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APPLICATION FOR STATUS CHANGE TO ACTIVE STATUS REGISTRATION FORM FOR THE BIENNIAL PERIOD 2021 - 2023 **NEVADA STATE BOARD OF MEDICAL EXAMINERS**

RECEIVED

Date Received by Board

FEB 0 2 2022

License No. 12548

0/2023

9600 Gateway Phone	Drive, Reno, NV 89521 (775) 688-2559	,,	MEDICAL EX	AMINERS	
		<u></u>	Or Board Ose	Incative-	Probetion 6t
I hereby apply for status char	ge to active status, and enclos	se the appropri	ate fee as ir	ndicated below:	
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CHANGE F	ROM INACTIVE TO ACTIVE S			/2022 - 6/30/2023	\$ 375.00
by credit card, it paying by	neck or money order payable credit card, please complete 2.5%) service fee will be ass	the Credit Ca	rd Authoriz	ation form on the Ir	XAMINERS," or ast page of this
Licensee's Name: Kiarash L. Mirkia, M.D.					
(a) Notify the Board in (b) File an affidavit wi (c) Complete the form (d) Pay the applicable (e) Satisfy the Board of the Board determines that warranted denial of an application active status. Your Status Will Not Be Che Registration Form. You Must Provide Written E	e licensees: reinstatement. The of medicine in this State, the awriting of his or her intent to rein the Board describing the act for registration for active statu fee for biennial registration; and his or her competence to prait the conduct or competence or ion for a license to practice medicanged Unless You Answer All Questions A On This Application is Public In	esume the pra ivities of the re is; and actice medicine if the registrant dicine in this Si uestions On Th	ctice of med gistrant duri e. during the pate, the Boa is Application	ing the period of inac period of inactive sta rd may refuse to plac	tus would have be the registrant
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. If your name and/or address you provide below is viewab public telephone and fax nu	have changed, indicate the char le on the NSBME website and wi mbers. <u>Please note</u> : if your nar worce decree, etc.) must be incl	II become your ne has change	nublic addres	se. Aleo plagas india	-t
lame Kiarash L. Mirkia, M.D.					
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Cellular Phone:

Email address

Street City County State Zip NEVADA STATE MEDICAL EX Phone Number 4. INDICATE BELOW YOUR PRIMARY AND SECONDARY SCOPES OF PRACTICE using the following codes: SCOPES OF PRACTICE CODES 1. ADDICTION MEDICINE 2. ADOLESCENT MEDICINE 3. ARROSPAGE MEDICINE 4. NEVROLOGY 4. NEVROLOGY 4. SPHROLOGY 4. NEUROLOGY 4. LIERGY 4. LIERGY MIMUNOLOGY 4. LIERGY 4. NEURO-OPHTHALMOLOGY 4. SPHROLOGY 4. SPHROLOGY 4. NEURO-OPHTHALMOLOGY 4. SPHROLOGY 4. SPHROLOGY 4. NEURO-OPHTHALMOLOGY 4. SPHROLOGY 4. S			******************			
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MEDICAL GENETICS 79 PEDIATRIC, PULMONARY 119 URGENT CARE		· . 78	3 PEDIATRIC, PH	IYSIATRY		
NEO(DEDINATAL MEDIONE AS MEDIAMENA MANAGEMENT		79	PEDIATRIC, PU	ILMONARY		
	NEO/PERINATAL MEDICINE	80	PEDIATRIC, RA	DIOLOGY		
<u>Code</u>		Code				Code
Primary Scope of Practice 106 Secondary Scope of Practice 15, 115	Primary Soons of Dract	106		•		. 15 115

List state licenses YOU HOLD OR HAVE HELD to practice medicine in any state, territory or country with the exception of training licenses. (Current direct source verification of these licenses must be received by the Board prior to any status change.)

