NEVADA STATE BOARD OF MEDICAL EXAMINERS
FEES FOR PHYSICIAN MEDICAL LICENSURE
BETWEEN JULY 1, 2011 AND JUNE 30, 2013

ONLY original applications for licensure sent from The Nevada State Board of Medical Examiners or downloaded online applications will be accepted. Any applications which appear to have been altered in any form will not be accepted. Applications must be typed or legibly handwritten (illegible or incomplete applications will be returned). Applications must be received on single sided white bond paper, 8 ½" x 11" in size.

Applications not completed within six (6) months from date of receipt will be rejected per NAC 630.180(2).

Active / Unrestricted	**$600 Application Fee**	**$800 Registration Fee**	**$75 Criminal Background Investigation Fee**	**=**	**$ 1,475**
Inactive Status	**$600 Application Fee**	**$400 Registration Fee**	**$75 Criminal Background Investigation Fee**	**=**	**$ 1,075**
Endorsement License	**$600 Application Fee**	**$800 Registration Fee**	**$75 Criminal Background Investigation Fee**	**=**	**$ 1,475**
Restricted License	**$400 Application Fee**	**$400 Registration Fee**	**$75 Criminal Background Investigation Fee**	**=**	**$ 875**
Authorized Facility	**$400 Application Fee**	**$400 Registration Fee**	**$75 Criminal Background Investigation Fee**	**=**	**$ 875**
Locum Tenens	**$400 Application Fee**	**$ 50 Registration Fee**	**$75 Criminal Background Investigation Fee**	**=**	**$ 525**
Temporary	**$400 Application Fee**	**$ 50 Registration Fee**	**$75 Criminal Background Investigation Fee**	**=**	**$ 525**

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.

The Application fee and Criminal Background Investigation fee will not be refunded.

Per Nevada Revised Statute 630.161, "The Board shall not issue a license to practice medicine to an applicant who has been licensed to practice any type of medicine in another jurisdiction and whose license was revoked for gross medical negligence by that jurisdiction".

The Board's staff conducts an investigation into your background during the application process. If staff becomes aware of circumstances** warranting a personal appearance at a Board meeting prior to acceptance of your application for licensure, your application must be completed 45 days prior to any regularly scheduled Board meeting in order for your appearance to be scheduled for that meeting for consideration of acceptance of your application. Under Nevada law, a public body cannot hold a meeting to consider the character, alleged misconduct, professional competence, or physical or mental health of any person unless it has given written notice to that person of the time and place of the meeting. The written notice must be sent by certified mail to the last known address of that person at least 21 working days before the meeting. A public body must receive proof of service of the notice before such a meeting may be held.

** You <u>may</u> be required to personally appear before the Board for acceptance of your application for licensure if you are applying for a license by Endorsement or for a restricted license.

** You <u>may</u> be required to personally appear before the Board for acceptance of your application for licensure if you have in any way ever been involved in any malpractice awards, judgments, or settlements in any amount

** You <u>may</u> be required to personally appear before the Board for acceptance of your application for licensure if you have answered in the affirmative ("Yes") to questions 8, 9, 10, 11, 12, 12a 13, 19, 27, 28, 29, 30, 31, 32 and 33.

If, at the time you meet with the Board, the Board votes to deny or <u>not</u> accept your application for licensure, this denial or non-acceptance of your application may become a reportable action to the Healthcare Integrity and Protection Data Bank, Federation of State Medical Boards of the United States, Inc. and American Medical Association, among other entities.

License Descriptions

Active / Unrestricted License

This license gives full and unrestricted privileges to practice clinical medicine in the state of Nevada.

Inactive Status Unrestricted License

This license is an unrestricted license but with an inactive status rather than an active status. The licensee would not be able to practice medicine in the state of Nevada and cannot prescribe. In order to change the status of this license to active, the licensee would have to apply for a status change (an additional application and fee).

Endorsement License

An Endorsement license is NOT RECIPROCITY in the state of Nevada. This license may be granted to applicants who do not otherwise meet all of the requirements for licensure. The applicant must have an active license to practice medicine in the District of Columbia or any state or territory of the United States. The applicant may be required to meet with the Full Board for consideration and approval of licensure by Endorsement. If granted, the license would give full and unrestricted privileges to practice clinical medicine.

Restricted License

There are three different restricted license types. They are granted:

- To practice medicine in certain medical specialties for which there are critically unmet needs determined by the Governor;
- To practice medicine in medically underserved area of a county determined by a board of county commissioners;
- For a graduate of a foreign medical school to teach, research, or practice medicine at a medical research facility or medical school – this license expires automatically once the licensee ceases to teach, research or practice clinical medicine in this State at the sponsoring medical research facility or medical school.

Authorized Facility License

There are two different authorized facility licenses. They are granted:

- To practice as a Psychiatrist in a Mental Health Center of the Division under the direct supervision of a licensed Psychiatrist;
- To practice in an institution of the Department of Corrections under the direct supervision of a physician who holds an unrestricted license.

Locum Tenens License

A locum tenens license will be effective not more than 3 months after issuance, and is granted to any physician who is licensed and in good standing in the District of Columbia or any state or territory of the United States, who meets the requirements for licensure in this State and who is of good moral character and reputation. The purpose of this license is to enable an eligible physician to serve as a substitute for another physician who is licensed to practice medicine in this State and who is absent from his practice for reasons deemed sufficient by the Board. A locum tenens license is not renewable.

Temporary License

A temporary license is granted for a specified period if the physician is licensed and in good standing in the District of Columbia or any state or territory of the United States, meets the requirements for licensure in this State, and is granted only if the Board determines that it is necessary in order to provide medical services for a community without adequate medical care. A temporary license is not renewable.

