AGENDA ITEM 24(c)

Uniforr Application for Lice sure

Application ID:		License Requested:	MD
FID:		License Type:	Permanent Medical License
		Submitted to:	Nevada State Board of Medical Examiners
		Submission Date:	11/30/2020 8:28 AM

Practitioner Name

Bauer, John Raymond

Contact Information

Address

Public Access	Board Contact	Type	Address
Yes	No	Business	2100 Powell Street, Suite 400 Emeryville, CA 94608 UNITED STATES

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Phone

Public Access	Board Contact	Type	Phone Number	Phone Extension
Yes	Yes	Mobile		

Email

Public Access	Board Contact	Email
No	No	
No	No	
Yes	Yes	

Identification

USMLE Number	SSN	Birth Date	Birth Place	Gender	NPI	Practitioner Type	US Citizen
		/1952	MOROCCO	M		MD	Yes

Medical School

Medical School Name	Address	Start Date	End Date	Graduation Date	Degree Code
Baylor College of Medicine	One Baylor Plaza Houston, TX 77030 UNITED STATES	06/23/1977	11/14/1980	11/14/1980	MD

Fifth Pathway

None Reported

ECFMG

Certificate Number	Issue Date
None Reported	

Postgraduate Training

Hospital Name:	Baylor Collé ,f Medicine Program Houston, TX UNITED STATES	Program Code:	ACGME 14 :1422
		Attendance Dates:	
Institution:	Baylor College of Medicine	Start Date:	06/24/1981
Training Specialty:	Internal Medicine	End Date:	06/23/1982
		Program Type:	Internship
Training Status:	Completed		
Clinical %:	90	Administrative %:	10

Hospital Name:	Baylor College of Medicine Program Houston, TX UNITED STATES	Program Code:	ACGME 1404821422
		Attendance Dates:	
Institution:	Baylor College of Medicine	Start Date:	01/03/1983
Training Specialty:	Internal Medicine	End Date:	12/31/1984
		Program Type:	Residency
Training Status:	Completed		
Clinical %:	90	Administrative %:	10

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Examination History

Exam	State	Last Attempt	Pass/Fail	Number Of Attempts
NBME Part I		09/06/1978	Pass	1
FLEX, Pre-1985	TX	12/09/1980		1

State Licensure History

MD, DO, PA License History

License Entity	Licensing State	License Number	Issue Date	Expiration Date	License Type	License Status
Medical Board of California	CA	C-42901	08/06/1991	07/31/2021	Full	Active
Texas Medical Board	TX	F8008	02/21/1981	02/28/1995	Full	Canceled

Physician Reported License History

Practitioner License Type	Licensing State	License Number	Issue Date	Expiration Date	Type	License Status

None Reported

Chronology of Activity Type

Practice/Emp/ Desc:	Baylor College of Medicine	Chronology Type:	Medical Education
	Address: Houston, TX US	Attendance Dates:	
	Position/Dept:	From:	06/23/1977 to 11/14/1980
	Clinical %:		
	Admin %:		

Employment: Staff Privileges: Affiliation:

Practice/Emp/ Desc:	N/A	Chronology Type:	Vacation

	Address:		Attendance Dates:	
	Position/Dept:		From:	11/15/1980 to 06/23/1981
	Clinical %:	0		
	Admin %:	0		

Employment: Staff Privileges: Affiliation:

Practice/Emp/ Desc:	Baylor College of Medicine Program		Chronology Type:	Accredited Training
	Address:	Houston, TX US	Attendance Dates:	
	Position/Dept:		From:	06/24/1981 to 06/23/1982
	Clinical %:	90		
	Admin %:	10		

Employment: Staff Privileges: Affiliation:

Practice/Emp/ Desc:	Took 6 months off after internship to travel to Alaska		Chronology Type:	Vacation
	Address:		Attendance Dates:	
	Position/Dept:		From:	06/24/1982 to 01/01/1983
	Clinical %:	0		
	Admin %:	0		

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Employment: Staff Privileges: Affiliation:

Practice/Emp/ Desc:	Baylor College of Medicine Program		Chronology Type:	Accredited Training
	Address:	Houston, TX US	Attendance Dates:	
	Position/Dept:		From:	01/03/1983 to 12/31/1984
	Clinical %:	90		
	Admin %:	10		

Employment: Staff Privileges: Affiliation:

Practice/Emp/ Desc:	Twelve Oaks Hospital		Chronology Type:	Work
	Address:	4200 Portsmouth St Houston, TX 77027 US	Attendance Dates:	
	Position/Dept:	Physician - Emergency Medicine	From:	01/01/1985 to 06/01/1985
	Clinical %:	90		
	Admin %:	10		

Employment: Staff Privileges: Affiliation:

Practice/Emp/ Desc:	Montgomery County Hospital District		Chronology Type:	Work
	Address:	1400 South Loop 336 West Conroe, TX 77304 US	Attendance Dates:	

	Position/Dept:	Physician - Emergency Medicine	From:	07/01/1985 to 08/30/1991
	Clinical %:	90		
	Admin %:	10		
	Employment:	Staff Privileges:	Affiliation:	

