

Demographic Details

First Name

Philip

Middle Name

Allen

Last Name *

CASE

Previous Name(s)

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

Gender

Male



Date of Birth

-1965



Name Suffix

II

City of Birth

Place of Birth

Weight (in lbs)

Eye Color

Comments (non-public information)

Public Information

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

#

Fax

#

Public Address

Street Address

ZIP / Postal Code

90244 Shoreline Dr

97146

Address Line 2


State / Province

Oregon

City

Country

Warrenton

United States 

County

Is your physical address different from your mailing address?

Clatsop

Yes No

Public Phone

#

Mailing Address


Street Address

City (Mailing)

Address Line 2

State / Province (Mailing)

ZIP / Postal Code (Mailing)

County (Mailing) 

County (Mailing)



Application Status

Applicant *

CASE, Philip Allen



Application Number

License Issued?

Yes No

Application Status

Pending Review by the Board



Assigned To



Manual Paper Application?

Yes No

License ID Card Conditions (max 120 characters)

License Details (Pre-Approval)

License Category

Practitioner of Respiratory Care



Obtained By

NBRC



Expected Issue Date



Credentials / Degree Suffix (Enter before approval!)

CRT

Expected Expiration Date



Application Details

Application Type

Practitioner of Respiratory Care



Application Date *

Jan-18-2022



Reviewed Date



Decision Date



Submitted Date

Approved Date

Jan-18-2022



Application Step

Expiration Date

16

Jan-18-2023



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

Yes No

Invoices

Application Invoice

Application Payment Date



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 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 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

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

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

Military Service Details

Licensee / Applicant *

CASE, Philip Allen



Military Occupation Specialty *

Civil Engineering



End Date

Apr-21-1987



Are you still serving?

Yes No

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

Have you ever served the Commissioned Corps of the United States Public Health Service or the Comissioned 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

Branch of Service *

U.S. Air Force



Start Date *

Jul-27-1983



Application

Application - - CASE, Philip Allen



Have you ever served on active duty in the Armed Forces of the United States?

Yes No

Did you separate from service under conditions other than dishonorable?

Yes No

Education Details

Licensee/Applicant *

CASE, Philip Allen 

Address

City

Johnsburg

State / Province

Illinois


Zip / Postal Code

Country

United States 

Application

Application - CASE, Philip Allen 

Specialty Type 


Name of School

Johnsburg High School

Education Type

High School 

Degree Attained

High School Diploma 

Date From

Sep-01-1980 

Date To

May-01-1983 

Did you graduate from the program?

Yes No

Graduation Date

May-29-1983 

Major Program

Education Details

Licensee/Applicant *

CASE, Philip Allen



Name of School

California College for Health Sciences

Address

Education Type

College/University



City

National City

Degree Attained

Certificate of Completion



State / Province

California

Date From

Aug-24-1994



Zip / Postal Code

Date To

Apr-18-1996



Country

United States



Did you graduate from the program?

Yes No

Application

Application - CASE, Philip Allen



Graduation Date

Apr-18-1996



Specialty Type



Major Program

Examination Details

Licensee / Applicant *

CASE, Philip Allen



Attended Date

Jul-13-1996



Number of Attempts

#

Application

Application -

CASE, Philip Allen



Location

Result

Examination Type

The National Board for Respiratory Care (NBRC)



Other Exam

Are you currently certified?

Yes No

Steps

CRT

Certificate Number

Exam Date

Jul-13-1996



Expiration Date



Other License Details

Licensee/Applicant

CASE, Philip Allen



Licensing Board or Regulatory Authority

Oregon

License Number

RT-P-1000947

State / Province

Country



Application

Application -

- CASE, Philip Allen



License Type

License Status

Active

Issue Date

Sep-14-2004



Expiration Date

Sep-30-2022



Notes

Application Activity Details

Licensee / Applicant

CASE, Philip Allen



Name of Organization / Institution

Start Date

Apr-30-1996



End Date

Jan-17-2022



Percent Clinical *

85

Position

Application

Application - - CASE, Philip Allen



Activity Type

Employment



Location Details

Street Address 1

Country

United States



City

tillamook

State / Province

Oregon

Zip / Postal Code

Specialty Details

Licensee / Applicant *

CASE, Philip Allen



Effective Date



Application

Application

CASE, Philip Allen



Specialty Type *

Respiratory Care



Other (Specialty)

End Date



Primary Specialty?