PHYSICIAN
APPLICATION CHECKLIST

TO BE RETURNED DIRECTLY TO BOARD OFFICE BY APPLICANT

_____	a.	APPLICATION: ☐ Properly completed, signed and notarized application, including pages 1 – 6, Applicant Responsibility statement, and Criminal Background Investigation report authorization form; ☐ Recent passport quality photograph (at least 2"x 2") attached to application, signed in ink on lower front edge; ☐ Appropriate explanations and copies of all pertinent documentation must be attached for affirmative responses to questions numbered 8, 9, 10, 11, 12, 12a, 13, 14, 19, 27, 28, 29, 30, 31, 32, and 33; ☐ Release form, signed and notarized (Form A);
_____	b.	FEES: • Proper application, registration, AND criminal background investigation fees – cashier's check or money order made payable to Nevada State Board of Medical Examiners (NSBME) or by credit card as instructed. Credit cards will only be accepted by receipt of the signed credit card authorization form. Note: Application and criminal background investigation fees are non-refundable;
_____	c.	IDENTITY (Important identity documents will be returned to you via secured mail): U.S. born citizens – Original or Certified Birth Certificate that bears an original seal or stamp of the issuing agency (notarized copies are not acceptable); • Foreign-born citizens - Original Certificate of Naturalization or current U.S. Passport; • Non U.S. citizens - Copy of both sides of Alien Registration card or Employment Authorization card or Visa;
_____	d.	SELF-QUERY VERIFICATION: • Self-query responses from the National Practitioner Data Bank (NPDB) AND the Healthcare Integrity and Protection Data Bank (HIPDB); see enclosed instruction sheet. The NPDB and HIPDB will send the combined report directly to you and you will forward the final report to the board office;
_____	e.	SUPPLEMENTARY FORMS: • FORM B: ONLY if you have answered affirmatively to either of the two malpractice questions on the application; • FORM C: ONLY if applying for a license by Endorsement (Endorsement is NOT reciprocity – please refer to the "License Description" page of your application for clarification) - completed, notarized and returned to the Board office with completed application for licensure; • FORM D: ONLY if applying for an unlimited license as a Resident currently in a program, who has passed all steps of United States Medical Licensing Examination (USMLE) and has completed 24 months of ACGME accredited progressive postgraduate training in the United States or Canada;
_____	f.	BOARD CERTIFICATION: • Copy of American Board of Medical Specialties (ABMS) Board certification certificate(s), copy of ABMS Board re-certification certificate(s); • If you hold "lifetime or historical" ABMS Board certification, a notarized statement agreeing to maintain Board certification (include name of the Board) for the duration of your licensure in the state of Nevada;
_____	g.	CONTINUING EDUCATION: ☐ Proof of 4 hours bio-terrorism AMA Category 1 continuing medical education (CME) relating to the medical consequences of an act of terrorism that involves the use of a weapon of mass destruction. Search for an online course by entering "AMA Category 1 bioterrorism continuing medical education" or take a classroom course; ☐ Review guidelines of the Centers for Disease Control and Prevention concerning the transmission of infectious agents through safe injection practices; (you will be required to attest within the application that you have reviewed these guidelines.) http://www.cdc.gov/hicpac/2007IP/2007isolationPrecautions.html - or - http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf
_____	h.	EXAMINATION REGARDING NEVADA LAW GOVERNING YOUR MEDICAL PRACTICE: • Jurisprudence examination familiarizing you with the Medical Practice Act (Nevada Revised Statutes, Chapters 630 and 629 and Nevada Administrative Code, Chapter 630) will **be mailed to you upon acknowledgement of receipt of your application and appropriate fees.** You must answer correctly at least 75% of the questions.

PHYSICIAN
APPLICATION CHECKLIST

DIRECT SOURCE VERIFICATIONS TO BE SOLICITED BY APPLICANT FOR DIRECT RETURN BY THE VERIFYING INSTITUTION TO BOARD OFFICE

Verifying agencies may charge a fee. ***Do not provide pre-stamped or pre-addressed envelopes for direct source verifications.***

_____	*	a.	MEDICAL SCHOOL: ☐ Verification of Medical Education (Form 1) to be completed by medical school(s); ☐ Official transcripts from all schools where professional medical instruction was received (if transcripts are not in English, a certified original and official English translation is required);
_____	*	b.	POSTGRADUATE TRAINING PROGRAM: • Certificate of Completion of Progressive Postgraduate Training (Form 2) to be completed by all institutions where any training occurred (internship, residency, fellowship and research fellowship);
_____	*	c.	RESIDENT APPLYING AFTER COMPLETION OF 24 MONTHS OF TRAINING: ☐ Verification of postgraduate training Form 2 showing postgraduate year 3 (PGY3) as "in progress"; ☐ Once postgraduate training program has been completed, proof of satisfactory completion of progressive postgraduate training (follow-up verification of postgraduate training Form 2) submitted directly to the Board from the program within 60 days after the scheduled completion of the program; ☐ Residents applying after completion of 24 months of training must meet Nevada's USMLE requirements (see Examination information below);
_____	*	d.	EXAMINATION: ☐ Certification of National Board, FLEX, USMLE, LMCC or SPEX scores - see instruction page. For State written examination certification – use Form 4; **Note: In the state of Nevada, for United States Medical Licensing Examination (USMLE) a person must pass Steps I, II and III of the USMLE within 7 years after the date on which the person first passes any step of the USMLE and a person is limited to a combined maximum of 9 attempts to pass steps I, II and no more than three attempts at step III of the USMLE.** ☐ Certification status report from the Educational Commission for Foreign Medical Graduates (ECFMG) – see instruction page;
_____		e.	BOARD CERTIFICATION: ☐ Verification of ABMS Board certification, if applying via state written exam/board certification; ☐ Verification of ABMS Board certification (direct source) if lifetime / historically board certified;
_____		f.	LICENSE VERIFICATIONS: • License verification (Form 3) from all states where applicant is currently licensed or has ever been licensed (this does not include training licenses or temporary permits);
_____		g.	HOSPITAL VERIFICATIONS: • Verification of hospital privileges Form 5 to be completed by appropriate entity and returned directly by the verifying institution to the Board office if you answered affirmatively to having had any disciplinary issues regarding your hospital privileges within the past 10 years (see Disclaimer below);
_____		h.	MALPRACTICE INSURANCE CARRIER VERIFICATIONS: • Malpractice insurance carrier verification Form 6 to be completed by appropriate entity and returned directly by the verifying institution to the Board office and must include the loss history report for any and all malpractice cases that occurred within the past 10 years (see Disclaimer below);
_____		i.	FINGERPRINT RESULTS: • FBI Criminal history background report – returned directly by the verifying institution to the Board office. **(Once application fees have been received, fingerprint cards and instructions will be mailed to the applicant. Note: The Board fingerprint cards contain the necessary Board account numbers required for processing.)**

* Federation Credentials Verification Service (FCVS) packet may verify these documents.

Disclaimer: Per Nevada Revised Statute 630.173(2) the Board has the right to consider information for any malpractice history or derogatory hospital privilege history that is more than 10 years old.

APPLICATION GUIDE

Identity - Licenses will be issued in the applicant's name as it is indicated on the submitted documented proof of such name (i.e. U.S. Birth Certificate, Certificate of Naturalization, Alien Registration card, Employment Authorization card, and/or other legal documentation reflecting name change).

Postgraduate Training - If you have ever had any actions, forms of remediation, restrictions or limitations imposed on you, or have been placed on probation while participating in any type of training program, you should answer affirmatively to question #19. Submit a signed and dated explanation addressed to the Board and copies of documentation you received from your program.
[i.e. Explanation addressed to the Board for any postgraduate training issues.]

Malpractice - Provide signed and dated explanations for all malpractice cases throughout your career. Provide copies of legal documentation for malpractice cases that occurred within the past 10 years unless otherwise instructed which includes copies of Complaints, Settlements and/or Dismissals. If you have a pending case or cases, request a letter from your attorney to be sent directly to the Board describing the current status of the case(s).
[i.e. Explanations for all cases addressed to the Board during your medical career answering who, what, where, when and why. Copies of legal documents for the past 10 years.]

Investigation - If you have ever been notified that you were under investigation by any medical licensing board, hospital, medical society, governmental entity or other agency, whether or not you were charged with or convicted of any violations of a statute, rule or regulation governing your practice as a physician, you should answer affirmatively to question #31 and submit the appropriate documentation. Provide signed and dated explanations and copies of any related documentation you received regarding any investigation unless otherwise instructed.

VERIFICATIONS THAT MAY BE EXPECTED FROM A DIRECT SOURCE OTHER THAN WHAT IS OUTLINED ON THE CHECKLIST

- Observerships, Externships, Research positions or Research Fellowships prior to completion of your postgraduate training in the United States or Canada.
- Employment in a medical setting between medical school and postgraduate training or in between postgraduate training years and prior to completion of your postgraduate training in the United States or Canada.

