

Demographic Details

First Name

Robert

Middle Name

Evan

Last Name *

Share

Previous Name(s)

Social Security Number

Tax Identification Number

Height

Hair Color

Is this person deceased?

Yes No

Date Deceased

Gender

Male

Date of Birth

1955

Name Suffix

City of Birth

USA

Place of Birth

Weight (in lbs)

Eye Color

Comments (non-public information)

Public Information

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

#

Fax

#

Public Address

Street Address

600 N. Lake Shore Drive

Address Line 2

City

CHICAGO

County

COOK

ZIP / Postal Code

60611-5061

State / Province

Illinois

Country

United States



Is your physical address different from your mailing address?

Yes No

Public Phone

#

(847) 347-7914

Mailing Address

Street Address

Address Line 2

ZIP / Postal Code (Mailing)

City (Mailing)

State / Province (Mailing)

County (Mailing)

County (Mailing)

Application Status

Applicant *

Application Number

License Issued?

Yes No

Application Status

Assigned To

Manual Paper Application?

Yes No

License ID Card Conditions (max 120 characters)

License Details (Pre-Approval)

License Category

Obtained By

Expected Issue Date

Credentials / Degree Suffix (Enter before approval!)

Expected Expiration Date

Application Details

Application Type

Application Date *

Reviewed Date

Decision Date

Submitted Date



Approved Date



Application Step

#

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



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

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

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

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

Examinations

Licensee / Applicant	Examination Type	Attended Date ↑
Share, Robert Evan	National Board of Medical Examiners (NBME)	Jun-07-1983
Share, Robert Evan	National Board of Medical Examiners (NBME)	Apr-02-1985
Share, Robert Evan	National Board of Medical Examiners (NBME)	Mar-05-1986

Examination Details

Licensee / Applicant *


Attended Date

Number of Attempts

#


Application

Location

Result

Examination Type

Other Exam

Are you currently certified?

Yes No

Steps

Certificate Number

Exam Date

Expiration Date

Examination Details

Licensee / Applicant *


Attended Date

Number of Attempts

#

Application

Location

Result

Examination Type

Other Exam

Are you currently certified?

Yes No

Steps

Certificate Number

Exam Date

Expiration Date

Examination Details

Licensee / Applicant *


Attended Date

Number of Attempts

#

Application

Location

Result

Examination Type

Other Exam

Are you currently certified?

Yes No

Steps

Certificate Number

Exam Date

Expiration Date

Board Certification

Licensee / Applicant	▼	Certifying Board	▼	Other Certifying Board	▼	Specialty	▼
Share, Robert Evan		American Board		N/A		Radiology	

Board Certification Details

Licensee / Applicant

Specialty

Certifying Board

Other Certifying Board

Initial Certification Date

Recertification Date


Certification Number

Archive Program

Historical Specialty

Connected Record

Application



 

Education

Licensee/Applicant ▼	Education Type ▼	Name of School ▼	Degree Attained ▼	Date From ▼	Date To ▼	Graduation
Share, Robert Evan	Medical School	Rosalind Franklin University of Medicine and Science	Medical Doctor Degree	Aug-03-1981	Jun-14-1985	Jun-14-1985

Education Details

Licensee/Applicant *

Address

City

State / Province

Zip / Postal Code

Country

Application

Specialty Type



  

Name of School

Education Type

Degree Attained

Date From

Date To

Did you graduate from the program?

Yes No

Graduation Date

Major Program

Postgraduate Training

Licensee / Applicant ▼	Name of School or Institution ▼	Specialty Type ▼	Date From ▼	Date To ↑ ▼	Program Type
Robert Share	University of Cincinnati Medical Center	Obstetrics / Gynecology	Jul-01-1985	Feb-29-1988	Residency
Robert Share	Rush University Medical Center Program	Oncology, Radiation	Jul-01-1988	Jun-30-1991	Residency

Postgraduate Training Details

Licensee / Applicant *

Program Type *

Date From

Name of School or Institution

Specialty Type

Other (Specialty)

Training Status *


Accreditation Type

Date To

Application

Historical Major Program

Historical Degree Attained

Location Details

City

State / Province

County

Street Address 1


Zip / Postal Code

Country


 

Postgraduate Training Details

Licensee / Applicant *

Program Type *

Date From

Name of School or Institution

Specialty Type

Other (Specialty)