State/Territory/Country	License #	Date of Issuance	Dates of Practice
Arizona	51400	8/2016	From (Mo./Yr.) To (Mo./Yr.) never
Michigan	4301502263	11/2019	never
New York	240608-1	6/2006	never
Wisconsin	62991-20	10/2014	never
Illinois	36110231 (If more space is needed, attac	10/2003 h a separate sheet.)	10/23 to 12/07; 1/15 to 8/15
Montana	29658	01/2014	never

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Questions:

NEVADA STATE BOARD OF MEDICAL EXAMINERS

All of the following questions refer to the time period since your last renewal

In the event that your status was not changed to Inactive <u>during</u> a renewal, all questions refer to the time period within the last 24 months prior to your submission of this form.

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.

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 Status Change to Active Status Registration* form.

1. Do you currently have a medical condition which in any way impairs or limits your ability	to practice medicin	e with rea	sonat	le skil
and safety?		Yes		
If you currently have a medical condition which in any way impairs or limits your ability t limitation reduced or ameliorated because of the field of practice, the setting, the manner in	to practice medicine n which you have ch	e, is that in nosen to p	npairm ractice	nent o
any other reasonable accommodation?	Yes	No	<u>X</u>	N/A
3. If you currently use chemical substances, does your use in any way impair or limit your	ability to practice me	dicine wit	n reaso	onable
skill and safety?	Yes	No	<u>X</u>	N/A
 Have you failed to initiate the performance of public service within one year after the dat satisfy a requirement of your receiving a loan or scholarship from the federal government 	te the public service nt or a state or loca	is require I governn	d to be	egin to r your
medical education?		Yes	Χ	No

[&]quot;Medical condition" includes physiological, mental or psychological condition or disorder.

[&]quot;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.

Questions (continued): The following questions refer to the time period within the last 24 months prior to your submission of this form.	since your last renewal OR
Malpractice Questions: Note: I responded to these questions using the last 24 months time	e frame:
5. Have you been named as a defendant, or been requested to respond as a defendant, to a liability, or malpractice, including any military tort claims if applicable?	egal action involving professional Yes X No
6. Have you had a professional liability, malpractice, claim paid on your behalf, or paid such a clatort claims if applicable?	aim yourself including any military X YesNo
Malpractice Explanation(s):	
List of <u>all</u> claims or suits for medical malpractice made against you. A claim is any formal or any person or organization. If have not answered "yes" to questions #5 and/or #6 and do not this section will be left blank. If you have more than 1 claim, make a copy or copies of this p with your application for licensure.	ot have any such claims or suits, age and submit all explanations
Name of patient involved:	RECEIVED
In which state did the action take place?	FEB 0 2 2022
Case number (if applicable):	NEVADA STATE BOARD OF MEDICAL EXAMINERS
Which court? (If settled before initiation of civil action, state here.)	
Current status of claim: Open Closed (settled or judgment) Dismissed (no money p	paid out) 🔲 Other
Date claim was closed/settled or dismissed:	
Amount of judgment or settlement \$	
Month and year of event precipitating claim:	
Month and year of lawsuit:	
Insurance carrier at time:	
What is/was your status? Primary defendant Co-defendant	Other
Please provide specifics in reference to the adverse event including the allegations	and your role in the event:
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	Questions (continued): The following questions refer to the time period since within the last 24 months prior to your submission of this form. Note: I responded to these questions using the last 24 months time frame.			
	7. Have you ever been arrested, investigated for, charged with, convicted of, or pled guilty or nolo conviolation of any federal (including the Uniform Code of Military Justice), state or local law, or the laws of a misdemeanor, gross misdemeanor, felony, violation of the Uniform Code of Military Justice; or synojurisdiction, excluding any minor traffic offense (driving or being in control of a motor vehicle while under substance, including alcohol, is not considered a minor traffic offense), or for any offense which is a distribution, prescribing, or dispensing of controlled substances? *Please note that you MUST disclose including those where the final disposition was dismissal, or expungement. (If "Yes," attach explanation	iny foreign counymous theret the influence elated to the ANY investiga on on separate	Intry, which is o in a foreign of a chemical manufacture,	
	8. Have you ever been denied a license, permission to practice medicine or any other healing art examination to practice medicine or any other healing art in any state, country or U.S. territory?	or permissio		
	9. Have you ever had a medical license or license to practice any other healing art revoked, suspended state, country or U.S. territory?	limited, or res	tricted in any	
		XYes	No	
	10. Have you ever voluntarily surrendered a license to practice medicine or any other healing art in territory?		untry or U.S. X No	
	11. Have you ever been denied membership, been asked to resign or expelled from a medical society or organization?		onal medical × No	
	그래 되었다고 있었다. 얼마나 하는 사람이 되었다는 그리다 하는 사람이 되었다.			
	12. Have you ever been: a) asked to respond to an investigation; b) notified that you were under investigation charged with; or e) convicted of any violation of a statute, rule or regulation governing your practice as licensing board, hospital, medical society, governmental entity or agency other than the Nevada State Board.	a physician by pard of Medical		
	13. Have you ever surrendered your state or federal controlled substance registration or had it revoked	X Yes	No	
		X Yes	No	
	14. List all hospitals where you have had staff privileges denied, suspended, limited, revoked or not renew (all) resignations from any medical staff in lieu of disciplinary or administrative action. (<u>Please Note</u> : Do restrictions for failure to complete hospital medical records, attend hospital department or staff meet malpractice insurance). Mailing Type of Hospital Address Action		spensions or ain required f Action	
	None in last 24 months.		***************************************	
•				
	//5/2000 0000 0000 0000 0000	RE(EIVE	Г
	(If more space is needed, attach a separate sheet.)			
•	A the shell are a la fermion at		0 2 2022	
4	Attestations/Affirmations:	NEVADA S	TATE BOARD	٦.
•	CHILD SUPPORT STATEMENT	MEDICA	L EXAMINERS	75
1	UNDERSTAND THAT THIS APPLICATION FOR STATUS CHANGE TO ACTIVE STATUS REGISTRAT HAVE NOT PLACED A CHECK MARK NEXT TO (a), (b), OR (c) UNDER THE CHILD SUPPORT STA	ON WILL BEI	DENIED IF I	
F	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;			
C	$^{\rm X}$ (b) I am subject to a court order for the support of one or more children and am in compliance with a plan approved by the district attorney or other public agency enforcing the order for the owed pursuant to the order; OR	e with the ord repayment of	er or am in the amount	
a	(c) I am subject to a court order for the support of one or more children and am NOT in compliant approved by the district attorney or other public agency enforcing the order for the repayment of the amount	ce with the ord ount owed pure	er or a plan suant to the	