Yes No


Ordinal ↑	Licensee/Applicant ↑	Declaration Question	Answer
N/A	Philip Case	ALL – Q5 – Named Defendant Respond to Legal Action	No
N/A	Philip Case	RT, Have you previously applied for an allied health license in Nevada?.	Yes
N/A	Philip Case	RT – Q18 – Denied License / Permission to Provide Services	No
N/A	Philip Case	RT – Q17 – Substances Impair Safe Practice	No
N/A	Philip Case	RT – Q16 – Medical Condition Field of Practice	No
N/A	Philip Case	RT – Q21 - Failed NBRC Examination	No
N/A	Philip Case	RT – Q20 – Voluntarily Surrendered License / Certificate	No
N/A	Philip Case	RT – Q19 – Certificate / License Revoked	No
N/A	Philip Case	ALL – Q6 – Malpractice Claim Paid	No
N/A	Philip Case	ALL – Q7 – Arrest Question	No
N/A	Philip Case	RT – Q22 – Registration / Certification Revoked	No
N/A	Philip Case	RT – Q15 – Medical Condition Impair Safe Practice	No
N/A	Philip Case	RT – Q23 – Investigation Respond To / Notify Of	No

Declaration

Licensee/Applicant

CASE, Philip Allen 

Declaration Question

RT, Have you previously applied for an allied health license in Nevada?. 

Answer

Yes No

Answer Details

Ordinal

#

Declaration Text

Related To

Application

Application - CASE, Philip Allen 

Renewal




Declaration

Licensee/Applicant

CASE, Philip Allen 

Declaration Question

ALL – Q7 – Arrest Question 

Answer

Yes No

Answer Details


Ordinal

#

Declaration Text

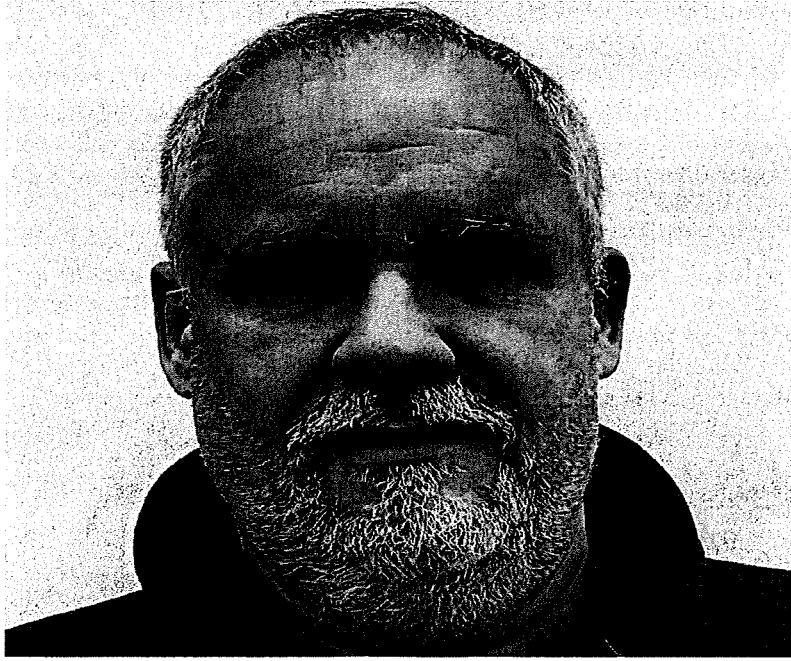
Related To

Application

Application - CASE, Philip Allen 

Renewal





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 Philip A Case

Sign your name _____

Date 2/21/2022

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.