Demographic Details

First Name	Gender	
Louis	Male	- A
Middle Name	Date of Birth	
Steven	1965	ä
Last Name ≠	Name Suffix	
DeLuca		
Previous Name(s)	City of Birth	
Social Security Number	Place of Birth	
Tax Identification Number	Weight (in lbs)	
Height	Eye Color	
Hair Color	Comments (non-public informa	ation)
	Public Information	
Is this person deceased?		
○ Yes ○ No		
Date Deceased		
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?	SPL?	
○ Yes ○ No	○ Yes ○ No	
	Date of SPL Issuance	
	ä	
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	
15639 Glencrest Avenue	33446	
Address Line 2	State / Province	
	Florida	
City	Country	
Delray Beach	United States	
County	Is your physical address different from your mailing address?	
Palm Beach	○ Yes No	
	Public Phone	
	# (561) 573-7251	

Mailing Address

Street Address	City (Mailing)
Address Line 2	State / Province (Mailing)
ZIP / Postal Code (Mailing)	County (Mailing)
	County (Mailing)

Application Status



Are you the spouse of an active duty member or su a veteran?	urviving spouse of	
○ Yes ○ No		
Invoices		
Application Invoice		Application Payment Date
y I	7	ä
Licensure Invoice		Licensure Payment Date
9		ā
Attestations I hereby attest to knowledge of and compliance with of the Centers for Disease Control and Prevention prevention of transmission of infectious agents through appropriate injection practices. I also attest that any currently, or will be under my control as their super the future, and who is not licensed pursuant to Chan Nevada Revised Statutes and whose duties involve practices, has knowledge of and is in compliance who of the Centers for Disease Control and Prevention prevention of transmission of infectious agents through the control injection practices. Yes No	concerning the bugh safe and y person who is rvising physician in apter 630 of the elinjection with the guidelines concerning the bugh safe and	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 service of process as defined under Nevada Revise 630.344, via electronic mail (more commonly know Further, should the electronic mail address provide for any reason, I agree to apprise the Board in writing electronic mail address within 30 days after the characteristics.	ed Statute (NRS) vn as e-mail). ed below change ing of my new	Child Support Attestation Type Subject to a court order and in compliance I have read this responsibility statement and understand that I alone am accountable for completing my application for medical licensure in Nevada.
The answers to the foregoing questions and stater above application, as well as any and all further excontained on any separate attached pages, are trull am the person named in the credentials to be subthe same were procured in the regular course of in examination without fraud or misrepresentation. It amy of my responses on this application are false, fimisleading, inaccurate, or incomplete, my application will be denied. I am responsible to keep the Board circumstance or event that would require a change responses provided to the Board in my application.	planations te and correct, that comitted, and that instruction and understand that if fraudulent, ion for licensure I informed of any te to my initial	 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

which occurs prior to my being granted licensure to practice

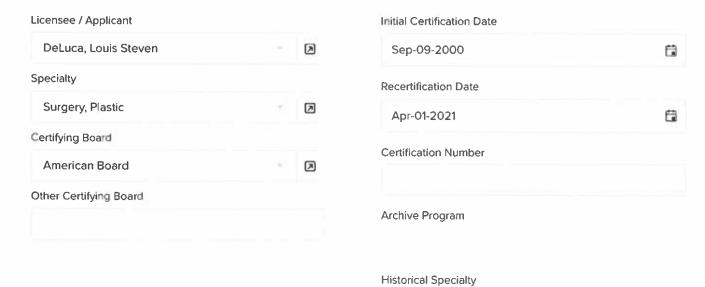
medicine in the state of Nevada.