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

I attest and affirm that I am aware of and understand the reporting requirements found in Nevada R	Revised S	tatute ·	432B.220
regarding the abuse or neglect of a child.	х	_Yes	No

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 <u>APPLICANT</u> 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.

X Yes No

http://www.cdc.gov/injectionsafety/IP07_standardPrecaution.html

MILITARY SERVICE ATTESTATION

1-Have you ever served in the United States Mi If your answer is "No", you do not have to complete to Attestation.	litary (to he remair	include National Guard or F ning questions for the Military S	Reserves)? ervice		EGEIVI	E-D
2-If yes, which branch of service did you serve?		Air Force Army Navy Marine Corps Coast Guard		NEV	FEB 0 2 2022 ADA STATE BOAR BEDICAL EXAMINE	?
3-Military occupation specialty or specialties?		Administration or Personnel Aviation Civil Engineering Communications Infantry or Armor Legal or Chaplin Corps	☐ Ma	gistics or Supply aintenance edical Services curity Forces or M her	•	
4&5-Dates of service in the Military:	From:	///	6- To :	DD MM	/	
6-Are you still serving?No						
7-Have you ever served on active duty in the Ar	med For	ces of the United States?		A second on .	Yes No	
8-Have you ever been assigned to duty for a minithe Armed Forces of the United States?	mum of	6 continuous years in the Na	tional Guard		omponent of _YesNo	
9-Have you ever served the Commissioned Corp the National Oceanic and Atmospheric Administra active duty in defense of the United States?	s of the ation of	United States Public Health the United States in the capa	Service or thacity of a com	nmissioned offi	ned Corps of icer while on _YesNo	
10-If the answer to question(s) 7, 8 and/or 9 i dishonorable?	s "yes,"	did you separate from suc	h service un	der conditions		

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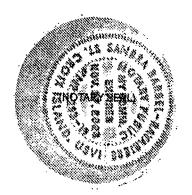
APPLICATION AFFIRMATION

I, Kiarash L. Mirkia, MD,

(Print your full name)

being duly swom, 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.



