

**PHYSICIAN  
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 ----- \$375.00

Note: Paper renewal fee of \$30.00 has been waived  
for County Restricted, Authorized Facility and Restricted Licenses

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's license expires on **JUNE 30, 2017**. If this form is not received by the Nevada State Board of Medical Examiners' (Board) office by July 1, 2017 at 5:00 p.m., your license will be automatically expired and you will not be able to practice medicine 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.
- **Your license will not be renewed unless you attach proof of continuing medical education (CME).** Refer to page 4 for a review of your CME requirement. Please retain proof of your CME as the Board does not retain copies.
- 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 \_\_\_\_\_

**Please indicate any American Board of Medical Specialties Board Certification or Recertification:**

Date of Initial Certification (Mo./Yr.)

Date of Last Recertification (Mo./Yr.)

Board: \_\_\_\_\_

Subboard: \_\_\_\_\_

If any of the ABMS Certifications or Recertifications were received after your last application with the Board, please attach copies of documents evidencing your Certifications or Recertifications.

**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  
July 1, 2015 – June 30, 2017, or since your last renewal.**

For all YES responses to the following questions, you must submit your written explanation(s) on a separate sheet attached to this form.

1. Do you currently have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? \_\_\_\_\_ Yes \_\_\_\_\_ No
2. If you currently have a medical condition which in any way impairs or limits your ability to practice medicine, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, the manner in which you have chosen to practice, or by any other reasonable accommodation? \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ N/A
3. If you currently use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety? \_\_\_\_\_ 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, permission to practice medicine or any other healing art, or permission to take an examination to practice medicine or any other healing art in any state, country or U.S. territory? \_\_\_\_\_ Yes \_\_\_\_\_ No

8. Have you had a medical license or license to practice any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory? \_\_\_\_\_Yes \_\_\_\_\_No
9. Have you voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory in lieu of any disciplinary action? \_\_\_\_\_Yes \_\_\_\_\_No
10. 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
11. 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 by any medical licensing board, hospital, medical society, governmental entity or agency other than the Nevada State Board of Medical Examiners? \_\_\_\_\_Yes \_\_\_\_\_No
12. Have you surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? \_\_\_\_\_Yes \_\_\_\_\_No
13. 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
14. Have you been denied membership, asked to resign, or expelled from a medical society or other professional medical organization? \_\_\_\_\_Yes \_\_\_\_\_No

*Pursuant to NRS 630.253: If you are a medical doctor whose specialty is psychiatry, a continuing medical education course of instruction that provides at least 2 hours of instruction on clinically-based suicide prevention and awareness and have completed prior to the renewal of your license.*

15. I am medical doctor **whose specialty is Psychiatry** and I am in compliance with NRS 630.253, as I have completed at minimum 2 hours of continuing medical education in the area of clinically-based suicide prevention and awareness. **Note: If you are not a Psychiatrist or hold Inactive status licensure your answer should be "No."** \_\_\_\_\_Yes \_\_\_\_\_No
16. Have you actively practiced medicine in Nevada within the past 24 months? \_\_\_\_\_Yes \_\_\_\_\_No

## 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 FOR APPLICANT PHYSICIANS**

I hereby attest to knowledge of and compliance with the guidelines of the Centers for Disease Control and Prevention concerning the prevention of transmission of infectious agents through safe and appropriate injection practices. I also attest that any person who is currently, or will be under my control as their supervising physician in the future, and who is not licensed pursuant to Chapter 630 of the Nevada Revised Statutes and whose duties involve injection practices, has knowledge of and is in compliance with the guidelines of the Centers for Disease Control and Prevention concerning the prevention of transmission of infectious agents through safe and appropriate injection practices.

\_\_\_\_\_Yes \_\_\_\_\_No

[http://www.cdc.gov/injectionsafety/IP07\\_standardPrecaution.html](http://www.cdc.gov/injectionsafety/IP07_standardPrecaution.html)

**MILITARY SERVICE 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 Service Attestation.*

If yes, which branch of service did you serve?

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

Military occupation specialty or specialties?

- |  |   |
|--|---|
| <input type="checkbox"/> Administration or Personnel | <input type="checkbox"/> Logistics or Supply                |
| <input type="checkbox"/> Aviation                    | <input type="checkbox"/> Maintenance                        |
| <input type="checkbox"/> Civil Engineering           | <input type="checkbox"/> Medical Services                   |
| <input type="checkbox"/> Communications              | <input type="checkbox"/> Security Forces or Military Police |
| <input type="checkbox"/> Infantry or Armor           | <input type="checkbox"/> Other                              |
| <input type="checkbox"/> Legal or Chaplain Corps     |   |

Dates of service in the Military:

**From:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **To:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
MM DD YYYY MM DD YYYY

**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: \_\_\_\_\_.

**CONSCIOUS SEDATION, DEEP SEDATION, OR GENERAL ANESTHESIA ATTESTATION**

Nevada Revised Statutes (NRS) require the Nevada State Board of Medical Examiners to obtain from each applicant who seeks renewal of his or her license to practice medicine, a report stating the number and type of surgeries requiring conscious sedation, deep sedation or general anesthesia performed by the holder of the license at his or her office or any other facility, excluding any surgical care performed at a medical facility as defined in NRS 449.0151, or outside the state of Nevada.

**I hereby attest that I am in compliance with the reporting requirements of NRS 630.30665, and am aware that failure to submit a report or filing false information in a report is grounds for disciplinary action under Nevada's Medical Practice Act.**

**\*\*\* I HAVE SUBMITTED MY A OR B REPORT TO THE BOARD:** \_\_\_\_\_Yes \_\_\_\_\_No

Forms and instructions are located on the Board's website: [http://medboard.nv.gov/Forms/In-Office\\_Surgery/](http://medboard.nv.gov/Forms/In-Office_Surgery/)

**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 CONTINUING MEDICAL EDUCATION 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 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 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 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 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.

\_\_\_\_\_ I am exempt from submitting proof of completion of CME because I have completed a full year of residency or fellowship training during the biennial period of July 1, 2015 through June 30, 2017. ***If you checked this statement, please attach a copy of proof of completion of your training.***

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