SPECIAL PURPOSE PHYSICIAN
APPLICATION FOR REGISTRATION RENEWAL
FOR THE BIENNIAL REGISTRATION PERIOD 2019 – 2021
NEVADA STATE BOARD OF MEDICAL EXAMINERS

Phone: (775) 688-2559
Address: 9600 Gateway Drive Reno, Nevada 89521

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 ---------- $780.00

SAVE $20 by renewing online at www.medboard.nv.gov

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 special purpose physician's license expires on **JULY 1, 2019**. If this form is not received by the Nevada State Board of Medical Examiners' (Board) office by JULY 1, 2019, at 5:00 p.m. PDT, 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 by a check or credit card authorization for the proper fee.

- 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.

- All information provided on this application is **PUBLIC** information.

- **PLEASE TYPE OR PRINT LEGIBLY.**

Per NRS 630.261(1)(e) & NRS 630.261(2)
A special purpose license is granted to a physician who is licensed in another state to perform any of the acts described in subsections 1 and 2 of NRS 630.020 by using equipment that transfers information concerning the medical condition of a patient in this State electronically, telephonically or by fiber optics including, without limitation, through telehealth, from within or outside this State or the United States. A physician who holds a special purpose license issued pursuant to this paragraph:

(1) Except as otherwise provided by specific statute or regulation, shall comply with the provisions of this chapter and the regulations of the Board; and

(2) To the extent not inconsistent with the Nevada Constitution or the United States Constitution, is subject to the jurisdiction of the courts of this State.

2. For the purpose of paragraph (e) of subsection 1, the physician must:
(a) Hold a full and unrestricted license to practice medicine in another state;
(b) Not have had any disciplinary or other action taken against him or her by any state or other jurisdiction; and
(c) Be certified by a specialty board of the American Board of Medical Specialties or its successor.

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 e-mail address will greatly assist the Board to expedite communication for your renewal.

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, 2017 – July 1, 2019, 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, 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 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

15. I hereby attest that I am in compliance with NRS 630.253, as I have completed or will complete between July 1, 2017 and June 30, 2021, a minimum of 2 hours of instruction on evidence-based suicide prevention and awareness.
_____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 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 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 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 to the Military Service Attestation.

2-If yes, which branch of service did you serve?

- ☐ Air Force
- ☐ Army
- ☐ Navy
- ☐ Marine Corps
- ☐ 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 your answer to question(s) 7, 8 and/or 9 is "Yes," did you separate from such service under conditions other than dishonorable? (Unless you were dishonorably discharged, your answer should be "Yes.") _____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: _____

CONSCIOUS SEDATION, DEEP SEDATION, OR GENERAL ANESTHESIA ATTESTATION

I hereby attest that I am in compliance with the reporting requirements of NRS 630.30665, to wit, that if I have performed a surgery or procedure in Nevada outside a "Medical Facility" as defined by NRS 449.0151, and that if surgery or procedure utilized conscious sedation, deep sedation or general anesthesia, then I have submitted a report to the Board stating the number and type of surgeries or procedure performed, and I am aware that the failure to submit a report or filing false information in a report is grounds for disciplinary action under Nevada's Medical Practice Act.

(If you have performed no such surgeries or procedures, then your answer should be "YES.") _____Yes _____No

Forms and instructions are located on the Board's website: http://medboard.nv.gov

COMMUNICATIONS AFFIRMATION

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.

Printed Name of Licensee: _____

Signature of Licensee: _____

Electronic Mail Address: _____

CONTINUING EDUCATION

ALL CONTINUING MEDICAL EDUCATION MUST HAVE BEEN COMPLETED DURING THE PERIOD OF JULY 1, 2017 THROUGH JULY 1, 2019. Please place a check mark next to the statement that applies to you.

_____ I was initially licensed in Nevada prior to July 1, 2017 or during the first 6 months of the biennial period of registration (July 1, 2017 through December 31, 2017) 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 addiction care, and twenty (20) hours of which were in my scope of practice or specialty. (At least 2 hours every 4 years must be on Suicide Detection, Intervention and Prevention.)

_____ I was initially licensed in Nevada during the second 6 months of the biennial period of registration (January 1, 2018 through June 30, 2018) 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 addiction care, and fifteen (15) hours of which were in my scope of practice or specialty. (At least 2 hours every 4 years must be on Suicide Detection, Intervention and Prevention.)

_____ I was initially licensed in Nevada during the third 6 months of the biennial period of registration (July 1, 2018 through December 31, 2018) 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 addiction care, and ten (10) hours of which were in my scope of practice or specialty. (At least 2 hours every 4 years must be on Suicide Detection, Intervention and Prevention.)

_____ I was initially licensed in Nevada during the fourth 6 months of the biennial period of registration (January 1, 2019 through July 1, 2019) 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 addiction care, and five (5) hours of which were in my scope of practice or specialty. (At least 2 hours every 4 years must be on Suicide Detection, Intervention and Prevention.)

_____ 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, 2017 through July 1, 2019. ***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
9600 Gateway Drive
Reno, NV 89521
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)

Credit Card Authorization Code: _____ (Three or four digit code on back of credit 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 $ _____, and an additional 2% service fee.

Printed Name: _____

Authorized Signature: _____ Date: _____