Disclaimer: Per Nevada Revised Statute 630.173 (2) the Board has the right to consider information that is more than 10 years old regarding malpractice, investigations by another licensing board, complaints or disciplinary actions from a hospital, clinic or medical facility if the Board receives the information from the applicant or any other source from which the Board is verifying the information provided by the applicant.

ATTENTION APPLICANT!

RESPONSIBILITY STATEMENT

Please sign and return this statement with your application for licensure to:
The Nevada State Board of Medical Examiners,
P.O. Box 7238, Reno, NV 89510
or
1105 Terminal Way, Ste 301, Reno, NV 89502

Because you are applying for the privilege of practicing medicine in Nevada, you should know that our state has some of the most stringent licensing requirements and comprehensive investigation programs in the United States.

Via FBI fingerprinting and other investigative modalities, our licensing specialists are likely to discover if data you have submitted on your application is erroneous or incomplete; therefore, you must answer all questions truthfully and completely. Specifically, this includes any sanctions or disciplinary actions you may have experienced during medical school or your postgraduate training, or any involvement you may have had with the legal system, either civil or criminal — criminal to include charges that may have ultimately been expunged, lessened, or dismissed, and no matter how long ago the event(s) occurred.

Explaining and documenting a problem to your licensing specialist will be much less painful than discussing your veracity before the entire Board of Medical Examiners due to inconsistencies between your application and incongruent input from outside sources.

ONLY YOU — NOT A LAWYER, DOCTOR, SPOUSE, OR CREDENTIALING COMPANY — ARE RESPONSIBLE FOR READING AND ANSWERING EVERY QUESTION ACCURATELY AND COMPLETELY.

If you have *any* questions about your application, ASK YOUR LICENSING SPECIALIST. Our licensing specialists are here to help you.

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I have read this responsibility statement and understand that I alone am accountable for completing my application for medical licensure in Nevada.

Print your name_____

Sign your name_____

Date_____

Note: It is your responsibility to keep the Board informed of any circumstance or event that would require a change to your initial responses provided to the Board in your application for licensure, and which occur prior to you being granted licensure to practice medicine in the state of Nevada.

INSTRUCTIONS FOR REQUESTING EXAM SCORES, "BOARD ACTION HISTORY REPORT" AND NPDB/HIPDB "SELF QUERY"

NATIONAL PRACTITIONER DATA BANK AND HEALTHCARE INTEGRITY AND PROTECTION DATA BANK'S "PRACTITIONER REQUEST" FOR INFORMATION DISCLOSURE (SELF-QUERY):

The request form for the NPDB and HIPDB is available at www.npdb-hipdb.hrsa.gov/welcomesq.html. Click on "Individual Self-Query" in the center of the page and follow the instructions provided. If you require additional information, please call the NPDB/HIPDB at (800) 767-6732. Once you have received the final report or self-query response from the NPDB and HIPDB, forward a copy of this report to the Board office.

FLEX, SPEX and USMLE AND BOARD ACTION HISTORY REPORT (EBAHR) FROM THE FEDERATION OF STATE MEDICAL BOARDS OF THE UNITED STATES

The Federation of State Medical Boards of the United States, Inc.'s EBAHR will certify a complete history of your scores for a designated examination(s). The Federation maintains scores for FLEX, SPEX, and the USMLE Steps 1, 2, and 3.
Request transcripts online at www.fsmb.org/transcripts.html. For questions or assistance, please call (817) 868-4041 or email usmle@fsmb.org.

NATIONAL BOARD SCORES:

The request form for the National Board of Medical Examiners is available on the NBME web site at www.nbme.org/programs-services/medical-students/tabs/certifications-transcripts.html. If you are unsuccessful in downloading or printing this form, or do not have access to a computer, please send to the NBME a signed, written request for your scores which includes the state to which you are applying, your name (please print), USMLE ID# or NBME ID# or SSN, date of birth, current address, phone number and e-mail address (if applicable). Include $50 for one endorsement and $5 for each additional endorsement requested at the same time. Make your check payable to NBME and mail to:
NBME
PO Box 48014
Newark, NJ 07101-4814.
For additional information, please call the NBME Examinee Records office at (215) 590-9700 or email: scores@nbme.org.

LMCC EXAMINATION TRANSCRIPT OF SCORES

Navigate to this website: www.mcc.ca. Click on **English; go** to **MCC documents** on the menu line; then go to **Certified Transcript of Examinations**. Click on **Service Request Form**. Print the Service Request Form and complete it. Mail it along with your check to the address on the top of the form. Or, if you are paying by credit card, you can fax the form to the fax number located on the form itself and also on the instruction page. For questions or assistance, please call (613) 521-6012.

ECFMG VERIFICATIONS

International medical graduates must contact the ECFMG for certification status to be sent to the Nevada State Board of Medical Examiners. You can contact ECFMG's Applicant Information Services at (215) 386-5900. The request form can be found on ECFMG's website at www.ecfmg.org. If you are using FCVS, you do not need to contact the ECFMG, FCVS will coordinate with the ECFMG to obtain your certification.

THE FOLLOWING CONSTITUTE GROUNDS FOR DENIAL OF LICENSURE, AS SET OUT IN NRS 630.301 THROUGH NRS 630.3065:

NRS 630.301 Criminal offenses; disciplinary action taken by other jurisdiction; surrender of previous license while under investigation; malpractice; engaging in sexual activity with patient; disruptive behavior; violating or exploiting trust of patient for financial or personal gain; failure to offer appropriate care with intent to positively influence financial well-being; engaging in disreputable conduct; engaging in sexual contact with surrogate of patient or relatives of patient. The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure:

1. Conviction of a felony relating to the practice of medicine or the ability to practice medicine. A plea of nolo contendere is a conviction for the purposes of this subsection.

2. Conviction of violating any of the provisions of NRS 616D.200, 616D.220, 616D.240, 616D.300, 616D.310, or 616D.350 to 616D.440, inclusive.

3. Any disciplinary action, including, without limitation, the revocation, suspension, modification or limitation of a license to practice any type of medicine, taken by another state, the Federal Government, a foreign country or any other jurisdiction or the surrender of the license or discontinuing the practice of medicine while under investigation by any licensing authority, a medical facility, a branch of the Armed Services of the United States, an insurance company, an agency of the Federal Government or an employer.

4. Malpractice, which may be evidenced by claims settled against a practitioner, but only if the malpractice is established by a preponderance of the evidence.

5. The engaging by a practitioner in any sexual activity with a patient who is currently being treated by the practitioner.

6. Disruptive behavior with physicians, hospital personnel, patients, members of the families of patients or any other persons if the behavior interferes with patient care or has an adverse impact on the quality of care rendered to a patient.

7. The engaging in conduct that violates the trust of a patient and exploits the relationship between the physician and the patient for financial or other personal gain.

8. The failure to offer appropriate procedures or studies, to protest inappropriate denials by organizations for managed care, to provide necessary services or to refer a patient to an appropriate provider, when the failure occurs with the intent of positively influencing the financial well-being of the practitioner or an insurer.

9. The engaging in conduct that brings the medical profession into disrepute, including, without limitation, conduct that violates any provision of a code of ethics adopted by the Board by regulation based on a national code of ethics.

