PHYSICIAN

Date Received by Board

APPLICATION FOR STATUS CHANGE TO ACTIVE STATUS REGISTRATION FORM FOR THE BIENNIAL PERIOD 2015 - 2017 NEVADA STATE BOARD OF MEDICAL EXAMINERS

1105 Terminal Way, Suite 301 Reno, NV 89502 Phone (775) 688-2559

License No	
File No	

(For Board Use Only)

 CHANGE FROM INACTIVE TO ACTIVE STATUS	between 7/1/2016 - 6/30/2017	\$ 375.00

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.

<u>PLEASE NOTE:</u>

Licensee's Name:

NRS 630.255 (4) (5) Inactive licensees: reinstatement.

- 4. Before resuming the practice of medicine in this State, the inactive registrant must:
 - (a) Notify the Board in writing of his or her intent to resume the practice of medicine in this State;
 - (b) File an affidavit with the Board describing the activities of the registrant during the period of inactive status;
 - (c) Complete the form for registration for active status;
 - (d) Pay the applicable fee for biennial registration; and
 - (e) Satisfy the Board of his or her competence to practice medicine.
- 5. If the Board determines that the conduct or competence of the registrant during the period of inactive status would have warranted denial of an application for a license to practice medicine in this State, the Board may refuse to place the registrant on active status.
- Your Status Will Not Be Changed Unless You Answer <u>All Questions On This Application For Status Change To Active Status Registration Form.</u>
- You Must <u>Provide Written Explanations</u> For All Questions Answered "Yes."
- All Information You Provide On This Application Is <u>Public</u> Information.

PLEASE TYPE OR PRINT LEGIBLY

- 1. Active status registration requires the submission of proof of completion of AMA Category 1 continuing medical education (CME), 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 STATUS CHANGE TO ACTIVE STATUS REGISTRATION form. A detailed description of the number of continuing medical education hours required for your change of status can be found on page 8 of this application.
- 2. If your name and/or address have changed, indicate the change in the space provided below. Please be advised, the address you provide below is viewable on the NSBME website and will become your <u>public</u> address. Also, please indicate your current <u>public</u> telephone and fax numbers. <u>Please note</u>: 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	
Public Phone Number	Public	Fax Number		
Cellular Phone:	Private	Public □		
Email address				

### Phone Number ### AND SECONDARY SCOPES OF PRACTICE using the following codes: ### SCOPES OF PRACTICE CODES ADDICTION MEDICINE	Name				
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4. INDICATE BELOW YOUR PRIMARY AND SECONDARY SCOPES OF PRACTICE using the following codes: SCOPES OF PRACTICE CODES 1. ADDICTION MEDICINE					Zip
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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 Other States of Current or Previous Licensure: List state licenses YOU HOLD OR HAVE HELD to practice medicine in any state, territory or country with the exception of licenses. (Current direct source verification of these licenses must be received by the Board prior to any status change.)	33 INTERNAL MEDICINE	73	PEDIATRIC, INFECTIOUS DISEASES	S 113	
36 MATERNAL/FETAL MEDICINE 37 MEDICAL ACUPUNCTURE 38 MEDICAL ETHICS 39 MEDICAL ETHICS 39 MEDICAL GENETICS 39 MEDICAL GENETICS 39 MEDICAL GENETICS 39 PEDIATRIC, PHYSIATRY 39 MEDICAL GENETICS 39 PEDIATRIC, PULMONARY 39 MEDICAL GENETICS 39 PEDIATRIC, PULMONARY 39 MEDICAL GENETICS 39 PEDIATRIC, PULMONARY 39 PEDIATRIC, RADIOLOGY 40 NEO/PERINATAL MEDICINE 40 PEDIATRIC, RADIOLOGY 40 NEO/PERINATAL MEDICINE 40 Secondary Scope of Practice Code Code Code Other States of Current or Previous Licensure: List state licenses YOU HOLD OR HAVE HELD to practice medicine in any state, territory or country with the exception of licenses. (Current direct source verification of these licenses must be received by the Board prior to any status change.)			•		
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 Primary Scope of Practice Secondary Scope of Practice Code Other States of Current or Previous Licensure: List state licenses YOU HOLD OR HAVE HELD to practice medicine in any state, territory or country with the exception of licenses. (Current direct source verification of these licenses must be received by the Board prior to any status change.)					
38 MEDICAL ETHICS 39 MEDICAL GENETICS 40 NEO/PERINATAL MEDICINE Code Code Primary Scope of Practice Code Secondary Scope of Practice Code Other States of Current or Previous Licensure: List state licenses YOU HOLD OR HAVE HELD to practice medicine in any state, territory or country with the exception of licenses. (Current direct source verification of these licenses must be received by the Board prior to any status change.)					
MEDICAL GENETICS NEO/PERINATAL MEDICINE Tode Code Primary Scope of Practice Secondary Scope of Practice Other States of Current or Previous Licensure: List state licenses YOU HOLD OR HAVE HELD to practice medicine in any state, territory or country with the exception of licenses. (Current direct source verification of these licenses must be received by the Board prior to any status change.)					
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Code Primary Scope of Practice Secondary Scope of Practice Other States of Current or Previous Licensure: List state licenses YOU HOLD OR HAVE HELD to practice medicine in any state, territory or country with the exception of licenses. (Current direct source verification of these licenses must be received by the Board prior to any status change.)					
Primary Scope of Practice Secondary Scope of Practice Other States of Current or Previous Licensure: List state licenses YOU HOLD OR HAVE HELD to practice medicine in any state, territory or country with the exception of licenses. (Current direct source verification of these licenses must be received by the Board prior to any status change.)		Code			Code
Other States of Current or Previous Licensure: List state licenses YOU HOLD OR HAVE HELD to practice medicine in any state, territory or country with the exception of licenses. (Current direct source verification of these licenses must be received by the Board prior to any status change.)					
List state licenses YOU HOLD OR HAVE HELD to practice medicine in any state, territory or country with the exception of licenses. (Current direct source verification of these licenses must be received by the Board prior to any status change.)	Primary Scope of Practice		Seconda	ry Scope of Prac	tice
List state licenses YOU HOLD OR HAVE HELD to practice medicine in any state, territory or country with the exception of licenses. (Current direct source verification of these licenses must be received by the Board prior to any status change.)	Other States of Current or	Drovious	Liconcuro		
licenses. (Current direct source verification of these licenses must be received by the Board prior to any status change.)				to torritory or count	try with the execution of training
State/Territory/Country License # Date of Issuance Dates of Pro					
	State/Territory/Country	Lic	ense # D	ate of Issuance	Dates of Practice
From (Mo./Yr.) To					From (Mo./Yr.) To (Mo./Yr.)

