**PHYSICIAN ASSISTANT**
**APPLICATION FOR REGISTRATION RENEWAL**
**FOR THE BIENNIAL REGISTRATION PERIOD 2017 – 2019**
**NEVADA STATE BOARD OF MEDICAL EXAMINERS**

Phone (775) 688-2559
Physical Address: 1105 Terminal Way, Suite 301 Reno, Nevada 89502

Date Received by Board

License No._____

File No. _____
(For Board Use Only)

I hereby apply for renewal of biennial registration and enclose the appropriate fee(s) as indicated below:

ACTIVE STATUS ---------- $405.00

Make checks payable to:
**NEVADA STATE BOARD OF MEDICAL EXAMINERS**
(Foreign checks must indicate "U.S. Funds")
Credit card authorization may also be utilized.

**PLEASE NOTE THE FOLLOWING IMPORTANT INSTRUCTIONS REGARDING YOUR APPLICATION:**

- Your current physician assistant license expires on **JUNE 30, 2017**. If this form is not received by the Nevada State Board of Medical Examiners' (Board) office by JUNE 30, 2017 at 5:00 p.m., your license will be automatically expired and you will not be able to work as a physician assistant until you reinstate your license. **NEVADA HAS NO GRACE PERIOD**.
- Your license will not be renewed unless you answer **ALL** questions on this application and provide written explanation(s) for any/all question(s) answered "yes."
- Your license will not be renewed until the Board receives your original signed *Application for Registration Renewal* form. **A faxed copy is not acceptable.**
- Your license will not be renewed unless it is accompanied with a check for the proper fee or credit card authorization.
- You may have been selected in a random continuing medical education (CME) audit of all licensees. If you were randomly selected, you will be contacted by the Board for proof of your CME. Your license will not be renewed if you do not have proof of the required CME. Refer to page 5 for a review of your CME requirement. Please retain proof of your CME as the Board does not retain copies.
- If you have recertified with the National Commission on Certification of Physician Assistants (NCCPA) since your last renewal or initial licensure, please attach a copy of your current certification.
- All information provided on this application is **PUBLIC** information.
- **PLEASE TYPE OR PRINT LEGIBLY**.

Please print your name and address clearly in the space provided below. Be advised that the address you provide below is viewable on the Board website and is listed as the public address. Also, please provide your current public telephone and fax numbers. [Note: If your name has changed, a copy of the document authorizing your legal name change (marriage license, divorce decree, etc.) must be included.]

Name_____

Street_____

City _____ County _____ State _____

Zip _____

Phone Number _____ Cell Phone Number _____

Fax Number _____ E-mail address _____

In the event that you were selected in the random audit, providing an email address will greatly assist the Board to expedite communication for your renewal.

## QUESTIONS

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

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

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

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

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

### Please answer all of the following questions for the time period <u>July 1, 2015 – June 30, 2017, or since your last renewal</u>.

For all <u>YES</u> responses to the following questions, <u>you must submit your written explanation(s) on a separate sheet</u> attached to this 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, 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 during this time period. _____Yes _____No

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

8. 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

9. 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 in lieu of any disciplinary action? _____Yes _____No

10. 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 agency other than the Nevada State Board of Medical Examiners? _____Yes _____No

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

12. Have you had staff privileges denied, suspended, limited, revoked or not renewed by a hospital, including any and all resignations from any medical staff in lieu of disciplinary or administrative action? ***If the answer is "YES," on a separate sheet list the name of the hospital, the hospital's mailing address, the type of action taken, and the date or dates of the actions taken.*** (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.) _____Yes _____No

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

14. Are you currently certified by the National Commission on Certification of Physician Assistants? _____Yes _____No

15. Have you actively practiced medicine in Nevada within the past 24 months? _____Yes _____No

## SUPERVISING PHYSICIAN

Please list the name or names of your supervising physician(s) with their addresses and telephone number for **EVERY** location from which you practice (use separate sheet if needed):