10. The engaging in sexual contact with the surrogate of a patient or other key persons related to a patient, including, without limitation, a spouse, parent or legal guardian, which exploits the relationship between the physician and the patient in a sexual manner.

11. Conviction of:

(a) Murder, voluntary manslaughter or mayhem;

(b) Any felony involving the use of a firearm or other deadly weapon;

(c) Assault with intent to kill or to commit sexual assault or mayhem;

(d) Sexual assault, statutory sexual seduction, incest, lewdness, indecent exposure or any other sexually related crime;

(e) Abuse or neglect of a child or contributory delinquency;

(f) A violation of any federal or state law regulating the possession, distribution or use of any controlled substance or any dangerous drug as defined in chapter 454 of NRS; or

(g) Any offense involving moral turpitude.

(Added to NRS by 1977, 824; A 1981, 590; 1983, 305; 1985, 2236; 1987, 197; 1991, 1070; 1993, 782; 1997, 684; 2001, 766; 2003, 2707, 3433; 2003, 20th Special Session, 264, 265; 2005, 2522; 2007, 3045)

NRS 630.304 Misrepresentation in obtaining or renewing license; false advertising; practicing under another name; signing blank prescription forms; influencing patient to engage in sexual activity; discouraging second opinion; terminating care without adequate notice. The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure:

1. Obtaining, maintaining or renewing or attempting to obtain, maintain or renew a license to practice medicine by bribery, fraud or misrepresentation or by any false, misleading, inaccurate or incomplete statement.

2. Advertising the practice of medicine in a false, deceptive or misleading manner.

3. Practicing or attempting to practice medicine under another name.

4. Signing a blank prescription form.

5. Influencing a patient in order to engage in sexual activity with the patient or with others.

6. Attempting directly or indirectly, by way of intimidation, coercion or deception, to obtain or retain a patient or to discourage the use of a second opinion.

7. Terminating the medical care of a patient without adequate notice or without making other arrangements for the continued care of the patient.

(Added to NRS by 1983, 301; A 1985, 2236; 1987, 198)

NRS 630.305 Accepting compensation to influence evaluation or treatment; inappropriate division of fees; inappropriate referral to health facility, laboratory or commercial establishment; charging for services not rendered; aiding practice by unlicensed person; delegating responsibility to unqualified person; failing to disclose conflict of interest; failing to initiate performance of community service; exception.

1. The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure:

(a) Directly or indirectly receiving from any person, corporation or other business organization any fee, commission, rebate or other form of compensation which is intended or tends to influence the physician's objective evaluation or treatment of a patient.

(b) Dividing a fee between licensees except where the patient is informed of the division of fees and the division of fees is made in proportion to the services personally performed and the responsibility assumed by each licensee.

(c) Referring, in violation of NRS 439B.425, a patient to a health facility, medical laboratory or commercial establishment in which the licensee has a financial interest.

(d) Charging for visits to the physician's office which did not occur or for services which were not rendered or documented in the records of the patient.

(e) Aiding, assisting, employing or advising, directly or indirectly, any unlicensed person to engage in the practice of medicine contrary to the provisions of this chapter or the regulations of the Board.

(f) Delegating responsibility for the care of a patient to a person if the licensee knows, or has reason to know, that the person is not qualified to undertake that responsibility.

(g) Failing to disclose to a patient any financial or other conflict of interest.

(h) Failing to initiate the performance of community service within 1 year after the date the community service is required to begin, if the community service was imposed as a requirement of the licensee's receiving loans or scholarships from the Federal Government or a state or local government for the licensee's medical education.

2. Nothing in this section prohibits a physician from forming an association or other business relationship with an optometrist pursuant to the provisions of NRS 636.373.

(Added to NRS by 1983, 301; A 1985, 2237; 1987, 198; 1989, 1114; 1991, 2437; 1993, 2302, 2596; 1995, 714, 2562)

THE FOLLOWING CONSTITUTE GROUNDS FOR DENIAL OF LICENSURE, AS SET OUT IN NRS 630.301 THROUGH NRS 630.3065 (cont.):

NRS 630.306 Inability to practice medicine; deceptive conduct; violation of regulation governing practice of medicine or adopted by State Board of Pharmacy; unlawful distribution of controlled substance; injection of silicone; practice beyond scope of license; practicing experimental medicine without consent of patient or patient's family; lack of skill or diligence; habitual intoxication or dependency on controlled substances; filing of false report; failure to report certain changes of information or disciplinary or criminal action in another jurisdiction; failure to be found competent after examination; certain operation of a medical facility; prohibited administration of anesthesia or sedation; engaging in unsafe or unprofessional conduct; violating remediation agreement. [Effective through June 30, 2011.] The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure:

1. Inability to practice medicine with reasonable skill and safety because of illness, a mental or physical condition or the use of alcohol, drugs, narcotics or any other substance.
2. Engaging in any conduct:
(a) Which is intended to deceive;
(b) Which the Board has determined is a violation of the standards of practice established by regulation of the Board; or
(c) Which is in violation of a regulation adopted by the State Board of Pharmacy.
3. Administering, dispensing or prescribing any controlled substance, or any dangerous drug as defined in chapter 454 of NRS, to or for himself or herself or to others except as authorized by law.
4. Performing, assisting or advising the injection of any substance containing liquid silicone into the human body, except for the use of silicone oil to repair a retinal detachment.
5. Practicing or offering to practice beyond the scope permitted by law or performing services which the licensee knows or has reason to know that he or she is not competent to perform or which are beyond the scope of his or her training.
6. Performing, without first obtaining the informed consent of the patient or the patient's family, any procedure or prescribing any therapy which by the current standards of the practice of medicine is experimental.
7. Continual failure to exercise the skill or diligence or use the methods ordinarily exercised under the same circumstances by physicians in good standing practicing in the same specialty or field.
8. Habitual intoxication from alcohol or dependency on controlled substances.
9. Making or filing a report which the licensee or applicant knows to be false or failing to file a record or report as required by law or regulation.
10. Failing to comply with the requirements of NRS 630.254.
11. Failure by a licensee or applicant to report in writing, within 30 days, any disciplinary action taken against the licensee or applicant by another state, the Federal Government or a foreign country, including, without limitation, the revocation, suspension or surrender of a license to practice medicine in another jurisdiction.
12. Failure by a licensee or applicant to report in writing, within 30 days, any criminal action taken or conviction obtained against the licensee or applicant, other than a minor traffic violation, in this State or any other state or by the Federal Government, a branch of the Armed Forces of the United States or any local or federal jurisdiction of a foreign country.
13. Failure to be found competent to practice medicine as a result of an examination to determine medical competency pursuant to NRS 630.318.
14. Operation of a medical facility at any time during which:
(a) The license of the facility is suspended or revoked; or
(b) An act or omission occurs which results in the suspension or revocation of the license pursuant to NRS 449.160.
This subsection applies to an owner or other principal responsible for the operation of the facility.
15. Failure to comply with the requirements of NRS 630.373.
16. Engaging in any act that is unsafe or unprofessional conduct in accordance with regulations adopted by the Board.
(Added to NRS by 1983, 302; A 1985, 2238; 1987, 199, 800, 1554, 1575; 2007, 3046; 2009, 533, 879, 2961, 2962, effective July 1, 2011)

