

Demographic Details

First Name

Kathryn

Middle Name

Ann

Last Name *

Cox

Previous Name(s)

Schmale, Schrotenboer

Social Security Number

Tax Identification Number

Height

Hair Color

Is this person deceased?

Yes No

Date Deceased



Do you have a Nevada Business License in your individual name?

Yes No

Nevada BIN

Historical File Number

Gender

Female



Date of Birth

-1950



Name Suffix

City of Birth

Michigan

Place of Birth

Weight (in lbs)

Eye Color

Comments (non-public information)

Public Information

Military Detail

Have you ever served in the United States Military (to include National Guard or Reserves)?

Yes No

Discipline / SPL

Disciplinary Action?

Yes No

SPL?

Yes No

Date of SPL Issuance

Calendar icon

Contact Information

Primary Phone

(917) 543-4578

Primary Phone Extension

Primary E-mail Address



Cell Phone

#

Secondary Phone

#

Secondary Phone Extension

Mail should be directed to



Fax

#

Public Address

Street Address

6355 Wetzel court

Address Line 2

City

Reno

County

Washoe

ZIP / Postal Code

89511

State / Province

Nevada

Country

United States



Is your physical address different from your mailing address?

Yes No

Public Phone

(917) 543-4578

Mailing Address

Street Address

City (Mailing)

Address Line 2

State / Province (Mailing)

ZIP / Postal Code (Mailing)

County (Mailing)



County (Mailing)

Online Service

Application Status

Applicant *

Cox, Kathryn Ann



Application Number

License Issued?

Yes No

Application Status



Assigned To



Manual Paper Application?

Yes No

License Details (Pre-Approval)

License Category

Medical Doctor



Obtained By



Credentials / Degree Suffix (Enter before approval!)

M.D.

Application Details

Application Type

Medical Doctor - Active



Application Date *

Mar-17-2021



Submitted Date

Apr-12-2021



Application Step

#

Reviewed Date



Decision Date



Approved Date



Expiration Date



Have you ever served in the United States Military (to include National Guard or Reserves)?

Yes No

Invoices

Application Invoice

001960 - Paid in Full



Application Payment Date

Apr-12-2021



Licensure Invoice



Licensure Payment Date



Attestations

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

Yes No

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.

Yes No

I attest and affirm that I am aware of and understand the reporting requirements found in Nevada Revised Statute 432B.220 regarding the abuse or neglect of a child.

Yes No

I 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.

Yes No

Child Support Attestation Type

Subject to a court order and not in compliance

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

Yes No

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.

Yes No

In consideration for processing my application I, the undersigned, whose name and signature voluntarily appears below; do hereby and irrevocably agree to the Civil Applicant Waiver.

Yes No

Examination Details

Licensee / Applicant *

Cox, Kathryn Ann



Attended Date

Jun-12-1973



Number of Attempts

1

Application

Application - Cox, Kathryn Ann



Location

new york

Result

560

Examination Type

National Board of Medical Examiners (NBME)



Other Exam

Are you currently certified?

Yes No

Steps

1

Certificate Number

Exam Date



Expiration Date



Examination Details

Licensee / Applicant *

Cox, Kathryn Ann



Attended Date

Apr-09-1974



Number of Attempts

#

Application

Application

Cox, Kathryn Ann



Location

Result

555

Examination Type

National Board of Medical Examiners (NBME)



Other Exam

Are you currently certified?

Yes No

Steps

II

Certificate Number

Exam Date



Expiration Date



Examination Details

Licensee / Applicant *

Cox, Kathryn Ann



Examination Type

National Board of Medical Examiners (NBME)



Other Exam

Are you currently certified?

Yes No

Steps

III

Certificate Number

Exam Date



Expiration Date



Attended Date

Mar-10-1976



Number of Attempts

#

Application

Application

- Cox, Kathryn Ann



Location

Result

420

Board Certification Details

Licensee / Applicant

Cox, Kathryn Ann

Specialty

Obstetrics / Gynecology

Certifying Board

American Board

Other Certifying Board

Initial Certification Date

Nov-07-1981

Recertification Date

Certification Number

18403

Archive Program

Historical Specialty

Connected Record

Application

Application

Cox, Kathryn Ann

Connected Record

Connected Record

Connected Record

Education Details

Licensee/Applicant *

Cox, Kathryn Ann

Address

City

Ann Arbor

State / Province

Michigan

Zip / Postal Code

48109

Country

United States

Application

Application

Cox, Kathryn Ann

Specialty Type

Name of School

University of Michigan Medical School

Education Type

Medical School

Degree Attained

Medical Doctor Degree

Date From

Aug-30-1971

Date To

May-23-1975

Did you graduate from the program?