Yes ○ No

Board Certifications

Licensee / Applicant	Certifying Board	▼ Other Certifying Box	rd ▼ Specialty	▼ Initial Certificatio	n Date Y Recertification Date	T
DeLuca, Louis Steven	American Board	N/A	Surgery. Plastic	Sep-09-2000	Apr-01-2021	

Board Certification Details



Connected Record

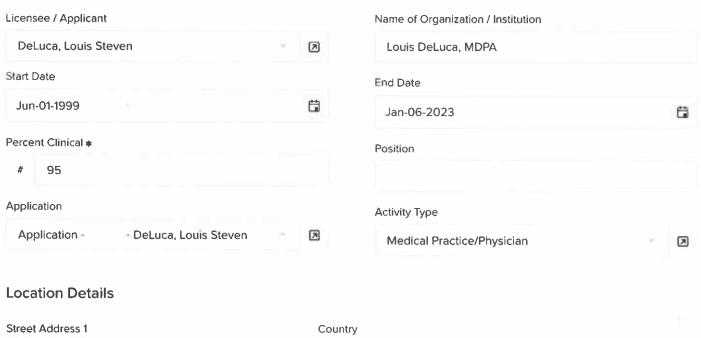


Application - - DeLuca, Louis Steven

Activities

Licensee / Applicant	T	Name of Organization / Institution	T	Start Date	T	End Date	Ŧ	Percent Clinical	
DeLuca, Louis Steven		Louis DeLuca, MDPA		Jun-01-1999		Jan 06 2023		95	

Application Activity Details





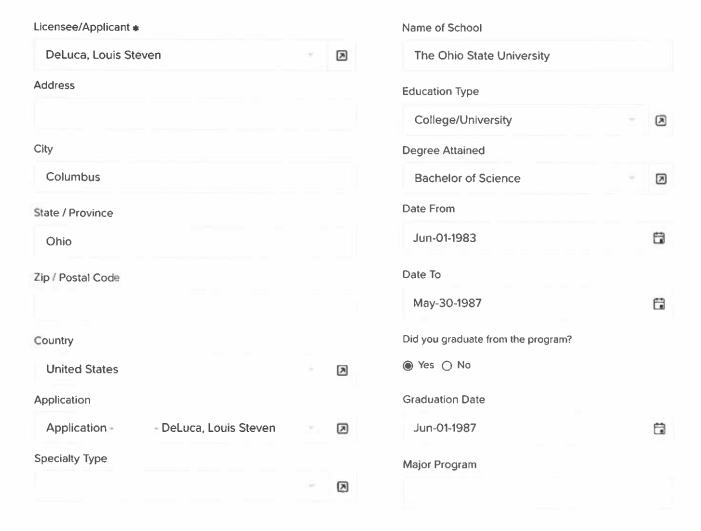
Declarations

Ordinal † T	Licensee/Applicant	T Declaration Question T Answer T Answer Details
1	Louis DeLuca	MD, PA – Q1 – Medical Condition Impair Safe Practice
2	Louis DeLuca	MD, PA = Q2 = Medical Condition Field of Practice
3	Louis DeLuca	MD, PA – Q3 – Chemical Substances Impair Safe Practice No
4	Louis DeLuca	MD. PA, LL = Q4 - Performance of Public Service Requirement No
5	Louis DeLuca	ALL – Q5 – Named Defendant Respond to Legal Action No
6	Louis DeLuca	ALL - Q6 - Malpractice Claim Paid No
7	Louis DeLuca	ALL – Q7 – Arrest Question No
8	Louis DeLuca	MD – QB – Denied License / Permission to Practice Medicine No
9	Louis DeLuca	MD = Q9 = Medical License Revoked No S
10	Louis DeLuca	MD, PA – Q10 – Controlled Substance Registration No
11	Louis DeLuca	MD – Qt1 – Voluntarily Surrendered a License
12	Louis DeLuca	MD = Q12 = Denied Membership No
13	Louis DeLuca	MD – Q13 – Investigation – Respond To/Notify Of No
14	Louis DeLuca	MD = Investigation Disciplinary during Training Program No
N/A	Louis DeLuca	MD, Previously applied for licensure in Nevada. No
N/A	Louis DeLuca	MD, PA, CCP, Hospital Privileges Denied, Suspended No

Education

Licensee/Applicant	Education Type 🔻	Name of School	Degree Attained 🔻	Date From	Ŧ	Date To †	T	Graduation Date
Louis DeLuca	College/University	The Ohie State University	Bachelor of Science	Jun-01-1983		May-30-1987		Jun-01-1987
Louis DeLuca	Graduate	The Ohio State University	Added Qualifications	Jun-01-1987		May-31-1988		Jun-01-1988
DeLuca, Louis Steven	Medical School	Case Western Reserve University	Medical Doctor Degree	Aug-01-1988		May-24-1992		May-24-1992