NRS 630.3062 Failure to maintain proper medical records; altering medical records; making false report; failure to file or obstructing required report; failure to allow inspection and copying of medical records; failure to report other person in violation of chapter or regulations. The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure:

1. Failure to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of a patient.
2. Altering medical records of a patient.
3. Making or filing a report which the licensee knows to be false, failing to file a record or report as required by law or willfully obstructing or inducing another to obstruct such filing.
4. Failure to make the medical records of a patient available for inspection and copying as provided in NRS 629.061.
5. Failure to comply with the requirements of NRS 630.3068.
6. Failure to report any person the licensee knows, or has reason to know, is in violation of the provisions of this chapter or the regulations of the Board within 30 days after the date the licensee knows or has reason to know of the violation.
(Added to NRS by 1985, 2223; A 1987, 199; 2001, 767; 2002 Special Session, 19; 2003, 3433; 2009, 2963)

NRS 630.3065 Willful disclosure of privileged communication; willful failure to comply with statute or regulation governing practice of medicine. The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure:

1. Willful disclosure of a communication privileged pursuant to a statute or court order.
2. Willful failure to comply with:
(a) A regulation, subpoena or order of the Board or a committee designated by the Board to investigate a complaint against a physician;
(b) A court order relating to this chapter; or
(c) A provision of this chapter.
3. Willful failure to perform a statutory or other legal obligation imposed upon a licensed physician, including a violation of the provisions of NRS 439B.410.
(Added to NRS by 1983, 302; A 1985, 2238; 1987, 200; 1989, 1663; 1993, 2302)

7/1/2011 - 6/30/2013 PHYSICIAN (M.D.)
APPLICATION FOR LICENSURE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

Post Office Box 7238 Reno, Nevada 89510 Phone (775) 688-2559

Date Received by Board

License No._____

File No._____

(For Board Use Only)

1. Present Legal Name _____
Last First Middle Maiden

List any other name(s) ever used _____

2. Mailing Address _____
Street City County State Zip

3. Home Address _____
Street City County State Zip

4. Telephone Numbers _(____)_____ _(____)_____ _(____)_____ _(____)_____
Office Fax Home Cellular (Optional)

Email address_____

5. Date of Birth _____Place of Birth _____Gender____F____M
(Month / Day / Year) (City, State, Country)

6. Citizenship: U.S. Citizen _____ Alien Registration # _____Employment Authorization # _____ Applying for Visa_____
Submit a certified birth certificate or original Certificate of Naturalization or current U.S. passport or copy of the front and back of your alien registration card, Employment Authorization or Visa. Please note: Copy of document authorizing a name change (marriage license, divorce decree, etc) must be included.

7. Social Security Number _____ Color of Eyes _____ Color of Hair _____ Height _____ Weight _____
NRS 630.165(3) An application submitted pursuant to subsection 1 or 2 must include the social security number of the applicant;
NRS 630.165(5) The applicant bears the burden of proving and documenting his qualifications for licensure.
NRS 630.173(2) The Board has the right to consider information for any malpractice history or derogatory hospital privilege history that is more than 10 years old.

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 LICENSURE* FORM.

8. 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

9. 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? _____Yes _____No _____N/A

10. 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

11. 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

12. Have you EVER 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

12a. Have you EVER 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

13. Have you EVER 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

14. Have you previously applied for medical licensure in Nevada (including in a Residency program)? _____Yes _____No

15. List names and addresses of all medical schools attended. **HAVE EACH MEDICAL SCHOOL SUBMIT AN OFFICIAL TRANSCRIPT DIRECTLY TO THE BOARD.**

Medical School Name	City/State/Country	Place Where Instruction Received	Dates of Attendance From (Mo./Yr.) To (Mo./Yr.)

(All information must begin on the application. If more space is needed, please attach separate sheet.)

16. Doctor of Medicine Degree granted by:

Medical School Name	City/State/Country	Exact Date of Issuance (Month/Day/Year)

17. List all ACGME* approved postgraduate medical education you have received as an Intern, Resident or Fellowship in the United States or Canada.
*Accreditation Council for Graduate Medical Education

Postgraduate Year (e.g. PGY1, PGY2, etc.)	Hospital/ Institution	City/State	Specify (I =Internship or R = Residency) (F = Fellowship)	Type of Specialty	Dates of Attendance From (Mo./Yr.) To (Mo./Yr.)

(All information must begin on the application. If more space is needed, please attach separate sheet.)

18. List non-ACGME Fellowship training or non-ACGME combined postgraduate medical education attended in the United States or Canada.

If combined program list Postgraduate Year (e.g. PGY1, PGY2, etc.)	Hospital/ Institution	City/State	Specify (I =Internship or R = Residency) (F = Fellowship)	Type of Specialty	Dates of Attendance From (Mo./Yr.) To (Mo./Yr.)

(All information must begin on the application. If more space is needed, please attach separate sheet.)

19. Have you EVER been the subject of an investigation (including matters that resulted in no adverse action or outcome to you), have you resigned, been dismissed, or have any actions, form of remediation(s), restrictions, limitations, probations, terminations or any other disciplinary actions ever been imposed on you while participating in any type of training program? (If "Yes," attach explanation on separate sheet.) _____Yes _____No

20. If you graduated from a medical school located outside the United States of America or Canada, list your ECFMG#:_____

21. For each of the following licensing examinations, list the location, parts and dates taken, and scores obtained. (Also include failed examinations.) FOR EACH EXAM TAKEN, HAVE CERTIFICATE OF SCORES SUBMITTED FROM THE TESTING ENTITY DIRECTLY TO THE BOARD OFFICE.

21a. State Written Examination:

Location	Date (Mo/Yr)	Results (Scores)

21b. NATIONAL BOARD (not ABMS Board certification): (ALSO INCLUDE ALL INFORMATION PERTAINING TO ANY AND ALL FAILED EXAMS)

Location	Part Taken	Date (Mo/Yr)	Results (Two Digit Scores)

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

21c. FLEX (Federation Licensing Examination): (ALSO INCLUDE ALL INFORMATION PERTAINING TO ANY AND ALL FAILED EXAMS)

Location	Date (Mo/Yr)	Results (FLEX weighted average)

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

21d. USMLE (United States Medical Licensing Examination): (ALSO INCLUDE ALL INFORMATION PERTAINING TO ANY AND ALL FAILED EXAMS)

Location	Step Taken	Date (Mo/Yr)	Results (Two Digit Scores)

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

21e. LMCC (Licentiate of the Medical Counsel of Canada): (ALSO INCLUDE ALL INFORMATION PERTAINING TO ANY AND ALL FAILED EXAMS)

Location	Part Taken	Date (Mo/Yr)	Results (Scores)

21f. SPEX (Special Purpose Examination):

Location	Date (Mo/Yr)	Results (Scores)

22. State your scope of practice/specialty (ies): _____

23. List any and all certifications and re-certifications by a board or sub-board recognized by the **AMERICAN BOARD OF MEDICAL SPECIALTIES.**

Specialty Board	Certification #	Dates of Certification and/or Recertification (Mo/Yr)

24. Account for, **in chronological order**, all activities since graduation from medical school. **ALL PERIODS OF TIME MUST BE ACCOUNTED FOR. (Curriculum Vitae cannot be submitted in lieu of your answer to this question.)**

Activities	Location (City/State/Country)	From (Mo./Yr.)	To (Mo./Yr.)