Questions:

All of the following questions refer to the time period since your last renewal

In the event that your status was not changed to Inactive <u>during</u> a renewal, all questions refer to the time period within the last 24 months prior to your submission of this form.

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.

"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 Status Change to Active Status Registration form.

 Do you currently have a medical condition which in any way impairs or limits your ability to pracand safety? 	tice medicii —	ne with reasona Yes	
2. If you currently have a medical condition which in any way impairs or limits your ability to practi imitation reduced or ameliorated because of the field of practice, the setting, the manner in which			
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 skill and safety?	•		
	res	No	IN/A
4. Have you failed to initiate the performance of public service within one year after the date the perstaining a loan or scholarship from the federal government or a semedical education?		•	for your
		103	110

[&]quot;Medical condition" includes physiological, mental or psychological condition or disorder.

Questions (continued): The following questions refer to the time period since your last renewal OR within the last 24 months prior to your submission of this form.
Malpractice Questions:
5. 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?YesNo
6. 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?
Malpractice Explanation(s):
List of <u>all</u> 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 have not answered "yes" to questions #5 and/or #6 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:
Insurance carrier at time:
What is/was your status?
Please provide specifics in reference to the adverse event including the allegations and your role in the event:

Questions (continued) within the last 24 months		g questions refer to the tin	ne period since	your last renewal OR
violation of any federal (inclu a misdemeanor, gross miso jurisdiction, excluding any m substance, including alcoho distribution, prescribing, or o	uding the Uniform Code demeanor, felony, violat ninor traffic offense (driv ol, is not considered a dispensing of controlled	charged with, convicted of, or pl of Military Justice), state or local ion of the Uniform Code of Milita ving or being in control of a motor minor traffic offense), or for any substances? *Please note that y missal, or expungement. (If "Yes	law, or the laws of a ary Justice, or synor vehicle while under offense which is r you MUST disclose	any foreign country, which is nymous thereto in a foreign the influence of a chemical elated to the manufacture, ANY investigation or arrest,
8. Have you ever been de examination to practice med	nied a license, permis dicine or any other heal	sion to practice medicine or an ing art in any state, country or U	y other healing art .S. territory?	, or permission to take anNo
9. Have you ever had a med state, country or U.S. territo		o practice any other healing art re	evoked, suspended	, limited, or restricted in anyYesNo
10. Have you ever voluntar territory?	rily surrendered a licen	se to practice medicine or any o	•	any state, country or U.SNo
11. Have you ever been den organization?	nied membership, been	asked to resign or expelled from a		other professional medicalYesNo
d) charged with; or e) convic	ted of any violation of a	nvestigation; b) notified that you statute, rule or regulation govern ental entity or agency other than	ning your practice as	a physician by any medical
13. Have you ever surrende	ered your state or federa	al controlled substance registrati	on or had it revoked	d or restricted in any way?YesNo
(all) resignations from any material restrictions for failure to co	nedical staff in lieu of dis	eges denied, suspended, limited, sciplinary or administrative action al records, attend hospital depar	n. (<u>Please Note</u> : Do	not include suspensions or
