

PHYSICIAN (M.D.)
APPLICATION FOR LICENSURE
NEVADA STATE BOARD OF
MEDICAL EXAMINERS

9600 Gateway Drive, Reno, Nevada 89521
Phone (775) 688-2559

RECEIVED
Date Received by Board
JUN 14 2021
NEVADA STATE BOARD OF
MEDICAL EXAMINERS
(For Board Use Only)

License No. _____

File No. _____

Identity:

1. Present Legal Name Schweitzer Mark Eliot N/A
Last First Middle Maiden
 any other name(s) ever used

Address:

The **Public Access Address** will be available to the public on the Board's website, and will also be your contact address once licensed. It can be changed if the Licensee completes the Notification of Address Change form available on the Board's website: www.medboard.nv.gov.
The **Mailing Address** that you choose will be used for communication only during the application process. It can be one and the same.

2. Public Address 2799 E Grand Boulevard Detroit MI 48202
Street City County State Zip

Please check if you choose to have your Mailing Address the same as the Public Address you have entered above.

3. Mailing Address _____
Street City County State Zip

4. Telephone Numbers (313) 577 7742 () () ()
Office Fax Home Cellular (Optional)

Email address _____

5. Date of Birth _____ Place of Birth _____ Gender F M
(Month / Day / Year) (City, State, Country)

6. Citizenship: U.S. Citizen Alien Registration # _____ Employment Authorization # _____ Visa

Non U.S. Citizen (without the foregoing): Individual Taxpayer Identification Number (ITIN) _____

Submit a Certified Birth Certificate or original Certificate of Naturalization or current U.S. Passport or copy of the front and back of your Alien Registration card, Employment Authorization card or Visa. Non Citizens (without the foregoing) submit an Original ITIN assignment letter from the IRS. Please note: Copy of the document authorizing your name change (marriage license, divorce decree, etc.) must be included.

7. Social Security Number _____ Color of Eyes _____ Color of Hair _____ Height _____ Weight _____

NRS 630.197(1)(a) An applicant for the issuance of a license to practice medicine shall include the social security number of the applicant in the application submitted to the Board, however, AB275 (2019) provides that an applicant who does not have a social security number must provide an Individual Taxpayer Identification Number (ITIN) when completing an application for licensure.
NRS 630.165(5) The applicant bears the burden of proving and documenting his qualifications for licensure.

Questions:

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 SIGNED WRITTEN EXPLANATION(S) ON A SEPARATE SHEET ATTACHED TO YOUR COMPLETED APPLICATION FOR LICENSURE FORM.

8. Do you currently have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety?
(If "Yes," attach explanation on separate sheet.) _____ Yes No
9. 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?
(If "Yes," attach explanation on separate sheet.) _____ Yes _____ No N/A
10. 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?
(If "Yes," attach explanation on separate sheet.) _____ Yes _____ No N/A
11. 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?
(If "Yes," attach explanation on separate sheet.) _____ Yes No

Malpractice Questions:

12. Have you EVER 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 No

12a. Have you EVER had a professional liability, malpractice, claim paid on your behalf, or paid such a claim yourself including any military tort claims if applicable? 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 you have not answered "yes" to questions #12 and/or #12a 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/or 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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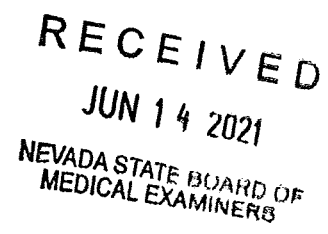
Month and year of lawsuit:

Insurance carrier at time:

What is/or 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:

[Empty rectangular box for providing details of the adverse event]



Arrest Question:

13. 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. _____ Yes No
(If "Yes," attach explanation on separate sheet.)

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Nevada License History:

14. Have you previously applied for medical licensure in Nevada (including in a Residency program)? _____ Yes No
(If "Yes," attach explanation on separate sheet.)

Medical School and Postgraduate Training History:

15. List names and addresses of all medical schools attended. HAVE EACH MEDICAL SCHOOL SUBMIT AN OFFICIAL TRANSCRIPT DIRECTLY TO THE BOARD.

Medical School Name	City/State/Country	Place Where Instruction Received	Dates of Attendance From (Mo./Yr.) To (Mo./Yr.)
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(All information must begin on the application. If more space is needed, please attach separate sheet.)