(All information must begin on the application. If more space is needed, please attach separate sheet.)

25. List below the requested information for all hospitals or surgery centers in which you **ARE, OR HAVE EVER BEEN** a staff member at any level during the last ten years. If none, please indicate. Do not list internship, residency or fellowship affiliation.

Hospital	Complete Mailing Address	Dates of Appointment From (Mo./Yr.)	To (Mo./Yr.)

(All information must begin on the application, if more space is needed, please attach separate sheet.)

26. List any and all licenses (including training licenses and permits) **YOU HOLD OR HAVE HELD** to practice medicine in any state, territory or country.

State/Territory Country	License #	Date of Issuance (Mo./Yr.)	Status

(All information must begin on the application, if more space is needed, please attach separate sheet.)

27. Have you EVER 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? (If "Yes," attach explanation on separate sheet.) _____Yes _____No

28. Have you EVER 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? (If "Yes," attach explanation on separate sheet.) _____Yes _____No

29. Have you EVER voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory? (If "Yes," attach explanation on separate sheet.) _____Yes _____No

30. Have you EVER been denied membership, asked to resign, or expelled from a medical society or other professional medical organization? (If "Yes," attach explanation on separate sheet.) _____Yes _____No

31. Have you EVER 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? (If "Yes," attach explanation on separate sheet.) _____Yes _____No

32. Have you EVER surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? _____Yes _____No
(If "Yes," attach explanation on separate sheet.)

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

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

(All information must begin on the application, if more space is needed, please attach separate sheet.)

CHILD SUPPORT STATEMENT

The law of the state of Nevada requires that all applicants for issuance of a license be required to provide the following information concerning the support of a child. You are advised that this questions is part of your application, your response is given under oath, and any response hereto which is false, fraudulent, misleading, inaccurate or incomplete, may result in your application being denied. You must mark one of the following responses, and failure to mark one of the responses may result in denial of your application.

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.

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.

http://www.cdc.gov/hicpac/2007IP/2007isolationPrecautions.html
– or –
http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf

Applicant: _____ Date: _____

I, _____

(Print your full name)

being duly sworn, depose and say: That the answers to the foregoing questions and statements made in the above application as well as any and all further explanations contained on any separate attached pages are true and correct, that I am the person named in the credentials to be submitted, and that the same were procured in the regular course of instruction and examination without fraud or misrepresentation. I understand that if any of my responses on this application are false, fraudulent, misleading, inaccurate, or incomplete, my application for licensure will be denied.

I am responsible to keep the Board informed of any circumstance or event that would require a change to my initial responses provided to the Board in my application for licensure, and which occur prior to my being granted licensure to practice medicine in the state of Nevada.

_____ _____

Signature of applicant **Date**

(NOTARY SEAL)

State of _____ County of _____

Subscribed and sworn to before me this _____ day of

_____, 2 _____.

Notary Public for the State of _____

My Commission Expires: _____

Residing at: _____

City State

_____

Signature of Notary

****

APPLICANT PHOTOGRAPH:

ATTACH A FINISHED PHOTOGRAPH OF PASSPORT QUALITY OF YOUR HEAD AND SHOULDERS ONLY.

PHOTOGRAPH MUST HAVE BEEN TAKEN WITHIN THE LAST SIX MONTHS AND BE AT LEAST 2" x 2" IN SIZE.

SIGN THE PHOTOGRAPH IN INK ACROSS THE LOWER PORTION OF ITS FRONT SIDE.

CENTER AND ATTACH PHOTOGRAPH HERE.

I hereby certify that the attached photograph is a true likeness of me taken within the last six months.

_____ _____

Signature of applicant **Date**

FORM A

RELEASE

I hereby authorize all hospitals, medical institutions or organizations, my references, personal physicians, employers (past and present) business and professional associates (past and present) and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Nevada State Board of Medical Examiners any information, files or records required by the Nevada State Board of Medical Examiners for its evaluation of my professional, ethical, physical, and mental qualifications for licensure in the state of Nevada.

DATED this _____ day of _____, 2_____.

Signature: _____

Typed or Printed Name: _____

(NOTARY SEAL)

State of _____ County of _____

Subscribed and sworn to before me this _____ day of

_____, 2_____.

Notary Public for the State of _____

My Commission Expires: _____

Residing at: _____

City State

_____

Signature of Notary

A photocopy of this form will serve as an original.

Please return completed form to:

Nevada State Board of Medical Examiners
P.O. Box 7238
Reno, NV 89510
or
1105 Terminal Way #301
Reno, NV 89502

FORM B

LIST OF MALPRACTICE INSURANCE CARRIERS

If you answered affirmatively to questions #12 and/or #12a on the Application for Licensure, list all malpractice carriers since completion of your postgraduate training.

Name of Insured: _____

Insurance Company: _____
Address: _____

Phone Number: _____
Fax Number: _____
Policy Number: _____
Dates: _____

Insurance Company: _____
Address: _____

Fax Number: _____
Policy Number: _____
Dates: _____

Insurance Company: _____
Address: _____

Fax Number: _____
Policy Number: _____
Dates: _____

Insurance Company: _____
Address: _____

Fax Number: _____
Policy Number: _____
Dates: _____

Insurance Company: _____
Address: _____

Fax Number: _____
Policy Number: _____
Dates: _____

(If more space is needed, please copy this page or attach a separate sheet.)

FORM C

REQUEST FOR LICENSURE BY ENDORSEMENT

(ENDORSEMENT IS NOT THE SAME AS RECIPROCITY)

State your Name, and fill in the State, territory, or District of Columbia in which licensed:

I, _____, being first duly sworn, do hereby swear or affirm under the penalties of perjury that the statements contained herein are true and correct to the best of my knowledge.

That I am now, and have been continuously licensed to practice medicine by the licensing agency of

_____, since _____.
(state, territory, or District of Columbia) (month / day / year)

That I have never had a license to practice any type of medicine in any jurisdiction, country, state, territory, or District of Columbia, revoked for gross medical negligence.

That I am the person named in the license to practice medicine in _____,
(state, territory, or District of Columbia)
and that said license to practice medicine was obtained by me without fraud or misrepresentation or any mistake of which I am aware, and that all information contained in this application for licensure by Endorsement, and any accompanying materials are complete and correct.

DATED this _____ day of _____, 2_____.

Signature: _____

Typed or Printed Name: _____

State of _____ County of _____

Subscribed and sworn to before me this _____ day of

_____, 2_____.

(NOTARY SEAL)

Notary Public for the State of _____

My Commission Expires: _____

Residing at: _____
City State

_____
Signature of Notary

Please return completed form to:

Nevada State Board of Medical Examiners
P.O. Box 7238
Reno, NV 89510
or
1105 Terminal Way #301
Reno, NV 89502

FORM D

REQUEST FOR LICENSURE BY A RESIDENT

(You must be currently enrolled in an approved postgraduate training program)

ONLY complete this form if you are currently enrolled in a postgraduate training program, have completed at least 24 months of progressive postgraduate training and meet all requirements for an unlimited license in the state of Nevada including having passed all 3 steps of USMLE within the time period allowed by NAC 630.080.