Education Details



Education Details

Licensee/Applicant *				Name of School		
DeLuca, Louis Steve	en	- 5	A	The Ohio State University		
Address				Education Type		
				Graduate	5	Ø
City				Degree Attained		
Columbus				Added Qualifications	-	2
State / Province				Date From		
Ohio				Jun-01-1987		
Zip / Postal Code				Date To		
				May-31-1988		
Country				Did you graduate from the program?		
United States			2	Yes ○ No		
Application				Graduation Date		
Application -	- DeLuca, Louis Steven	×	7	Jun-01-1988		
Specialty Type				Major Program		
		N	2			

Education Details

Licensee/Applicant #			Name of School					
DeLuca, Louis Stev	en	7	Case Western Reserve University	Case Western Reserve University				
Address			Education Type					
			Medical School		Ø			
City			Degree Attained					
Cleveland			Medical Doctor Degree	Ψ.	7			
State / Province			Date From					
Ohio			Aug-01-1988					
Zip / Postal Code			Date To					
			May-24-1992					
Country			Did you graduate from the program?					
United States		2	Yes ○ No					
Application			Graduation Date					
Application -	- DeLuca, Louis Steven	- 3	May-24-1992					
Specialty Type			Major Program					
		7						

Examinations

Licensee / Applicant	7	Examination Type	T	Attended Date
DeLuca, Louis Steven		Federation Licensing Examination (FLEX)		Jun-16-1992

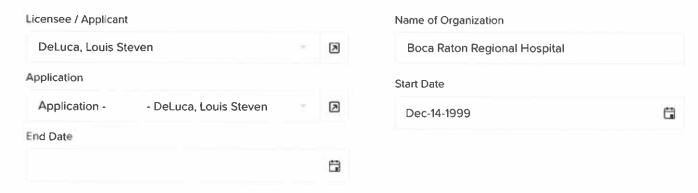
Examination Details

Licensee / Applicant *		Examination Type		
DeLuca, Louis Steven	A	Federation Licensing Examination (FLEX)	v	A
Attended Date		Other Exam		
Jun-16-1992				
Number of Attempts		Are you currently certified?		
# 1		○ Yes ○ No		
Application		Steps		
Application DeLuca, Louis Steven	A	1		
Location		Certificate Number		
New York				
Result		Exam Date		
Comp 1: 80 Comp 2: 82				
		Expiration Date		

Hospitals

						7	
Licensee / Applicant	T	Name of Organization	7	Start Date	7	End Date	
Louis DeLuca		Boca Ratum Regional Hospital		Dec-14-1999		N/A	
Louis DeLuca		Delray Medical Center		Dec-14-1999		N/A	
		1885					