16. Doctor of Medicine Degree granted by:

Medical School Name	City/State/Country	Exact Date of Issuance (Month/Day/Year)
State University of New York at Buffalo (SUNY at Buffalo)	Buffalo, NY	06/01/1986

17. List all ACGME* approved postgraduate medical education you have received as an Intern, Resident or Fellowship in the United States or Canada.

*Accreditation Council for Graduate Medical Education

Postgraduate Year (e.g. PGY1, PGY2, etc.)	Hospital/ Institution	City/State	Specify (I = Internship or R = Residency) (F = Fellowship)	Type of Specialty	Dates of Attendance From (Mo./Yr.) To (Mo./Yr.)
PGY1	Nassau County Medical Center	East Meadow, NY	R	Radiology	07/1986 – 06/1990
PGY2	UCSD	La Jolla, CA	R	Musculoskeletal Radiology	07/1990 – 06/1991

(All information must begin on the application. If more space is needed, please attach separate sheet.)

18. List non-ACGME Fellowship training or non-ACGME combined postgraduate medical education attended in the United States or Canada.

If combined program list Postgraduate Year (e.g. PGY1, PGY2, etc.)	Hospital/ Institution	City/State	Specify (I = Internship or R = Residency) (F = Fellowship)	Type of Specialty	Dates of Attendance From (Mo./Yr.) To (Mo./Yr.)
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(All information must begin on the application. If more space is needed, please attach separate sheet.)

19. Have you EVER been the subject of an investigation (including matters that resulted in no adverse action or outcome to you), have you resigned, been dismissed, or have any actions, restrictions, limitations, probations, terminations or any other disciplinary actions ever been imposed on you while participating in any type of training program? _____ Yes No
(If "Yes," attach explanation on separate sheet.)

20. If you graduated from a medical school located outside the United States of America or Canada, list your ECFMG#: _____

Examinations:

21. For each of the following licensing examinations, list the location, parts and dates taken, and scores obtained. (Also include failed examinations.) FOR EACH EXAM TAKEN, HAVE CERTIFICATE OF SCORES SUBMITTED FROM THE TESTING ENTITY DIRECTLY TO THE BOARD OFFICE.

21a. STATE Written Examination:

Location

Date (Mo./Yr.)

Results (Scores)

21b. NATIONAL BOARD (not ABMS Board certification): (ALSO INCLUDE ALL INFORMATION PERTAINING TO ANY AND ALL FAILED EXAMS)

Part Taken

Date (Mo./Yr.)

Results (Scores)

NBME Part I

06/01/1984

NBME Part II

04/01/1986

NBME Part III

03/01/1987

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

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21c. FLEX (Federation Licensing Examination): (ALSO INCLUDE ALL INFORMATION PERTAINING TO ANY AND ALL FAILED EXAMS)

Date (Mo./Yr.)

Results (FLEX weighted average)

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

21d. USMLE (United States Medical Licensing Examination): (ALSO INCLUDE ALL INFORMATION PERTAINING TO ANY AND ALL FAILED EXAMS)

Step Taken

Number of Attempts

Date (Mo./Yr.)

Results (Three Digit Scores)

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

21e. LMCC (Licentiate of the Medical Counsel of Canada): (ALSO INCLUDE ALL INFORMATION PERTAINING TO ANY AND ALL FAILED EXAMS)

Part Taken

Date (Mo./Yr.)

Results (Scores)

21f. SPEX (Special Purpose Examination):

Date (Mo./Yr.)

Results (Score)

Specialty:

22. State your scope of practice / specialty(ies) Diagnostic Radiology

23. List any and all certifications and re-certifications by a board or sub-board recognized by the AMERICAN BOARD OF MEDICAL SPECIALTIES (ABMS). INCLUDE ALL INFORMATION PERTAINING TO ANY AND ALL FAILED ATTEMPTS.

ABMS Primary Board

Specialty Board

If you are Lifetime Board Certified, indicate "Lifetime"

Certification #

Dates of Certification and Recertification (Mo./Yr.)

