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PHYSICIAN
APPLICATION FOR STATUS CHANGE TO ACTIVE STATUS
REGISTRATION FORM FOR THE BIENNIAL PERIOD 2021 - 2023
NEVADA STATE BOARD OF MEDICAL EXAMINERS
9600 Gateway Drive, Reno, NV 89521
Phone (775) 688-2559

Date Received by Board
FEB 02 2022
NEVADA STATE BOARD OF MEDICAL EXAMINERS
(For Board Use Only)

License No. 12548
Case No. _____

Inactive-Probation 6/30/2023

I hereby apply for status change to active status, and enclose the appropriate fee as indicated below:

X	CHANGE FROM INACTIVE TO ACTIVE STATUS	between 7/1/2021 - 6/30/2022	**$ 750.00**
_____	CHANGE FROM INACTIVE TO ACTIVE STATUS	between 7/1/2022 - 6/30/2023	**$ 375.00**

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 (2.5%) service fee will be assessed for payment by credit card.

Licensee's Name:
Kiarash L. Mirkia, M.D.

PLEASE NOTE:

NRS 630.255 (4) (5) Inactive licensees: reinstatement.

4. Before resuming the practice of medicine in this State, the inactive registrant must:
   (a) Notify the Board in writing of his or her intent to resume the practice of medicine in this State;
   (b) File an affidavit with the Board describing the activities of the registrant during the period of inactive status;
   (c) Complete the form for registration for active status;
   (d) Pay the applicable fee for biennial registration; and
   (e) Satisfy the Board of his or her competence to practice medicine.
5. If the Board determines that the conduct or competence of the registrant during the period of inactive status would have warranted denial of an application for a license to practice medicine in this State, the Board may refuse to place the registrant on active status.

- Your Status Will Not Be Changed Unless You Answer All Questions On This *Application For Status Change To Active Status Registration* Form.
- You Must Provide Written Explanations For All Questions Answered "Yes."
- All Information You Provide On This Application Is Public Information.

PLEASE TYPE OR PRINT LEGIBLY

1. Active status registration requires the submission of proof of completion of **AMA Category 1** continuing medical education (CME), **completed during the preceding 24-month time period of the date of your submission of this form**. Submit your proof of completion of CME with your completed ***APPLICATION FOR STATUS CHANGE TO ACTIVE STATUS REGISTRATION*** form. A detailed description of the number of continuing medical education hours required for your change of status can be found on page 8 of this application.

2. If your name and/or address have changed, indicate the change in the space provided below. Please be advised, the address you provide below is viewable on the NSBME website and will become your public address. Also, please indicate your current public telephone and fax numbers. Please note: if your name has changed, a copy of the document authorizing your name change (marriage license, divorce decree, etc.) must be included.

Name Kiarash L. Mirkia, M.D.
Street _____
City _____ County _____ State _____ Zip _____
Public Phone Number _____ Public Fax Number _____
Cellular Phone: _____ Private ☐ Public
Email address _____

3. **IF YOU HAVE RETIRED OR MOVED YOUR PRACTICE,** indicate the location of patient records below:

Name_____

Street_____

City_____ County_____ State_____ Zip_____

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 AEROSPACE MEDICINE
4 ALLERGY
5 ALLERGY/IMMUNOLOGY
6 AMBULATORY MEDICINE
7 ANESTHESIOLOGY
8 BLOODBANKING
9 BRONCO-ESOPHAGOLOGY
10 CARDIOVASCULAR DISEASES
11 CATSCAN/ULTRASOUND
12 CHILD NEUROLOGY
13 CHILD PSYCHIATRY
14 CLINICAL PHARMACOLOGY
15 CRITICAL CARE
16 DERMATOLOGY
17 DERMATOPATHOLOGY
18 EMERGENCY MEDICINE
19 ENDOCRINOLOGY
20 FAMILY PRACTICE
21 GASTROENTEROLOGY
22 GENERAL PRACTICE
23 GERIATRIC PSYCHIATRY
24 GERIATRICS
CARDIOVASCULAR
25 GYNECOLOGY
26 HAIR TRANSPLANTATION
27 HEMATOLOGY
28 HOMEOPATHY
29 HYPNOSIS
30 IMMUNOLOGY
31 INFECTIOUS DISEASES
32 INFERTILITY
33 INTERNAL MEDICINE
34 LARYNGOLOGY
35 LEGAL MEDICINE
36 MATERNAL/FETAL MEDICINE
37 MEDICAL ACUPUNCTURE
38 MEDICAL ETHICS
39 MEDICAL GENETICS
40 NEO/PERINATAL MEDICINE
41 NEOPLASTIC DISEASES
42 NEPHROLOGY
43 NEUROLOGY
44 NEURO-OPHTHALMOLOGY
45 NEUROPATHOLOGY
46 NEURORADIOLOGY
47 NON-CONVENTIONAL MEDICINE
48 NUCLEAR MEDICINE
49 NUTRITION
50 OBSTETRICS
51 OBSTETRICS/GYNECOLOGY
52 OCCUPATIONAL MEDICINE
53 ONCOLOGY
54 ONCOLOGY, GYNECOLOGICAL
55 ONCOLOGY, HEMATOLOGY
56 ONCOLOGY, RADIATION
57 ONCOLOGY, SURGICAL
58 OPHTHALMOLOGY
59 OTOLARYNGOLOGY
60 OTOLOGY
61 PAIN MANAGEMENT
62 PATHOLOGY
63 PATHOLOGY, ANATOMIC
64 PATHOLOGY, CLINICAL
65 PATHOLOGY, FORENSIC
66 PEDIATRIC, ALLERGY
67 PEDIATRIC, CARDIOLOGY
68 PEDIATRIC, CRITICAL CARE
69 PEDIATRIC, EMERGENCY MEDICINE
70 PEDIATRIC, ENDOCRINOLOGY
71 PEDIATRIC, GASTROENTEROLOGY
72 PEDIATRIC, HEMATOLOGY/ONCOLOGY
73 PEDIATRIC, INFECTIOUS DISEASES
74 PEDIATRIC, INTENSIVIST
75 PEDIATRIC, NEPHROLOGY
76 PEDIATRIC, NEUROLOGY
77 PEDIATRIC, OPHTHALMOLOGY
78 PEDIATRIC, PHYSIATRY
79 PEDIATRIC, PULMONARY
80 PEDIATRIC, RADIOLOGY
81 PEDIATRIC, RHEUMATOLOGY
82 PEDIATRIC, SURGERY
83 PEDIATRIC, UROLOGY
84 PEDIATRICS
85 PHYSICAL MEDICINE/REHABILITATION
86 PREVENTIVE MEDICINE
87 PSYCHIATRY
88 PSYCHOANALYSIS
89 PUBLIC HEALTH
90 PSYCHOMATIC MEDICINE
91 PULMONARY DISEASES
92 RADIOLOGY
93 RADIOLOGY, DIAGNOSTIC
94 RADIOLOGY, INTERVENTIONAL
95 RADIOLOGY, NUCLEAR
96 RADIOLOGY, THERAPEUTIC
97 RADIOLOGY, VASCULAR
98 RHEUMATOLOGY
99 RHINOLOGY
100 SLEEP DISORDERS
101 SPORTS MEDICINE
102 SURGERY, ABDOMINAL
103 SURGERY, CARDIOTHORACIC
104 SURGERY,
105 SURGERY, COLON/RECTAL
106 SURGERY, GENERAL
107 SURGERY, HAND
108 SURGERY, HEAD/NECK
109 SURGERY, MAXILLOFACIAL
110 SURGERY, NEUROLOGICAL
111 SURGERY, ORTHOPEDIC
112 SURGERY, PLASTIC
113 SURGERY, THORACIC
114 SURGERY, TRANSPLANT
115 SURGERY, TRAUMATIC
116 SURGERY, UROLOGIC
117 SURGERY, VASCULAR
118 TOXICOLOGY
119 URGENT CARE
120 UROLOGY

