Demographic Details

First Name

Kevin

Gender

Male

Middle Name

Westray

Date of Birth

-1963

Last Name *

HOLCOMBE

Name Suffix

Previous Name(s)

City of Birth

SOUTH AFRICA

Social Security Number

Place of Birth

Tax Identification Number

Weight (in lbs)

Height

Eye Color

Hair Color

Comments (non-public information)

Public Information

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

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

Contact Information

Primary Phone

#

Secondary Phone

#

Primary Phone Extension

Secondary Phone Extension

Primary E-mail Address

Mail should be directed to

Cell Phone

, ...3

Fax

#

Public Address

Street Address

470 INDIAN BAY BLVD

ZIP / Postal Code

32953

Address Line 2

State / Province

Florida

City

MERRITT ISLAND

Country

United States

County

BREVARD

Is your physical address different from your mailing address?

○ Yes ◉ No

Public Phone

(864) 238-5448

Mailing Address

Street Address

City (Mailing)

Address Line 2

State / Province (Mailing)

ZIP / Postal Code (Mailing)

County (Mailing)

County (Mailing)

Application Status

Applicant *

HOLCOMBE, Kevin Westray

Application Status

Application Number

Assigned To

License Issued?

○ Yes ○ No

Manual Paper Application?

○ Yes ◉ No

License Details (Pre-Approval)

License Category

Medical Doctor

Obtained By

USMLE

Credentials / Degree Suffix (Enter before approval!)

M.D.

Application Details

Application Type

Medical Doctor - Active

Application Date *

Mar-30-2021

Submitted Date

Apr-29-2021

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

Licensure Invoice

Application Payment Date

Apr-29-2021

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

Not subject to a court order

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

Education Details

Licensee/Applicant *

HOLCOMBE, Kevin Westray

Address

City

GAINESVILLE

State / Province

Florida

Zip / Postal Code

Country

United States

Application

Application - HOLCOMBE, Kevin Westray

Specialty Type

Name of School

UNIVERSITY OF FLORIDA COLLEGE

Education Type

Medical School

Degree Attained

Medical Doctor Degree

Date From

Aug-01-1994

Date To

May-23-1998

Did you graduate from the program?

(•) Yes ( ) No

Graduation Date

May-23-1998

Major Program

Postgraduate Training Details

Licensee / Applicant *

HOLCOMBE, Kevin Westray

Training Status *

Program Type *

Internship/Residency

Accreditation Type

ACGME (Accreditation Council for Graduate Medical Education)

Date From

Jul-01-1998

Date To

Jul-30-2001

Name of School or Institution

Prisma Health - Upstate

Application

Application - HOLCOMBE, Kevin Westray

Specialty Type

Family Medicine

Historical Major Program

Other (Specialty)

Historical Degree Attained

Location Details

City

Greenville

Street Address 1

State / Province

South Carolina

Zip / Postal Code

County

Country

Examination Details

Licensee / Applicant *

HOLCOMBE, Kevin Westray

Attended Date

Jun-11-1996

Number of Attempts

1

Application

Application - 5 - HOLCOMBE, Kevin Westray

Location

Result

197

Examination Type

United States Medical Licensing Examination (USMLE

Other Exam

Are you currently certified?

○ Yes ○ No

Steps

Step 1

Certificate Number

Exam Date

Expiration Date

Examination Details

Licensee / Applicant *

HOLCOMBE, Kevin Westray

Attended Date

Aug-26-1997

Number of Attempts

1

Application

Application - 5 - HOLCOMBE, Kevin Westray

Location

Result

197

Examination Type

United States Medical Licensing Examination (USMLE)

Other Exam

Are you currently certified?

O Yes O No

Steps

Step 2 CK

Certificate Number

Exam Date

Expiration Date

Examination Details

Licensee / Applicant *

HOLCOMBE, Kevin Westray

Attended Date

May-11-1999

Number of Attempts

1

Application

Application - - HOLCOMBE, Kevin Westray

Location

Result

206

Examination Type

United States Medical Licensing Examination (USMLE)

Other Exam

Are you currently certified?

○ Yes ○ No

Steps

Step 3

Certificate Number

Exam Date

Expiration Date

HOSPITALS

Licensee / Applicant	Name of Organization	Start Date	End Date
HOLCOMBE, Kevin Westray	Sebastian River Medical Center	Aug-22-2015	May-11-2018
HOLCOMBE, Kevin Westray	Health First	Jan-18-2021	N/A
HOLCOMBE, Kevin Westray	Baptist Health South Florida	Oct-22-2015	N/A

LICENSES

Licensee/Applicant	License Number	License Type	Issue Date	Expiration Date	State / Province
HOLCOMBE, KEVIN WESTRAY	ME112246	N/A	Feb-28-2012	Jan-31-2022	Florida
HOLCOMBE, KEVIN WESTRAY	21450	N/A	Dec-08-1999	Jun-30-2023	South Carolina
HOLCOMBE, KEVIN WESTRAY	2007-00145	N/A	Jan-18-2007	Aug-03-2018	North Carolina

