renewal of license; suspension and reinstatement of license.

(3) If a licensee fails to pay the fee for biennial registration after it becomes due, his or her license to practice in this State is automatically expired. Within 2 years after the date the license is expired, the holder may be reinstated to practice as a physician assistant if the holder:

- (a) Pays twice the amount of the current fee for biennial registration to the Secretary-Treasurer of the Board; and
- (b) Is found to be in good standing and qualified pursuant to this chapter (630 of NAC).

- YOUR LICENSE WILL NOT BE REINSTATED UNTIL THE BOARD RECEIVES YOUR ORIGINAL SIGNED *APPLICATION FOR REINSTATEMENT TO ACTIVE STATUS REGISTRATION FORM*. **A FAXED COPY IS NOT ACCEPTABLE.**
- YOU WILL NOT BE REINSTATED UNLESS YOU ANSWER ALL QUESTIONS ON THIS *APPLICATION FOR REINSTATEMENT TO ACTIVE STATUS REGISTRATION FORM*.
- YOU MUST PROVIDE WRITTEN EXPLANATIONS FOR ALL QUESTIONS ANSWERED "YES."
- ALL INFORMATION YOU PROVIDE ON THIS *APPLICATION FOR REINSTATEMENT TO ACTIVE STATUS REGISTRATION FORM* IS PUBLIC INFORMATION.

**PLEASE TYPE OR PRINT LEGIBLY**

1. Active status registration requires the submission of proof of completion of forty (40) hours of American Academy of Physician Assistants (AAPA) OR AMA Category 1 continuing medical education (CME), which includes two (2) hours of CME in medical ethics; **completed during the preceding 24-month time period of the date of your submission of this form.** Submit your proof of completion of CME with your completed ***APPLICATION FOR REINSTATEMENT TO ACTIVE STATUS REGISTRATION*** form. (See last page of this form for specific CME statement information.)

2. If your name and/or address have changed, clearly indicate the change in the space provided below. Please be advised, the address you indicate below is viewable on the NSBME website and is listed as the public address. Also, please indicate your current public telephone and fax numbers. [Please note: if your name has changed, a copy of the document authorizing your name change (marriage license, divorce decree, etc.) must be included.]

Name \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

E-mail address \_\_\_\_\_

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

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

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

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

**SCOPES OF PRACTICE CODES**

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

**Code**

**Code**

**Primary Scope of Practice** \_\_\_\_\_

**Secondary Scope of Practice** \_\_\_\_\_

**All of the following questions refer to the preceding  
24-month time period of the date of your  
submission of this form or since your last renewal.**

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

**"Ability to practice medicine"** is to be construed to include all of the following:

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

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

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

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

1. Do you currently have a medical condition which in any way impairs or limits your ability to practice as a physician assistant with reasonable skill and safety? \_\_\_\_\_Yes \_\_\_\_\_No
  
2. If you currently have a medical condition which in any way impairs or limits your ability to practice as a physician assistant, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice or by any other reasonable accommodation? \_\_\_\_\_Yes \_\_\_\_\_No \_\_\_\_\_N/A
  
3. If you currently use chemical substances, does your use in any way impair or limit your ability to practice as a physician assistant with reasonable skill and safety? \_\_\_\_\_Yes \_\_\_\_\_No \_\_\_\_\_N/A
  
4. Have you been named as a defendant, or been requested to respond as a defendant, to a legal action involving professional liability, or malpractice, including any military tort claims if applicable? \_\_\_\_\_Yes \_\_\_\_\_No
  
5. Have you had a professional liability, malpractice, claim paid on your behalf, or paid such a claim yourself including any military tort claims if applicable? \_\_\_\_\_Yes \_\_\_\_\_No
  
6. Have you been arrested, investigated for, charged with, convicted of, or pled guilty or nolo contendere to any 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
  
8. Have you been denied a license or certificate to practice as a physician assistant, or in any other healing art, or permission to take an examination to practice as a physician assistant or in any other healing art(s) in any state, country or U.S. territory? \_\_\_\_\_Yes \_\_\_\_\_No
  