Primary Scope of Practice Code: 106

Secondary Scope of Practice Code: 15, 115

Other States of Current or Previous Licensure:

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 From (Mo./Yr.) To (Mo./Yr.)
Arizona	51400	8/2016	never
Michigan	4301502263	11/2019	never
New York	240608-1	6/2006	never
Wisconsin	62991-20	10/2014	never
Illinois	36110231	10/2003	10/23 to 12/07; 1/15 to 8/15
Montana	29658	01/2014	never

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

Questions:

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 during 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.

"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 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 medicine with reasonable skill and safety?
_____Yes X No

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?
_____Yes _____No X 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?
_____Yes _____No X N/A

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?
_____Yes X No

Questions (continued): **The following questions refer to the time period since your last renewal OR within the last 24 months prior to your submission of this form.**

Malpractice Questions: Note: I responded to these questions using the last 24 months time frame:

5. Have you 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 X No

6. Have you had a professional liability, malpractice, claim paid on your behalf, or paid such a claim yourself including any military tort claims if applicable? X Yes _____No

Malpractice Explanation(s):

List of all claims or suits for medical malpractice made against you. A claim is any formal or informal demand for payment to any person or organization. If have not answered "yes" to questions #5 and/or #6 and do not have any such claims or suits, this section will be left blank. If you have more than 1 claim, make a copy or copies of this page and submit all explanations with your application for licensure.

Name of patient involved:

In which state did the action take place?

Case number (if applicable):

Which court?
(If settled before initiation of civil action, state here.)

Current status of claim:

☐ Open ☐ Closed (settled or judgment) ☐ Dismissed (no money paid out) ☐ Other

Date claim was closed/settled or dismissed: _____ _____
Month/Year

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:

Questions (continued): **The following questions refer to the time period since your last renewal OR 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 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 X No

8. 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? _____Yes X No

9. 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?

X Yes _____No

10. Have you ever voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory?

_____Yes X No

11. Have you ever been denied membership, been asked to resign or expelled from a medical society or other professional medical organization?

_____Yes X No

12. 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?

X Yes _____No

13. Have you ever surrendered your state or federal controlled substance registration or had it revoked or restricted in any way?

X Yes _____No

14. 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.)
None in last 24 months.			

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

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Attestations/Affirmations:

CHILD SUPPORT STATEMENT

I UNDERSTAND THAT THIS *APPLICATION FOR STATUS CHANGE TO ACTIVE STATUS REGISTRATION* WILL BE DENIED IF I HAVE NOT PLACED A CHECK MARK NEXT TO (a), (b), OR (c) UNDER THE CHILD SUPPORT STATEMENT SECTION.

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;

X (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

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.

X 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 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.

X Yes _____No

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

MILITARY SERVICE ATTESTATION

1-Have you ever served in the United States Military (to include National Guard or Reserves)? _____Yes X No

If your answer is "No", you do not have to complete the remaining questions for the Military Service Attestation.

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

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APPLICATION AFFIRMATION

I, Kiarash L. Mirkia, MD,

(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 — Date: 01/28/2022

(NOTARY SEAL)

State of The U.S. Virgin Islands County of St. Croix

Subscribed and sworn to before me this 28th day of January 2022

Notary Public for the State of The U.S. Virgin Islands

My Commission Expires: 11/27/2023

Residing at: Christiansted USVI
City State

Signature of Notary

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

Continuing Education:

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 prior to or during 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
or
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.

END OF STATUS CHANGE APPLICATION

FORM B

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: PPIC
Address: Roger Peltyn, 1953 N. Decatur Blvd, Las vegs, NV 89108

Phone Number:
Fax Number:
Policy Number:
Dates: 2009-2014 and 2015-2019

Insurance Company: PPIC, HSHS Medical Group INC
Address: 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:

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Insurance Company:
Address:

Phone Number:
Fax Number:
Policy Number:
Dates:

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