Acknowledgement of statutory requirements NRS 630.160

I _____ am a Resident who is enrolled in a progressive postgraduate
(print your name)
training program in the United States or Canada approved by the Board, the Accreditation Council for Graduate Medical Education or the Coordinating Council of Medical Education of the Canadian Medical Association, and have completed at least 24 months of the program, and now commit in writing to the Nevada State Board of Medical Examiners (Board) that I will complete the program; and I hereby acknowledge that I will provide or cause to be provided to the Board proof of satisfactory completion of the program within sixty (60) days after the scheduled completion of the program.

If after issuing a license to practice medicine to me, the Board obtains information from a primary or other source of information, and that information differs from the information provided by me (the applicant) or otherwise received by the Board, or if I fail to provide or cause to be provided to the Board proof of satisfactory completion of the program within sixty (60) days after the scheduled completion of the program, the Board may take action pursuant to sections 4 and 5 of NRS 630.160, as well as any other disciplinary action deemed appropriate.

_____ Applicant Signature

_____ Date

(NOTARY SEAL)

State of _____ County of _____

Subscribed and sworn to before me this _____ day of

_____, 2_____.

Notary Public for the State of _____

My Commission Expires: _____

Residing at: _____
City State

_____
Signature of Notary

Applicant: Each medical school where instruction was received must complete this form. If more than one medical school was attended, photocopies of this blank form may be made and used.

FORM 1

NEVADA STATE BOARD OF MEDICAL EXAMINERS
VERIFICATION OF MEDICAL EDUCATION

This certifies that _____
(name of applicant)

was enrolled in _____
(name of Medical School) (Location – City / State / Country)

The following information to be completed by program only.

The undersigned further certifies that the records of this institution show that the applicant attended this institution

from _____ to _____
(month / year) (month / year)

Please check one:

☐ The applicant was granted a medical degree by

☐ The applicant withdrew from

the above named Medical School on _____
(month / day / year)

ADVANCED (TRANSFER) CREDITS – Credits Granted Upon Admission from another Medical Institution

_____ _____ _____
(name of Medical or Professional School) (total credits) (dates attended - month/ year to month/ year)

Signed and the institutional seal affixed this

_____ day of _____ , 2 _____

By: _____
(typed name and title of President, Registrar or Dean)

Title: _____

Signature: _____
(signature of President, Registrar or Dean) **

Telephone: _____
Fax: _____
Email: _____

Affix Seal Here

** Signatures by personnel other than the President, Registrar or Dean must attach documentation granting authorization to sign in lieu of the President, Registrar or Dean.

Completed form is to be returned by the verifying institution directly to:

Nevada State Board of Medical Examiners

PO Box 7238
Reno, NV 89510

OR

(775) 688-2559

1105 Terminal Way, Ste 301
Reno, NV 89502

Applicant: Each institution where Internship, Residency and/or Fellowship training was received must complete this form. If more than one institution was attended, photocopies of this blank form may be made and used.

FORM 2

NEVADA STATE BOARD OF MEDICAL EXAMINERS
VERIFICATION OF POSTGRADUATE TRAINING

Institution: _____ Affiliated University: _____

Address: _____

Name of Physician: _____

DOB: _____ SS#: _____ Medical School: _____

The following information is to be completed by program only.

IMPORTANT – Program Participation:

- Report incomplete postgraduate years (PGY) separately from those that were successfully completed.
- If the postgraduate year is currently "In Progress", report the expected completion in the "To" field.
- Report Internships, Residencies and Fellowships separately.

PG/Year: _____ **DEPARTMENT / SPECIALTY:** _____
(e.g., 1, 2, 3, etc.)

☐ **Internship** **From:** ___/___/___ **To:** ___/___/___
☐ **Residency**
☐ **Fellowship** **Successfully Completed?** ☐ **Yes** ☐ **No** ☐ **In Progress**
☐ **Research**

PG/Year: _____ **DEPARTMENT / SPECIALTY:** _____
(e.g., 1, 2, 3, etc.)

☐ **Internship** **From:** ___/___/___ **To:** ___/___/___
☐ **Residency**
☐ **Fellowship** **Successfully Completed?** ☐ **Yes** ☐ **No** ☐ **In Progress**
☐ **Research**

PG/Year: _____ **DEPARTMENT / SPECIALTY:** _____
(e.g., 1, 2, 3, etc.)

☐ **Internship** From: ___/___/___ To: ___/___/___
☐ **Residency**
☐ **Fellowship** **Successfully Completed?** ☐ **Yes** ☐ **No** ☐ **In Progress**
☐ **Research**

Unusual Circumstances: Indicate the correct response to the questions below. "Yes" responses require written explanation.

1. Is this training approved by the Accreditation Council for Graduate Medical Education (ACGME) or Coordinating Council of Medical Education (CCME) of the Canadian Medical Association? ☐ **Yes** ☐ **No**
2. Did this individual ever take a leave of absence or break from their training? If yes, please explain. ☐ **Yes** ☐ **No**
3. Was this individual disciplined and/or placed under investigation or on probation? ☐ **Yes** ☐ **No**

Please explain below any "Yes" response(s) to the above two questions. If necessary, you may continue your explanation on a separate sheet of paper.

_____

_____

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct.

This section MUST be signed by the Program Director (M.D. or D.O. only)**
**Signature by personnel other than an M.D. or D.O. must attach an authorization letter.

Name: _____ ☐ **M.D.** ☐ **D.O.** Title: _____

Signature: _____ Date of Signature: _____

Telephone: _____ Fax: _____ E-mail: _____

Completed form is to be returned by the verifying institution directly to:
Nevada State Board of Medical Examiners

PO Box 7238
Reno, NV 89510

OR

(775) 688-2559

1105 Terminal Way, Ste 301
Reno, NV 89502

Applicant: ***Each state where licensure is or was held excluding training licenses and permits must be verified. If licensed in more than one state, photocopies of this blank form may be made and used. 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 direct source verification of your license does not have to be completed on this form. It is a courtesy form which provides the Board's address.***

FORM 3

NEVADA STATE BOARD OF MEDICAL EXAMINERS
VERIFICATION OF STATE LICENSURE

PART 1 – TO BE COMPLETED BY APPLICANT

Printed Name of Applicant: ______________________________

Address: ______________________________
(street) (apt. or suite #) (city) (state) (zip)

Date of Birth: ______________________________
(month) (day) (year)

I am in the process of applying for medical licensure in the state of Nevada. I hereby authorize release of the following information directly to the Nevada State Board of Medical Examiners at the address below.

____
(signature of applicant)

- -

PART 2 – TO BE COMPLETED BY LICENSING AGENCY

I certify that ______________________________ who
(name of applicant)

graduated from ______________________________
(name and location of Medical School)

on ______________ was granted license number ______________ by the state of ______________
(date of graduation)

on ______________ on the basis of ______________________________.
(date of issuance) (examination: NB / FLEX / 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)

I certify that the records in this office indicate that there are not now nor have there ever been any charges filed against the holder of this license.

NOTE: If any portion of this form is deleted or modified, please attach an explanation.