Yes No

Graduation Date

May-23-1975

Major Program

Postgraduate Training Details

Licensee / Applicant *

Cox, Kathryn Ann



Program Type *

Internship/Residency



Date From

Jul-01-1975



Name of School or Institution

New York Lying In Hospital/New York Hospital (currently

Specialty Type

Obstetrics / Gynecology



Other (Specialty)

Training Status *

Completed

Accreditation Type

ACGME (Accreditation Council for Graduate Medical Ed

Date To

Jun-30-1979

Application

Application - Cox, Kathryn Ann

Historical Major Program

Historical Degree Attained

Location Details

City

Street Address 1

State / Province

New York

Zip / Postal Code

County

Country

Licensee ID

Licensee ID

Licensee ID

Other License Details

Licensee/Applicant

Cox, Kathryn Ann



Licensing Board or Regulatory Authority

University of the state of New York

License Number

128919

State / Province

New York

Country

United States



Application

Application - - Cox, Kathryn Ann



License Type

License Status

active

Issue Date

Oct-08-1976



Expiration Date

Mar-31-2022



Notes

Hospital Details

Licensee / Applicant

Cox, Kathryn Ann



Application

Application - Cox, Kathryn Ann



End Date

Mar-18-2021



Name of Organization

New York Presbyterian-Weill Cornell Medical Cent

Start Date

Jul-01-1975



Address Details

Street Address Line 1

525 East 68th Street

Street Address Line 2

City

New York

State / Province

New York

ZIP / Postal Code

10065

Country

United States



Application Activity Details

Licensee / Applicant

Cox, Kathryn Ann



Start Date

Jan-01-1975



Percent Clinical *

100

Application

Application

Cox, Kathryn Ann



Name of Organization / Institution

New York Lying In Hospital/New York Hospital

End Date

Jun-30-1979



Position

Activity Type

Postgraduate Training



Location Details

Street Address 1

525 East 68th Street

City

New York

Country

United States



State / Province

New York

Zip / Postal Code

10065

Application Activity Details

Licensee / Applicant

Cox, Kathryn Ann



Start Date

Jul-01-1979



Percent Clinical *

100

Application

Application - Cox, Kathryn Ann



Name of Organization / Institution

Martens Ryan and Steadman MDs PC

End Date

Jun-30-1982



Position

Activity Type

Medical Practice/Physician



Location Details

Street Address 1

449 East 68th Street

City

New York

Country

United States



State / Province

New York

Zip / Postal Code

10065

Application Activity Details

Licensee / Applicant

Cox, Kathryn Ann



Start Date

Jul-01-1982



Percent Clinical *

80

Application

Application - Cox, Kathryn Ann



Name of Organization / Institution

Kathryn A. Cox, M.D P.C

End Date

Mar-18-2021



Position

Activity Type

Medical Practice/Physician



Location Details

Street Address 1

330 East 63rd Street #1J

City

new york

Country

United States



State / Province

New York

Zip / Postal Code

10065

Specialty Details

Licensee / Applicant *

Cox, Kathryn Ann



Effective Date

Jul-01-1975



Application

Application -

Cox, Kathryn Ann



Primary Specialty?

Yes No

Specialty Type *

Obstetrics / Gynecology



Other (Specialty)

End Date

Mar-18-2021



Licensee/Applicant	Declaration Question	Answer
Kathryn Cox	MD, PA, CCP, Hospital Privileges Denied, Suspended.	No
Kathryn Cox	ALL – Q5 – Named Defendant Respond to Legal Action	Yes
Kathryn Cox	ALL – Q6 – Malpractice Claim Paid	Yes
Kathryn Cox	MD, PA – Q1 – Medical Condition Impair Safe Practice	No
Kathryn Cox	MD, Previously applied for licensure in Nevada.	No
Kathryn Cox	MD, PA – Q3 – Chemical Substances Impair Safe Practice	No
Kathryn Cox	MD – Investigation Disciplinary during Training Program	No
Kathryn Cox	MD – Q13 – Investigation – Respond To/Notify Of	No
Kathryn Cox	MD – Q11 – Voluntarily Surrendered a License	No
Kathryn Cox	MD – Q9 – Medical License Revoked	No
Kathryn Cox	MD – Q12 – Denied Membership	No
Kathryn Cox	ALL – Q7 – Arrest Question	No
Kathryn Cox	MD, PA, LL – Q4 – Performance of Public Service Requirement	No
Kathryn Cox	MD – Q8 – Denied License / Permission to Practice Medicine	No
Kathryn Cox	MD, PA – Q2 – Medical Condition Field of Practice	No
Kathryn Cox	MD, PA – Q10 – Controlled Substance Registration	No



RECEIVED

MAY 24 2021

NEVADA STATE BOARD OF
MEDICAL EXAMINERS

ATTENTION APPLICANT!

RESPONSIBILITY STATEMENT

**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**

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 Kathryn Ann Coy

Sign your name _____

Date 5/7/2021

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.