malpractice insurance). Hospital	Mailing Address	Type of Action		Dates of Action From (Mo./Yr.) To (Mo./Yr.)
	(If more spa	ace is needed, attach a separate	sheet.)	
Attestations/Affirmation	ons:			
CHILD SUPPORT ST	ATEMENT			
		STATUS CHANGE TO ACTIVE S (a), (b), OR (c) UNDER THE CH		
Please place a check mar		_		
(a) I am not aubica	at to a court arder for th	a augus and af a abild.		

	(a)	I am not subject to a court order for the support of a child;
•	nce	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 with a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount ant 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 REPO	RIING	OF THE ABUSE OR NEGL	ECT (DF A CHILD
I attest and affirm that I am aware of and under regarding the abuse or neglect of a child.	erstand th	ne reporting requirements found	d in Ne	vada Revised Statute 432B.220 YesNo
www.leg.state	.nv.us/NI	RS/NRS-432B.html#NRS432BS	ec220	
SAFE INJECTION PRACTICE ATTESTA	<u>TION</u>			
ATTESTATION TO KNOWL THE CENTERS FOR DISEASE		F AND COMPLIANCE WITH TH LL AND PREVENTION FOR <u>AP</u>		
I hereby attest to knowledge of and compliance w prevention of transmission of infectious agents th currently, or will be under my control as their supe the Nevada Revised Statutes and whose duties ir of the Centers for Disease Control and Preventio appropriate injection practices.	rough sa ervising p nvolve inj	fe and appropriate injection prac hysician in the future, and who is ection practices, has knowledge	tices. I a not lice of and is	also attest that any person who is ensed pursuant to Chapter 630 of s in compliance with the guidelines
http://www.cdc.go	ov/injecti	onsafety/IP07 standardPrecau	tion.htr	<u>nl</u>
COMMUNICATIONS AFFIRMATION				
electronic mail, for physicians and physician and whose physical presence exists outside. I am willing to accept Board communications to n 630.344, via electronic mail (more commonly kno for any reason, I agree to apprise the Board in w	the state ne, to inclown as e-riting of r	of Nevada or the United State ude service of process as define mail). Further, should the electro ny new electronic mail address	ed unde nic mai within 3	er Nevada Revised Statute (NRS) I address provided below change 0 days after the change.
Printed Name of Applicant/Licensee:				
Signature of Applicant/Licensee:				
Electronic Mail Address:				
MILITARY SERVICE ATTESTATION				
Have you ever served in the United States Milita If your answer is "No", you do not have to complete				YesNo
If yes, 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

DD

MM

To:

DD

MM

From:

Dates of service in the Military:

APPLICATION AFFIRMATION

l,			
(Print your full name)		
being duly sworn, depose and say: That the an application, as well as any and all further expl correct, that I am the person named in the cre regular course of instruction and examination responses on this application are false, frau licensure will be denied.	lanations contained of edentials to be submin without fraud or missi	n any separate attac tted, and that the sa representation. I und	ched pages, are true and ime were procured in the derstand that if any of my
I am responsible to keep the Board informed of responses provided to the Board in my appli licensure to practice medicine in the state of N	ication for licensure,		
Signature of app	olicant		Date
	State of	County of	
	Subscribed and s	sworn to before me this _	day of
(NOTARY SEAL)		the State of	
	•	Expires:	
	Residing at:		
		City	State
		Signature of Notary	

Continuing Education:

CONTINUING MEDICAL EDUCATION (CME) STATEMENT:

Note: If you have previously submitted proof of 4 hours AMA Category 1 continuing medical education regarding bioterrorism or relating to medical consequences of act of terrorism involving use of weapon of mass destruction, you will not be responsible to do so again. For your information, this requirement became effective October 2003.