Training Status *


Accreditation Type

Date To

Application

Historical Major Program

Historical Degree Attained

Location Details

City

Street Address 1

State / Province

Zip / Postal Code

County

Country

Other Licenses

Licensee/Applicant ▼	License Number ▼	License Type ▼	Issue Date ▼	Expiration Date ▼	State / Province ↑ ▼
Share, Robert Evan	G167821	N/A	Feb-07-2020	Feb-29-2024	California
Share, Robert Evan	36076990	N/A	May-11-1988	Jul-31-2026	Illinois
Share, Robert Evan	MD60952583	N/A	Jul-27-2019	Jul-21-2024	Washington
Share, Robert Evan	TD60969452	Temporary	May-28-2019	Jul-27-2019	Washington

Other License Details

Licensee/Applicant

Licensing Board or Regulatory Authority

License Number

State / Province

Country

Application

License Type

License Status

Issue Date

Expiration Date

Notes

Other License Details

Licensee/Applicant

Licensing Board or Regulatory Authority

License Number

State / Province

Country

Application

License Type

License Status

Issue Date

Expiration Date

Notes

Other License Details

Licensee/Applicant

Licensing Board or Regulatory Authority


License Number

State / Province

Country

Application

License Type

License Status

Issue Date

Expiration Date

Notes

Other License Details

Licensee/Applicant

Share, Robert Evan 

Licensing Board or Regulatory Authority

Washington Medical Commission

License Number

TD60969452


State / Province

Washington

Country

United States 

Application

Application - - Share, Robert Evan 

License Type

Temporary

License Status

Expired

Issue Date

May-28-2019 

Expiration Date

Jul-27-2019 

Notes

Activities

Licensee / Applicant	Name of Organization / Institution	Start Date	End Date	Percent Clinical
Robert Share	University of Cincinnati Medical Center/College of Medicine Program	Jul-01-1985	Feb-29-1988	100
Robert Share	Time off for marriage and moving	Mar-01-1988	Jul-01-1988	0
Robert Share	Rush University Medical Center Program	Jul-01-1988	Jun-30-1991	100
Robert Share	Associated Urological Specialists	Aug-01-2008	Feb-26-2018	100
Robert Share	Retirement	Feb-26-2018	Mar-01-2019	0
Robert Share	Stephen William Doggett MD PA	Mar-02-2019	Mar-17-2023	100

Application Activity Details

Licensee / Applicant


Start Date


Percent Clinical *

#

Application

Name of Organization / Institution

End Date

Position

Activity Type

Location Details

Street Address 1

City

Country

State / Province

Zip / Postal Code

Application Activity Details

Licensee / Applicant

Name of Organization / Institution

Start Date


End Date

Percent Clinical *

Position

Application

Activity Type

Location Details

Street Address 1

Country

City

State / Province

Zip / Postal Code

Application Activity Details

Licensee / Applicant

Name of Organization / Institution

Start Date

End Date



 

Percent Clinical *

#

Position

Application

Activity Type

Location Details

Street Address 1

Country

City

State / Province

Zip / Postal Code

Application Activity Details

Licensee / Applicant

Name of Organization / Institution

Start Date

End Date


 

Percent Clinical *

#

Position

Application

Activity Type

Location Details

Street Address 1

Country

City

State / Province

Zip / Postal Code

Application Activity Details

Licensee / Applicant

Share, Robert Evan 


Start Date

Feb-26-2018 

Percent Clinical *

0

Application

Application - - Share, Robert Evan 

Name of Organization / Institution

Retirement

End Date

Mar-01-2019 

Position

Activity Type

Vacation 

Location Details

Street Address 1

City

Chicago

Country

United States 

State / Province

Illinois

Zip / Postal Code

Application Activity Details

Licensee / Applicant

Share, Robert Evan



Start Date

Mar-02-2019



Name of Organization / Institution

Stephen William Doggett MD PA

End Date

Mar-17-2023



Percent Clinical *

100

Position

Application

Application - - Share, Robert Evan



Activity Type

Medical Practice/Physician



Location Details

Street Address 1

20341 SW Birch St #330

Country

United States



City

Newport Beach

State / Province

California

Zip / Postal Code

92660

Specialty

Licensee / Applicant	▼	Specialty Type	▼	Primary Specialty?	▼	Effective Date	▼	End Date
Share, Robert Evan		Oncology,Radiation		Yes		Jun-30-1991		N/A

Specialty Details



Licensee / Applicant *

Share, Robert Evan  

Effective Date

Jun-30-1991 



Application

Application - - Share, Robert Evan  

Primary Specialty?