CHRONOLOGY OF ACTIVITIES

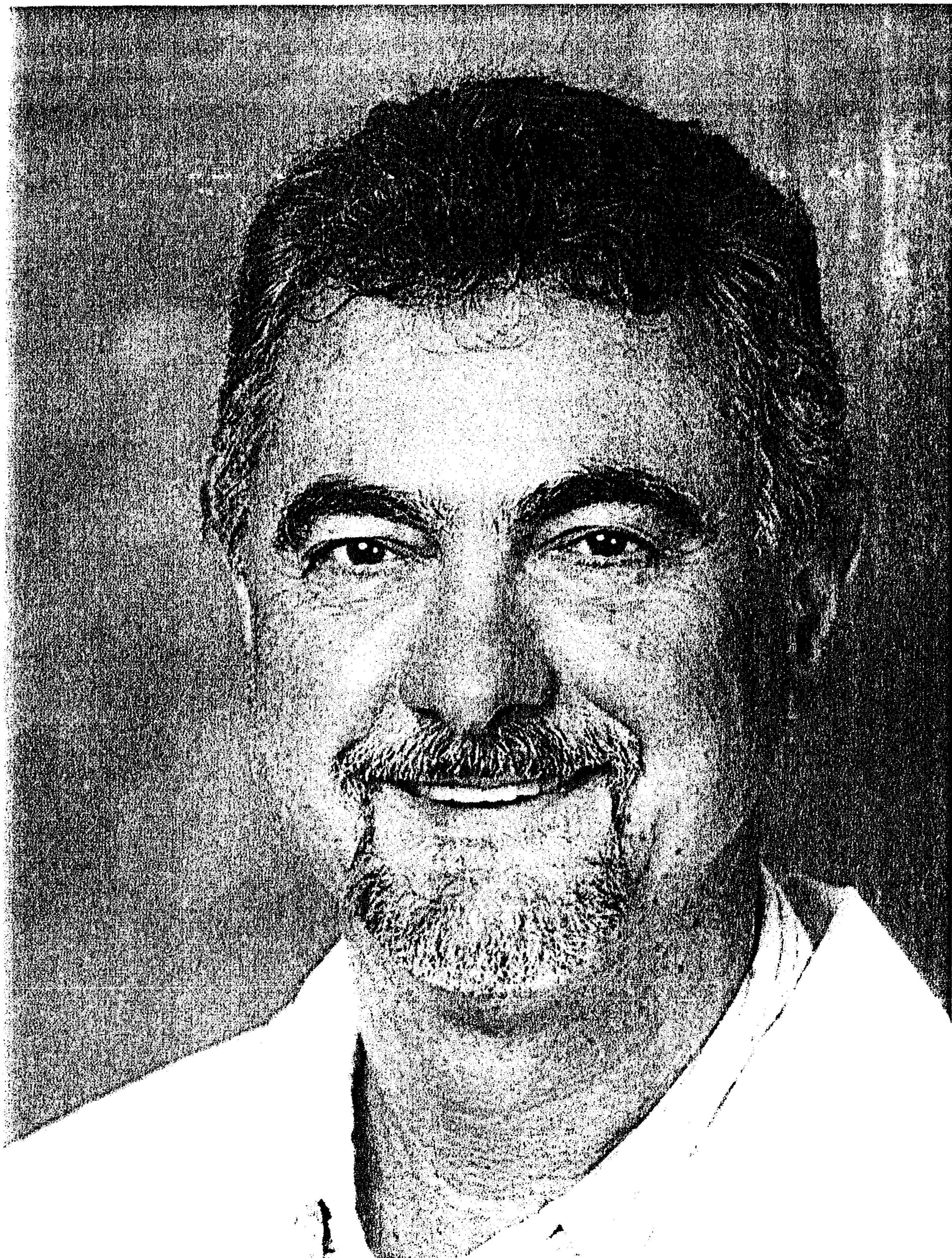
Licensee / Applicant	Name of Organization / Institution	Start Date	End Date	Percent Clinica
KEVIN HOLCOMBE	Bon Secours St Francis Hospital - Emergency Departments	Jul-01-2002	Jul-01-2004	100
KEVIN HOLCOMBE	Health First Medical Group	Feb-15-2021	Dec-31-2030	100
KEVIN HOLCOMBE	Mariners Community Hospital - Emergency Department	May-01-2018	Dec-31-2020	100
KEVIN HOLCOMBE	Greenville Hospital System - Emergency Departments	Nov-01-2008	Jan-31-2011	100
KEVIN HOLCOMBE	ASAP Urgent Care & Family Medicine	May-01-2018	Jan-31-2019	100
KEVIN HOLCOMBE	Palmetto Baptist Hospital Easley	Nov-01-2008	Dec-31-2009	100
KEVIN HOLCOMBE	Advanced Urgent Care	Jan-01-2019	Dec-31-2021	100
KEVIN HOLCOMBE	Doctors Care	May-01-2004	Oct-01-2004	100
KEVIN HOLCOMBE	Greenville Hospital System - Emergency Departments	Jul-30-2001	Jun-30-2002	100
KEVIN HOLCOMBE	GHS University Medical Group MD360 Urgent Care	Feb-01-2011	Mar-31-2013	100
KEVIN HOLCOMBE	Sebastian River Medical Center	Oct-01-2012	May-31-2018	100
KEVIN HOLCOMBE	Springs Memorial Hospital	Jul-01-2006	Oct-01-2008	100
KEVIN HOLCOMBE	Premier Family Medicine	Nov-01-2004	Jun-30-2006	100

DECLARATIONS

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

SPECIALTY

Licensee / Applicant	Specialty Type	Primary Specialty?	Effective Date	End Date
KEVIN HOLCOMBE	Family Medicine	Yes	Jul-30-2001	N/A
KEVIN HOLCOMBE	Emergency Medicine	No	Jul-30-2001	N/A



RECEIVED
JUN 21 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, perfusion or respiratory care 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.

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 KEVIN J. HOLCOMBE, MD

Sign your name ____________________

Date 03 June 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.