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 44 hours of AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics or pain management and/or addiction care, 20 hours of which were in my scope of practice or specialty and 4 of which were in bio-terrorism/weapons of mass destruction (if applicable); (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 34 hours of AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics or pain management and/or addiction care, 20 hours of which were in my scope of practice or specialty and 4 of which were in bio-terrorism/weapons of mass destruction (if applicable); (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 24 hours of AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics or pain management and/or addiction care, 18 hours of which were in my scope of practice or specialty and 4 of which were in bio-terrorism/weapons of mass destruction (if applicable); (d) I was initially licensed in Nevada during the time period January 1, 2017 through June 30, 2017, the fourth six months of the past biennial period, and completed a minimum of 14 hours of AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics or pain management and/or addiction care, 8 hours of which were in my scope of practice or specialty and 4 of which were in bio-terrorism/weapons of mass destruction (if applicable), OR (e) I am exempt from submitting proof of completion of continuing medical education (CME) because I have completed a full year of residency or fellowship training during the biennial period July 1, 2015 through June 30, 2017. Attach copies of proof of your completion of continuing medical education (CME) hours

or

Proof of completion of 1 year of residency or fellowship training obtained during the biennial.

Your copies of proof of CME or training completion will not be returned to you.

END OF STATUS CHANGE APPLICATION

CHECKLIST FOR STATUS CHANGE APPLICATION REQUESTING CHANGE FROM INACTIVE TO ACTIVE STATUS

a.	APPLICATION
	☐ Properly completed and signed application
	Appropriate explanations and copies of all pertinent documentation must be attached for any
	affirmative responses to questions 1 through 14, on pages 3 - 5
 b.	FEES
	Proper payment of registration fee payable either by: OURDATE OURRATE OURDATE OURRATE OURDATE OURDATE OURRATE OURDATE OURRATE OURRATE OURRATE OURRAT
	 Cashier's check made payable to Nevada State Board of Medical Examiners (NSBME); Money order made payable to Nevada State Board of Medical Examiners (NSBME);
	 Money order made payable to Nevada State Board of Medical Examiners (NSBME); Credit card – acceptable with signed credit card authorization form;
	[an additional 2% service fee will be charged for credit card payment]
 c.	CONTINUING MEDICAL EDUCATION
	Proof of completion of AMA Category 1 continuing medical education (CME) completed during
	the preceding 24-month time period of the date of submission of this application for Status
	Change. Refer to page 8 for a detailed summarization of your continuing education requirement.
 d.	ADDITIONAL REQUIREMENTS
	☐ A signed statement notifying the Board of your intent to resume the practice of medicine in
	the state of Nevada.
	☐ A Notarized sworn affidavit to the Board describing your activities during your Inactive
	status.
 e.	STATE LICENSE VERIFICATIONS
	• Direct source verification of all other state licenses that you hold or have held (not including
	training licenses).
f.	SELF-QUERY VERIFICATION
	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 <u>final report</u> or self-query response from the NPDB, forward a copy
	of this report to the Board office either by mail, fax or email.

Applicant: You may want to contact the state(s) where you were licensed since some states charge a fee for license verifications and some do not. The Nevada State Board of Medical Examiners also accepts VeriDoc and other secured sources of electronic verification. This is a courtesy form that provides the Board's address, however verification of your state license does not have to be met by use of this form.

NEVADA STATE BOARD OF MEDICAL EXAMINERS VERIFICATION OF STATE LICENSURE

TO DE COMPLETED DV ADDLICANT

PRINTED NAME OF	N I		
APPLICANT:			
Address:			
Date of Birth:			
I am in the process of applying for medical licer information directly to the Nevada State Board		address below.	
PART 2 – TO BE COMPLETED BY LICENSIN			
Name of Licensee:	First	 Middle	
Issuing State Board:		Middle	
License Number:			
Issue Date:	Expiration	Date:	
License was issued on the basis of			
Literise was issued on the basis of	Examination: NB / FL	EX / USMLE / LMCC / State Licensing examination	
I CERTIFY THAT the above license 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 pe	rtinent disciplinary documentation, if applicable.	
I CERTIFY THAT to the best of my knowledg		g is a true, accurate, and complete statement	
	Signature of certifyinç	Signature of certifying individual:	
	Print name:		
AFFIX BOARD SEAL HERE	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

1105 Terminal Way, Ste 301 Reno, NV 89502

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

<u>Please type or print legibly</u> .		
Name of Applicant:		
Method of Payment:		
Name on Credit Card:		
Business Name (if applicable):		
Credit Card Billing Address:		
Phone Number:		
Credit Card Number:		
Expiration Date: /		
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:		