____
(signature of certifying individual)

____
(title of certifying individual)

____
(licensing agency name)

____
(date of signature)

Completed form is to be returned by the verifying institution directly to:

Nevada State Board of Medical Examiners

PO Box 7238 **OR** **1105 Terminal Way, Ste 301**
Reno, NV 89510 **Reno, NV 89502**

(775) 688-2559

Applicant: ***This form to be completed ONLY if applying via state written examination with current ABMS certification. This form is to be completed by the state-licensing agency where examination was taken.***

FORM 4

NEVADA STATE BOARD OF MEDICAL EXAMINERS
VERIFICATION OF STATE LICENSING EXAMINATION

I certify that _____, who
(name of applicant)

graduated from _____
(name and location of Medical School)

on _____, was granted license number _____ on _____
(date of graduation) (date of issuance)

on the basis of the licensing agency regular written examination of the state of _____.

I further certify that this physician passed the regular written examination given by this licensing agency on _____
(date)

and obtained a general average of _____ percent in the following subjects. A score of _____ is

considered a passing score.

Subjects of Examination	Percent	Subjects of Examination	Percent

I certify that this license is valid, current, has never been suspended or revoked, and will expire on _____;
(date)

OR this license was valid, was never suspended or revoked, and expired on _____.
(date)

NOTE: If any portion of the above certification is deleted or modified, please attach an explanation.

_____ _____
(type or print name and title of agency official) (name of state licensing agency)

_____ _____
(signature of agency official) (address)

_____ _____
(date) (phone number)

(affix licensing agency seal)

Completed form is to be returned by the verifying institution directly to:

Nevada State Board of Medical Examiners
P.O. Box 7238
Reno, NV 89510
(775) 688–2559

If you answered affirmatively to questions #31 and/or #33 on the Application for Licensure, submit this form to all hospitals where you have had privileges within the past 10 years. If more than one hospital or surgery center, photocopies of the blank form may be made and used.

FORM 5

NEVADA STATE BOARD OF MEDICAL EXAMINERS
VERIFICATION OF HOSPITAL OR SURGERY CENTER PRIVILEGES

Hospital: _____
Attn: Medical Staff Office
Address: _____
_____

Name: _____
DOB: _____
Specialty: _____
Affiliation dates: _____

The above named physician submitted an application to obtain a medical license in Nevada. The applicant has indicated that he/she holds or has held staff privileges at your hospital. In order that the processing of the application may be completed, we ask that you provide us with the information requested below.

1. What privileges are/were extended to the applicant? _____
_____

2. Dates of hospital privileges: From_____ To_____
   month / year month / year

3. Have staff privileges ever been limited, restricted, suspended or revoked? No_____ Yes__
   If Yes, please explain: _____
_____

4. Is there any derogatory information on file? No _____ Yes_____ If Yes, please explain:
_____
_____

5. Do your records indicate applicant having privileges at any other hospitals in your area?
   No_____ Yes_____ If Yes, please attach list.

_____
Signature:
Hospital Chief-of-Staff or Administrator

_____
Typed Name, Title and Date

Phone #_____
Fax #_____
Email_____

RELEASE

I hereby authorize the above named institution to release any information, files, or records required by the Nevada State Board of Medical Examiners for licensure in the state of Nevada.

_____
Medical Doctor (applicant) signature and date

State of _____ County of _____
Subscribed and sworn to before me this _____ day of
_____, 2_____.
Notary Public for the State of _____
My Commission Expires: _____
Residing at: _____
City State

_____
Signature of Notary

Please return completed form to:

Nevada State Board of Medical Examiners
P.O. Box 7238, Reno, NV 89510 (Mailing Address)
1105 Terminal Way, Suite 301
Reno, NV 89502 (Physical Address)
Phone: (775) 688-2559

If you answered affirmatively to questions #12 and/or #12a on the Application for Licensure, submit this form to all malpractice carriers verifying all coverage within the past 10 years. If more than one malpractice carrier, photocopies of the blank form may be made and used.

FORM 6

MALPRACTICE INSURANCE CARRIER VERIFICATION

Insurance Carrier Information:

Name of Insured Physician: _____

Name of Insurance Company: _____

Address: _____

_____

_____

Phone: _____ Fax: _____

(To be completed by verifying agency only)

Policy Number: _____

Policy Period From: _____ To: _____

****Please provide a loss history report with this verification.**

Claims Experience:

Has this Physician had a settlement paid on his/her behalf? _____No _____Yes

If "yes", please provide the following information:

Occurrence Date	*Status*	*Date Closed*	*Indemnity Amount*

Description of Claim: _____

_____

Occurrence Date	*Status*	*Date Closed*	*Indemnity Amount*

Description of Claim: _____

_____

Insurance Carrier Agent:

_____
Print Name and Title

_____
Telephone

_____
Signature of Agent

Please return completed form to:

Nevada State Board of Medical Examiners
P.O. Box 7238, Reno, NV 89510 (Mailing Address)
1105 Terminal Way #301
Reno, NV 89502 (Physical Address)
Phone: (775) 688-2559

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Subscribed and sworn to before me this _____ day of

_____, 2_____.

Notary Public for the State of _____

My Commission Expires: _____

Residing at: _____
City State

_____
Signature of Notary

PERMISSION TO SEEK CRIMINAL BACKGROUND INVESTIGATION REPORT AND TO OBTAIN AND USE A SET OF MY FINGERPRINTS IN THIS REGARD

I understand that all applicants applying for licensure with the Nevada State Board of Medical Examiners, pursuant to the Nevada Revised Statutes, Chapter 630, must submit a full set of his/her fingerprints, along with an authorization for the Nevada State Board of Medical Examiners to forward his/her fingerprints to the Department of Public Safety Records and Technology Division and to the Federal Bureau of Investigation for a state and federal criminal background investigation and report.

I herewith and hereby grant permission and fully authorize the Nevada State Board of Medical Examiners to submit a complete set of my fingerprints to the Department of Public Safety Records and Technology Division for submission to the Federal Bureau of Investigation for their reports.

I UNDERSTAND THAT THE COSTS OF FINGERPRINTING, THE BACKGROUND CHECK AND THE REPORT SHALL BE AT MY OWN EXPENSE.

Dated this _____ day of _____, 2_____

_____

Signature of Applicant

_____

Print Name

By signing my signature on the line below, I do hereby understand that I must timely submit my fingerprints to the Nevada State Board of Medical Examiners in order for the Board to submit a complete set of my fingerprints to the Department of Public Safety Records and Technology Division for submission to the Federal Bureau of Investigation for their reports. Failure to do so could result in disciplinary action up to and including immediate summary suspension of my license. NRS 630.167.

_____

Signature of Applicant **Date**

Return this form to:

Nevada State Board of Medical Examiners
1105 Terminal Way, Ste. 301, Reno, NV 89502
or
P.O. Box 7238
Reno, NV 89510

CREDIT CARD AUTHORIZATION FORM

If you are using your credit card for payment of application fees, this authorization form must be submitted with the application.

Please type or print legibly.

Method of Payment: ☐ MasterCard ☐ Visa ☐ American Express ☐ Discover

Name on Credit Card: _____

Business Name (if applicable): _____

Credit Card Billing Address:

_____

_____

_____

Credit Card Number: _____

Expiration Date: _____ / _____
(MM) (YYYY)

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: _____

Signature: _____ Date: _____