State of TheUS. Virgin Tounty of St. Craix
Subscribed and sworn to before me this 26th day of
January 2022
Notary Public for the State of THE U.S. Virgin Islands
My Commission Expires: 11/27/2023
Residing at: Washington USVI
City State
Signature of Notary

SANDRA SARBEL RAVARISHE
Territory of the U.S. Virgin Islands
District of St. Croix Island
Notary Public No. NP-263-19
My Comm. Expires Nov. 27, 2023

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Continuing Education:

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NEVADA STATE BOARD OF MEDICAL EXAMINERS

CONTINUING MEDICAL EDUCATION (CME) STATEMENT:

Note: If you have previously submitted proof of 4 hours AMA Category 1 continuing medical education regarding bioterrorism or relating to medical consequences of act of terrorism involving use of weapon of mass destruction, you will not be responsible to do so again. For your information, this requirement became effective October 2003.

Please place a check mark next to one of the following statements:
X (a) I was initially licensed in Nevada <u>prior to or during</u> the time period July 1, 2021 through December 31, 2021 and completed a minimum of 44 hours of AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics or pain management and/or addiction care, 20 hours of which were in my scope of practice or specialty and 4 of which were in bio-terrorism/weapons of mass destruction (if applicable);
(b) I was initially licensed in Nevada during the time period January 1, 2022 through June 30, 2022, the second six months of the past biennial period, and completed a minimum of 34 hours of AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics or pain management and/or addiction care, 20 hours of which were in my scope of practice or specialty and 4 of which were in bio-terrorism/weapons of mass destruction (if applicable);
(c) I was initially licensed in Nevada during the time period July 1, 2022 through December 31, 2022, the third six months of the past biennial period, and completed a minimum of 24 hours of AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics or pain management and/or addiction care, 18 hours of which were in my scope of practice or specialty and 4 of which were in bio-terrorism/weapons of mass destruction (if applicable);
(d) I was initially licensed in Nevada during the time period January 1, 2023 through June 30, 2023, the fourth six months of the past biennial period, and completed a minimum of 14 hours of AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics or pain management and/or addiction care, 8 hours of which were in my scope of practice or specialty and 4 of which were in bio-terrorism/weapons of mass destruction (if applicable), OR
(e) I am exempt from submitting proof of completion of continuing medical education (CME) because I have completed a full year of residency or fellowship training during the biennial period July 1, 2019 through June 30, 2021.
Attach copies of proof of your completion of continuing medical education (CME) hours

Proof of completion of 1 year of residency or fellowship training obtained during the biennial.

Your copies of proof of CME or training completion will not be returned to you.

BND OF STATUS CHANGE APPLICATION

LIST OF MALPRACTICE INSURANCE CARRIERS

If you answered in the affirmative to being named in a malpractice case or a settlement has been payed on your behalf, list all malpractice carriers.

Name of Insured:	Kiarash Mirkia, MD
Insurance Company: Address:	PPIC Roger Peltyn, 1953 N. Decatur Blvd, Las vegs, NV 89108
Phone Number: Fax Number: Policy Number: Dates:	2009-2014 and 2015-2019
Insurance Company: Address:	PPIC, HSHS Medical Group INC 11605 Miracle Hills dr, Omaha, Nebraska 68154
Phone Number:	
Fax Number: Policy Number: Dates:	01/2015-07/2015
Insurance Company: Address:	
Phone Number: Fax Number: Policy Number: Dates:	
Insurance Company: Address:	
Phone Number: Fax Number: Policy Number:	
Dates:	RECEIVED
Insurance Company: Address:	MAY 0 9 2022
Phone Number: Fax Number: Policy Number: Dates:	NEVADA STATE BOARD OF MEDICAL EXAMINERS

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