American Board of Radiology

06/1990

Activities:

24. Account for, in **chronological order**, all activities since graduation from medical school. **ALL PERIODS OF TIME MUST BE ACCOUNTED FOR.** Activities include Postgraduate Training, Medical Practice/Physician, Non-Medical (such as seeking employment or vacation), Military Assignment, and Working at a Federal Facility. **Curriculum Vitae cannot be submitted in lieu of your answer to this question.**

Activities	Location (City/State/Country)	From (Mo./Yr.) To (Mo./Yr.)	Percent Clinical (%)
Residency (Radiology)	East Meadow, NY	07/1986 – 06/1990	
Residency (Musculoskeletal Radiology)	La Jolla, CA	07/1990 – 06/1991	
Faculty	Philadelphia, PA	07/1991 – 07/2003	
Faculty	New York, NY	07/2003 – 08/2008	

(All information must begin on the application. If more space is needed, please attach separate sheet.)

25. List below the requested information for all hospitals or surgery centers in which you **ARE, OR HAVE EVER BEEN** a staff member at any level during the last ten years. If none, please indicate. Do not list internship, residency or fellowship affiliation.

Hospital	Complete Mailing Address	Dates of Appointment	
		From (Mo./Yr.)	To (Mo./Yr.)
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(All information must begin on the application, if more space is needed, please attach separate sheet.)

26. List any and all licenses **YOU HOLD OR HAVE HELD** (including postgraduate training/resident licenses) to practice medicine in any state, territory or country. Note: You will not be required to verify your training licenses by direct source.

State/Territory Country	License #	Date of Issuance (Mo./Yr.)	Status
New York	171840	08/1987	Active
California	G65244	03/1989	Cancelled

(All information must begin on the application, if more space is needed, please attach separate sheet.)

Disciplinary Questions:

27. 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? (If "Yes," attach explanation on separate sheet.) ___ Yes No

28. 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? (If "Yes," attach explanation on separate sheet.) ___ Yes No

29. Have you **EVER** voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory in lieu of disciplinary action? (If "Yes," attach explanation on separate sheet.) ___ Yes No

30. Have you **EVER** been denied membership, asked to resign, or expelled from a medical society or other professional medical organization? (If "Yes," attach explanation on separate sheet.) ___ Yes No

31. 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? (If "Yes," attach explanation on separate sheet.) ___ Yes No

32. Have you **EVER** surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? (If "Yes," attach explanation on separate sheet.) ___ Yes No

33. 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.)

(All information must begin on the application, if more space is needed, please attach separate sheet.)

MILITARY SERVICE ATTESTATION CONTINUED

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

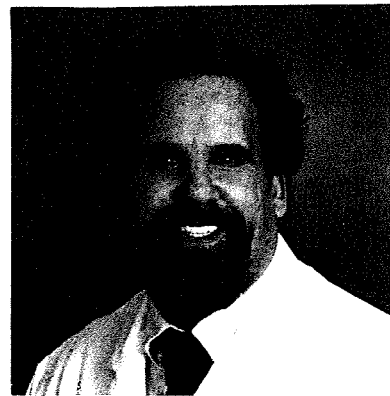
9-Have you ever served the Commissioned Corps of the United States Public Health Service or the Commissioned Corps of the National Oceanic and Atmospheric Administration of the United States in the capacity of a commissioned officer while on active duty in defense of the United States? _____Yes _____No

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? (If you were honorably discharged your answer should be "Yes.") _____Yes _____No _____N/A

APPLICANT PHOTOGRAPH

ATTACH A FINISHED PHOTOGRAPH OF PASSPORT QUALITY OF YOUR HEAD AND SHOULDERS ONLY.

PHOTOGRAPH MUST HAVE BEEN TAKEN WITHIN THE LAST SIX MONTHS AND BE AT LEAST 2" x 2" IN SIZE.



I hereby certify that the attached photograph is a true likeness of me taken within the last six months.

\ Signature of applicant

5/26/21

_____ Date

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APPLICATION AFFIRMATION

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I,

Mark Eliot Schweitzer, 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

5/26/21

(NOTARY SEAL)

State of Michigan County of Wayne
Subscribed and sworn to before me this 26 day of May, 2021
Notary Public for the State of Michigan
My Commission Expires: March 25, 2028
Residing at: Detroit MI
City State
Catherine M Martone
Signature of Notary

END OF APPLICATION