Practice/Emp/ Desc:	Vituity		Chronology Type:	Work
	Address:	2100 Powell St Suite 400 Emeryville, CA 94608 US	Attendance Dates:	
	Position/Dept:	Physician - Emergency Medicine	From:	09/01/1991 to In Progress
	Clinical %:	90		
	Admin %:	10		
	Employment:	Staff Privileges:	Affiliation:	

Practice/Emp/ Desc:	Sutter Auburn Faith Hospital		Chronology Type:	Work
	Address:	11815 Education Street Auburn, CA 95602 US	Attendance Dates:	
	Position/Dept:	Physician - Emergency Medicine	From:	03/26/1992 to In Progress
	Clinical %:	90		
	Admin %:	10		
	Employment:	Staff Privileges:	Affiliation:	

Malpractice

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ADDENDUM 3 – ADDITIONAL PHYSICIAN INFORMATION

CITIZENSHIP AND IDENTIFICATION

U.S. Citizen: Yes ☑ No ☐ Social Security Number: ____________

Non U.S. Citizen: Yes ☐ No ☐ Social Security Number: ____________ or

Individual Taxpayer Identification Number (ITIN): ____________

Visa ☐ Indicate Visa Type: ____________ Applying for Visa: Yes ☐ No ☐

For the items below, please provide your USCIS number.

Conditional Resident ☐ ____________ Permanent Resident ☐ ____________

Employment Authorization ☐ ____________ Asylee ☐ ____________

Color of Eyes: ________ Color of Hair: ________ Height: ______ ..eight: ________

EXAMINATION SCORES

List all licensure examinations you have taken, whether U.S. or International, on the Examination History tab of the online Uniform Application. Also list below the score you received on each exam taken. INCLUDE ALL INFORMATION PERTAINING TO ANY AND ALL FAILED ATTEMPTS.

Examination Name	Date Taken	Score Received	Examination Name	Date Taken	Score Received
NBME- part I	09/06/1978				
Old FLEX	12/09/1980	84.00			

SPECIALTY CERTIFICATION

Scope of Practice/Specialty(ies): Internal Medicine

List any and all certifications and re-certifications by a Board or Sub-Board recognized by the **American Board of Medical Specialties.** INCLUDE ALL INFORMATION PERTAINING TO ANY AND ALL FAILED ATTEMPTS.

Board / Specialty Board	If you are Lifetime Board Certified, indicate "Lifetime"	Certification #	Dates of Certification/ Recertification (MM/YY)
ABIM	Lifetime		09/1985

If you hold "lifetime or historical" ABMS Board Certification, please provide a notarized statement agreeing to maintain Board Certification for the duration of your licensure in the state of Nevada.

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ADDENDUM 4 – ATTESTATION 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.

FOR ALL "YES" RESPONSES TO THE FOLLOWING QUESTIONS, YOU MUST SUBMIT YOUR WRITTEN EXPLANATION(S) ON A SEPARATE SHEET ATTACHED TO THIS ADDENDUM.

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? If "Yes," attach an explanation on a separate sheet. — Yes ☐ No ☒ N/A ☐

2. If you currently have a medical condition which in any way impairs or limits your ability to practice medicine, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, the manner in which you have chosen to practice, or by any other reasonable accommodation? If "Yes," attach an explanation on a separate sheet. — 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? If "Yes," attach an explanation on a separate sheet. — Yes ☐ No ☒

4. 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? If "Yes," attach an explanation on a separate sheet. — Yes ☐ No ☒

5a. 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? If "Yes," please describe in the space provided on the Malpractice Liability Claims Information page within the online Uniform Application. Also complete addendum 5. — Yes ☒ No ☐

5b. 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? If "Yes," please describe in the space provided on the Malpractice Liability Claims Information page within the online Uniform Application. Also complete addenda 5 and 6. — Yes ☒ No ☐

6. 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 an explanation on a separate sheet. — Yes ☐ No ☒

7. Have you previously applied for medical licensure in Nevada (including in a Residency program)? If "Yes," attach an explanation on a separate sheet. — Yes ☐ No ☒

8. 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, 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 an explanation on a separate sheet. — Yes ☐ No ☒

9. 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 an explanation on a separate sheet. Yes ☐ No ☒

10. 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 an explanation on a separate sheet. Yes ☐ No ☒

11. 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 an explanation on a separate sheet. Yes ☐ No ☒

12. Have you EVER been denied membership, asked to resign, or expelled from a medical society or other professional medical organization? If "Yes," attach an explanation on a separate sheet. Yes ☐ No ☒

13. 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 an explanation on a separate sheet. Yes ☐ No ☒

14. Have you EVER surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? If "Yes," attach an explanation on a separate sheet. Yes ☐ No ☒

15. 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.

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(Please Note: Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital departmental or staff meetings, or maintain required malpractice insurance.)

Hospital	Mailing Address	Type of Action	Dates of Action

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 question 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.

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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.