Supervising Physician Name | Address of Practice Location | Telephone Number

_____

_____

_____

## ATTESTATIONS / AFFIRMATIONS

### CHILD SUPPORT STATEMENT

### PLEASE PLACE AN "X" NEXT TO THE STATEMENT THAT APPLIES TO YOU:

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

_____ 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**

_____ 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

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

I hereby attest to knowledge of and compliance with the guidelines of the Centers for Disease Control and Prevention concerning the prevention of transmission of infectious agents through safe and appropriate injection practices. I also attest that any person who is currently, or will be under my control as their supervising physician assistant 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 ATTESTATION

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 Attestation.*

If yes, in which branch of service did you serve?

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

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

Dates of service in the Military:

**From:** _____/_____/_____ (MM/DD/YYYY) **To:** _____/_____/_____ (MM/DD/YYYY)

## BUSINESS LICENSE ATTESTATION

Do you have a business license issued by the Nevada Secretary of State in your individual name? _____Yes _____No

If yes, provide the business license number: _____.

## COMMUNICATIONS AFFIRMATION

**Consent to accept communications and service of process from the Nevada State Board of Medical Examiners (Board) by electronic mail, for physicians and physician assistants who practice medicine in the state of Nevada or via telemedicine and whose physical presence exists outside the state of Nevada or the United States**

I hereby agree that as a condition of obtaining or maintaining licensure with the Board, I am willing to accept Board communications to me, to include service of process as defined under Nevada Revised Statute (NRS) 630.344, via electronic mail (more commonly known as e-mail). Further, should the electronic mail address provided below change for any reason, I agree to apprise the Board in writing of my new electronic mail address within 30 days after the change, and that the failure to do so may subject me to a fine or disciplinary action as allowed in NRS 630.244.

Printed Name of Applicant/Licensee: _____

Signature of Applicant/Licensee: _____

Electronic Mail Address: _____

## Continuing Education

**ALL CME MUST HAVE BEEN COMPLETED DURING THE PERIOD OF JULY 1, 2015 THROUGH JUNE 30, 2017.** Please place a check mark next to the statement that applies to you.

_____ I was initially licensed in Nevada prior to July 1, 2015 or during the first 6 months of the biennial period of registration (July 1, 2015 through December 31, 2015) and have 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, pain management and/or addition care, or instruction on clinically-based suicide prevention and awareness and twenty (20) hours of which were in my scope of practice or specialty.

_____ I was initially licensed in Nevada during the second 6 months of the biennial period of registration (January 1, 2016 through June 30, 2016) and have completed a minimum of thirty (30) hours of AAPA or AMA Category 1 CME, two (2) hours of which were in medical ethics, pain management and/or addition care, or instruction on clinically-based suicide prevention and awareness, and fifteen (15) hours of which were in my scope of practice or specialty.

_____ I was initially licensed in Nevada during the third 6 months of the biennial period of registration (July 1, 2016 through December 31, 2016) and have completed a minimum of twenty (20) hours of AAPA or AMA Category 1 CME, two (2) hours of which were in medical ethics, pain management and/or addition care, or instruction on clinically-based suicide prevention and awareness, and ten (10) hours of which were in my scope of practice or specialty.

_____ I was initially licensed in Nevada during the fourth 6 months of the biennial period of registration (January 1, 2017 through June 30, 2017) and completed a minimum of ten (10) hours of AAPA or AMA Category 1 CME, two (2) hours of which were in medical ethics, pain management and/or addition care, or instruction on clinically-based suicide prevention and awareness, and five (5) hours of which were in my scope of practice or specialty.

## Renewal Application Affirmation

**BY SIGNING BELOW, I SWEAR OR AFFIRM UNDER PENALTY OF PERJURY THAT I PERSONALLY ANSWERED ALL OF THE QUESTIONS IN THIS APPLICATION AND THAT THE ANSWERS I HAVE PROVIDED ARE TRUE AND CORRECT.**

_____

**Signature (Stamp Unacceptable)** **Date**

# 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 Licensee: _____

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: _____