9. Have you had a physician assistant license or certificate, or license or certificate to practice in any other healing art, revoked, suspended, limited, or restricted in any state, country or U.S. territory? \_\_\_\_\_Yes \_\_\_\_\_No

10. Have you voluntarily surrendered a license or certificate to practice as a physician assistant, or in any other healing art, in any state, country or U.S. territory? \_\_\_\_\_ Yes \_\_\_\_\_ No

11. Have you been denied membership, been asked to resign or expelled from a medical society or other professional medical organization? \_\_\_\_\_ Yes \_\_\_\_\_ No

12. Have you been: a) asked to respond to an investigation, b) notified that you were under investigation for; c) investigated for; d) charged with; or e) convicted of any violation of a statute, rule or regulation governing your practice as a physician assistant by any medical licensing board, hospital, medical society, governmental entity or other agency other than the Nevada State Board of Medical Examiners? \_\_\_\_\_ Yes \_\_\_\_\_ No

13. Have you surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? \_\_\_\_\_ Yes \_\_\_\_\_ No

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

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

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

**CHILD SUPPORT STATEMENT**

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

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

\_\_\_\_\_ (b) I am subject to a court order for the support of one or more children and am in compliance with the order or am in compliance with a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order; **OR**

\_\_\_\_\_ (c) I am subject to a court order for the support of one or more children and am NOT in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

**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](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 PHYSICIAN ASSISTANTS**

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](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  Logistics or Supply  
 Aviation  Maintenance  
 Civil Engineering  Medical Services  
 Communications  Security Forces or Military Police  
 Infantry or Armor  Other  
 Legal or Chaplain Corps

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

## **BUSINESS LICENSE ATTESTATION**

Do you hold a Nevada state business license issued in your individual name? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, provide the business license number: \_\_\_\_\_.

## **CONTINUING MEDICAL EDUCATION (CME) STATEMENT**

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

\_\_\_\_\_ (a) I was initially licensed in Nevada prior to or during the time period July 1, 2015 through December 31, 2015 and completed a minimum of forty (40) hours of AAPA or AMA Category 1 continuing medical education (CME), two (2) hours of which were in medical ethics or pain management and/or addiction care;

\_\_\_\_\_ (b) I was initially licensed in Nevada during the time period January 1, 2016 through June 30, 2016, the second six months of the past biennial period, and completed a minimum of thirty (30) hours of AAPA or AMA Category 1 continuing medical education (CME), two (2) hours of which were in medical ethics or pain management and/or addiction care;

\_\_\_\_\_ (c) I was initially licensed in Nevada during the time period July 1, 2016 through December 31, 2016, the third six months of the past biennial period, and completed a minimum of twenty (20) hours of AAPA or AMA Category 1 continuing medical education (CME), two (2) hours of which were in medical ethics or pain management and/or addiction care;

\_\_\_\_\_ (d) was initially licensed in Nevada during the time period January 1, 2017 through June 30, 2017, the fourth six months of the I past biennial period, and completed a minimum of ten (10) hours of AAPA or AMA Category 1 continuing medical education (CME), two (2) hours of which were in medical ethics or pain management and/or addiction care.

**ATTACH COPIES OF PROOF OF YOUR COMPLETION OF CONTINUING MEDICAL EDUCATION (CME) HOURS.**

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



# CREDIT CARD AUTHORIZATION FORM

*If mailing or faxing this page separately from the application, please mail to:*

*Nevada State Board of Medical Examiners*

*1105 Terminal Way, Suite 301*

*Reno, NV 89502*

*or fax to:*

*775-688-2321*

**Please type or print legibly.**

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

Method of Payment:  MasterCard  Visa  American Express  Discover

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

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

Credit Card Billing Address:

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

Phone Number: \_\_\_\_\_

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

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

***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 \$ \_\_\_\_\_, and an additional 2% service fee.

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

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