ATTESTATION REGARDING THE REPORTING OF THE ABUSE OR NEGLECT OF A CHILD

Yes ☒ No ☐ I attest and affirm that I am aware and understand the reporting requirements found in Nevada Revised Statute 432B.220 regarding the abuse or neglect of a child.
http://www.leg.state.nv.us/NRS/NRS-432B.html#NRS432BSec220

SAFE INJECTION PRACTICE ATTESTATION

ATTESTATION TO KNOWLEDGE OF AND COMPLIANCE WITH THE GUIDELINES OF THE CENTERS FOR DISEASE CONTROL AND PREVENTION FOR APPLICANT PHYSICIANS

Yes ☒ No ☐ 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/injectionsafety/IP07_standardPrecaution.html

COMMUNICATIONS AFFIRMATION

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

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

Printed Name of Applicant/Licensee: John Raymond Bauer

Signature of Applicant/Licensee: ______ E-mail Address: ______

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 for the Military Service Attestation.

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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:** ____/ ____/ ______ (DD MM YYYY) **5-To:** ____/ ____/ ______ (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 the answer to question(s) 7, 8 and/or 9 is "yes," did you separate from such service under conditions other than dishonorable? _______Yes _______No _______ N/A
(Unless you were dishonorably discharged, your answer should be "Yes.")

APPLICATION AFFIRMATION

I, John Raymond Bauer,
(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 occurs prior to my being granted licensure to practice medicine in the state of Nevada.

______________________ Signature of applicant

10/22/20
Date

State of Nevada County of Washoe

Subscribed and sworn to before me this 22 day of October, 2020.

(NOTARY SEAL)

Notary Public for the State of Nevada

My Commission Expires: 10/9/2022

Residing at: Reno NV
City State

______________________ Signature of Notary

ADDENDUM 5 – LIST OF MALPRACTICE INSURANCE CARRIERS

If you have answered in the affirmative ("Yes") to questions 5a and/or 5b of Addendum 4 of the UA, list all malpractice carriers.

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Name of Insured: John Raymond Bauer

Insurance Company: The Mutual Risk Retention Group Inc.
Address: 3000 Oak Road, Suite 600, Walnut Creek, CA, 94597

Phone Number: (925) 949-0100
Fax Number:
Policy Number:
Dates: 01/01/2020 to 01/01/2021

Insurance Company: James & Gable
Address: 1660 Olympic Blvd, Suite 325, Walnut Creek, CA, 94596

Phone Number: (925) 943-3264
Fax Number:
Policy Number:
Dates: 07/01/2008 to 07/01/2009, 07/01/2009 to 07/01/2010, 07/01/2010 to 04/01/2011

Insurance Company: James & Gable
Address: 1660 Olympic Blvd, Suite 325, Walnut Creek, CA, 94596

Phone Number: (925) 943-3264
Fax Number:
Policy Number:
Dates: 07/01/2007 to 07/01/2008

Insurance Company: James & Gable
Address: 1660 Olympic Blvd, Suite 325, Walnut Creek, CA, 94596

Phone Number: (925) 943-3264
Fax Number:
Policy Number:
Dates: 07/01/2006 to 07/01/2007

Insurance Company: James & Gable
Address: 1660 Olympic Blvd, Suite 325, Walnut Creek, CA, 94596

Phone Number: (925) 943-3264
Fax Number:
Policy Number:
Dates: 07/01/2005 to 07/01/2006

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

ADDENDUM 5 – LIST OF MALPRACTICE INSURANCE CARRIERS

If you have answered in the affirmative ("Yes") to questions 5a and/or 5b of Addendum 4 of the UA, list all malpractice carriers.

Name of Insured: John Raymond Bauer

Insurance Company: James & Gable
Address: 1660 Olympic Blvd, Suite 325, Walnut Creek, CA, 94596

Phone Number: (925) 943-3264
Fax Number:
Policy Number:
Dates: 12/01/1998 to 07/01/2005

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Insurance Company: Medical Protective Company
Address: 5814 Reed Road, Fort Wayne, IN 46885

Phone Number: (219) 485-9622
Fax Number:
Policy Number:
Dates: 05/01/1987 to 08/31/1991

Insurance Company:
Address:

Phone Number:
Fax Number:
Policy Number:
Dates:

Insurance Company:
Address:

Phone Number:
Fax Number:
Policy Number:
Dates:

Insurance Company:
Address:

Phone Number:
Fax Number:
Policy Number:
Dates:

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

ADDENDUM 1 – RESPONSIBILITY STATEMENT

ATTENTION APPLICANT!

Please sign and return this statement with your application for licensure to:

The Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521

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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.

o o o o o

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 John Raymond Bauer

Sign your name ____________________

Date 10/27/20

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 occurs prior to you being granted licensure to practice medicine in the state of Nevada.

Appointment Recorded in Washoe County
No: 18-3608-2 - Expires October 9, 2022

Applicant's signature (must be signed in the presence ... otary)

Bauer, John, R

Applicant's printed last name, first name, middle initial, and suffix (e.g., Jr.)

10/22/20

Date of signature (must correspond to date of notarization)

NOTARY:

[Please note: The Notary Public seal should overlap the bottom of the photo to the left. Do not cover the entire face with the seal.]