Yes No

Specialty Type *

Oncology,Radiation  

Other (Specialty)

End Date



Declarations

Ordinal ↑ ▼	Licensee/Applicant ▼	Declaration Question ▼	Answer ▼	Answer Details ▼
1	Robert Share	MD, PA – Q1 – Medical Condition Impair Safe Practice	No	
2	Robert Share	MD, PA – Q2 – Medical Condition Field of Practice	No	
3	Robert Share	MD, PA – Q3 – Chemical Substances Impair Safe Practice	No	
4	Robert Share	MD, PA, LL – Q4 – Performance of Public Service Requirement	No	
5	Robert Share	ALL – Q5 – Named Defendant Respond to Legal Action	No	
6	Robert Share	ALL – Q6 – Malpractice Claim Paid	No	
7	Robert Share	ALL – Q7 – Arrest Question	No	
8	Robert Share	MD, Previously applied for licensure In Nevada.	Yes	
9	Robert Share	MD – Investigation Disciplinary during Training Program	Yes	
10	Robert Share	MD – Q8 – Denied License / Permission to Practice Medicine	Yes	
11	Robert Share	MD – Q9 – Medical License Revoked	No	
12	Robert Share	MD – Q11 – Voluntarily Surrendered a License	No	
13	Robert Share	MD – Q12 – Denied Membership	No	
14	Robert Share	MD – Q13 – Investigation – Respond To/Notify Of	Yes	
15	Robert Share	MD, PA – Q10 – Controlled Substance Registration	No	
16	Robert Share	MD, PA, CCP, Hospital Privileges Denied, Suspended.	No	

Declaration

Licensee/Applicant

Share, Robert Evan 

Declaration Question

MD, Previously applied for licensure in Nevada. 

Answer

Yes No

Answer Details

Ordinal


8

Declaration Text

Have you previously applied for medical licensure in Nevada, including in a Residency program? (If "Yes," please explain)

Related To

Application

Application - - Share, Robert Evan 

Renewal



Declaration

Licensee/Applicant

Share, Robert Evan 

Declaration Question

MD – Investigation Disciplinary during Training Program 

Answer

Yes No

Answer Details

Ordinal


9

Declaration Text

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?

Related To

Application

Application - Share, Robert Evan 

Renewal



Declaration

Licensee/Applicant

Share, Robert Evan 

Declaration Question

MD – Q8 – Denied License / Permission to Practice Medicine 

Answer

Yes No

Answer Details

Ordinal


10

Declaration Text

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?

Related To

Application

Application - - Share, Robert Evan 

Renewal



Declaration

Licensee/Applicant

Share, Robert Evan 

Declaration Question

MD – Q13 – Investigation – Respond To/Notify Of 

Answer

Yes No

Answer Details

Ordinal

14

Declaration Text

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?

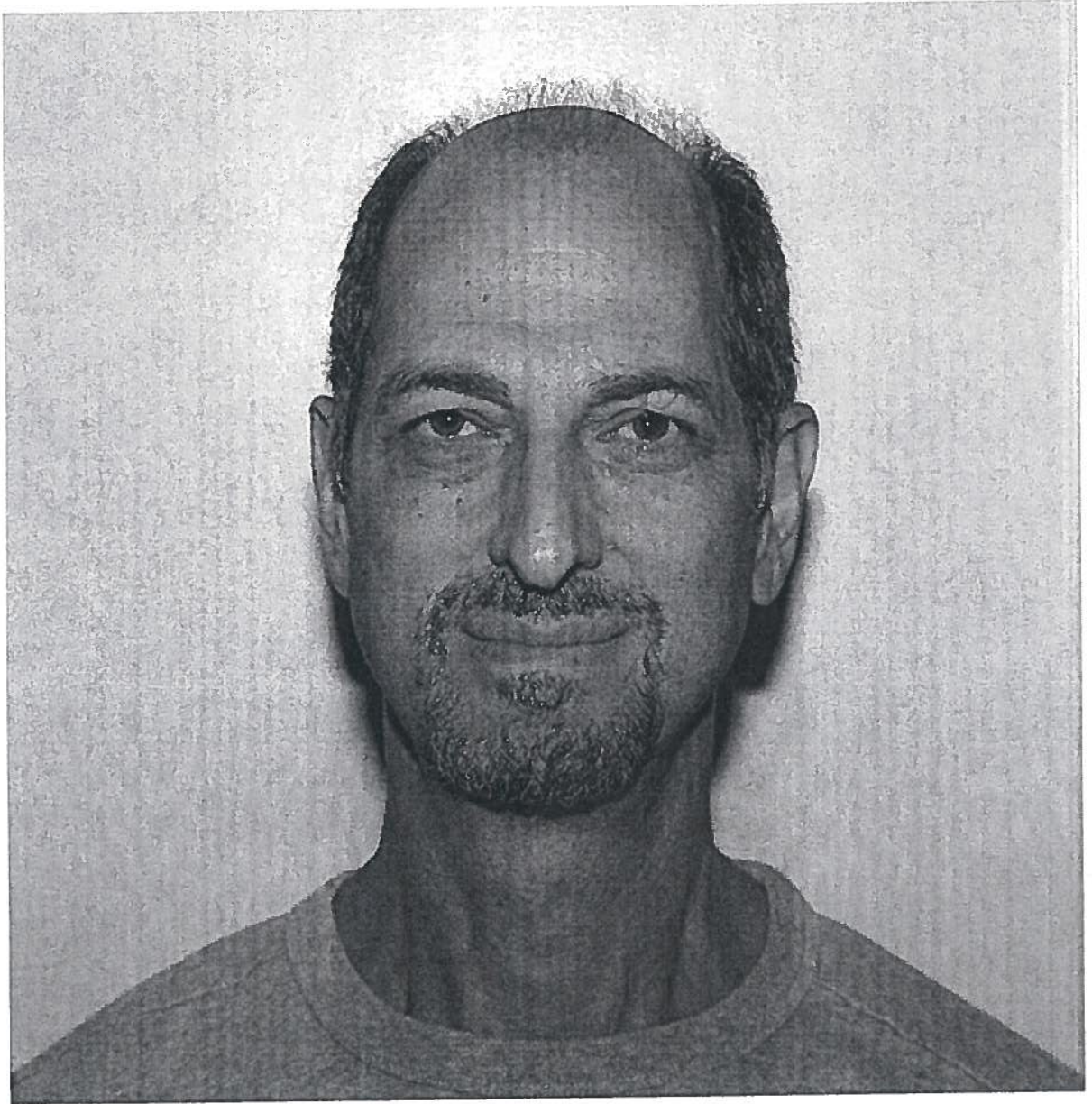
Related To

Application

Application - - Share, Robert Evan 

Renewal





REQUEST FOR LICENSURE BY ENDORSEMENT

RECEIVED

(ENDORSEMENT IS NOT THE SAME AS RECIPROCITY)

MAR 24 2023

State your Name, and fill in the state, territory, or District of Columbia in which licensed. NEVADA STATE BOARD OF MEDICAL EXAMINERS

I, Robert Evan Share, being first duly sworn, do hereby swear or affirm under the penalties of perjury that the statements contained herein are true and correct to the best of my knowledge.

That I am now, and have been continuously, licensed to practice medicine by the licensing agency of Washington, since 07/27/2019. (state, territory, or District of Columbia) (month / day / year)

That I have never had a license to practice any type of medicine in any jurisdiction, country, state, territory, or District of Columbia, revoked for gross medical negligence.

That I am the person named in the license to practice medicine in Washington (state, territory, or District of Columbia)

and that said license to practice medicine was obtained by me without fraud or misrepresentation or any mistake of which I am aware, and that all information contained in this application for licensure by Endorsement, and any accompanying materials, are complete and correct.

DATED this 16 day of March, 2023.

Signature: _____

Typed or Printed Name: Robert Evan Share

State of California County of Sacramento

Subscribed and sworn to before me this 16th day of March, 2023.

Notary Public for the State of California

My Commission Expires: 03/25/2026

Residing at: Sacramento California City State

[Signature] Signature of Notary

(NOTARY SEAL)



Please return completed form to:

Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521

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.

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 Robert Share

Sign your name _____

Date March 22, 2023

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.