Hospital Details



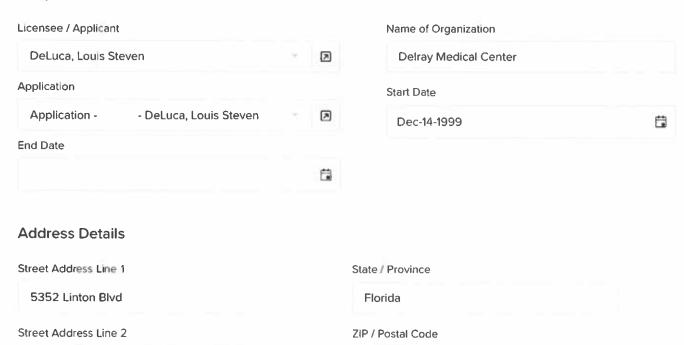
Address Details



Hospital Details

City

Delray Beach



33484

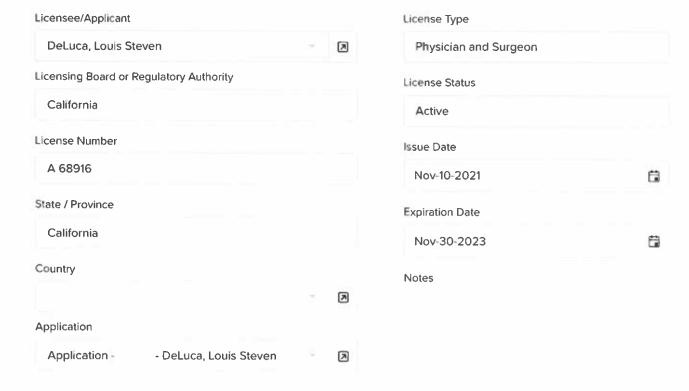
United States

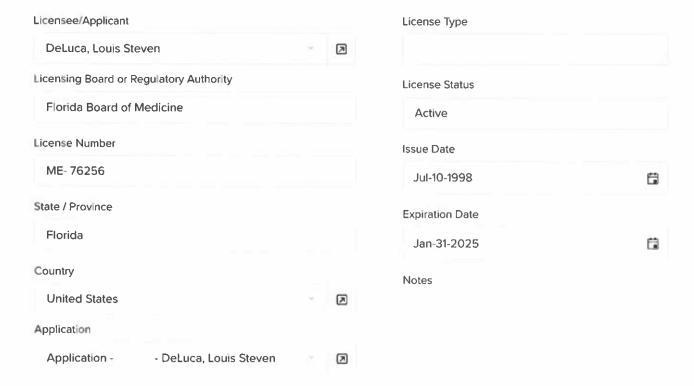
Ø

Country

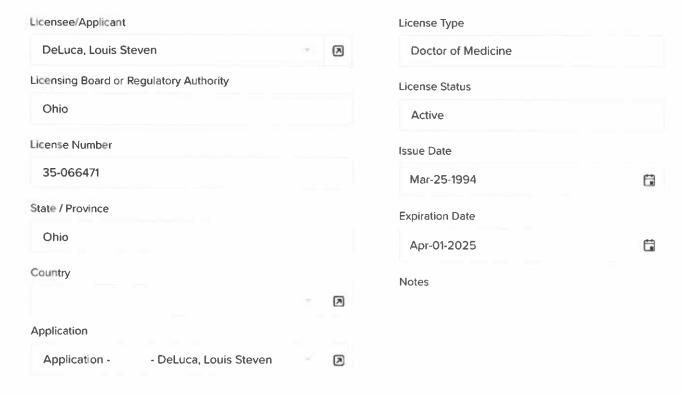
Other Licenses

Licensee/Applicant	Ŧ	License Number	Ŧ	License Type	T	Issue Date	т	Expiration Date	T	State / Province †
DeLuca, Louis Steven		A 68916		Physician and Surgeon		Nov-10-2021		Nov-30-2023		California
DeLuca, Louis Steven		ME- 76256		NIA		Jul 10-1998		Jan-31-202\$		Florida
DeLuca, Louis Steven		194574		Medical Doctor		Jan 03-1994		Apr-30-2025		New York
DeLuca, Louis Steven		35-066471		Doctor of Medicine		Mar-25-1994		Apr-01-2025		Ohio



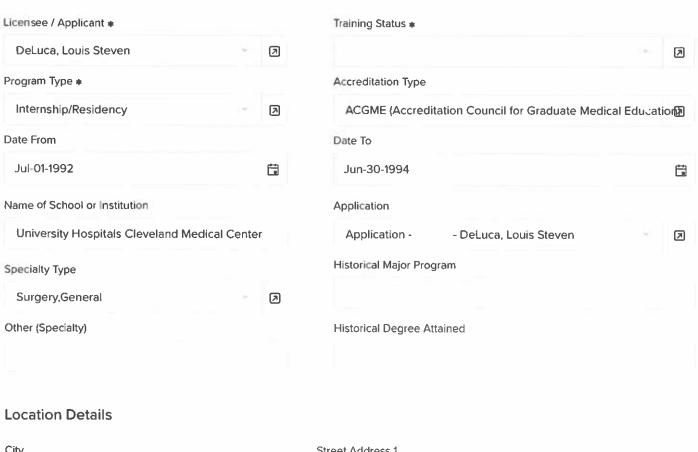


Licensee/Applicant License Type DeLuca, Louis Steven Ø **Medical Doctor** Licensing Board or Regulatory Authority License Status New York Active License Number Issue Date 194574 Jan-03-1994 State / Province **Expiration Date** New York Apr-30-2025 Country Notes Ø Application - DeLuca, Louis Steven Application -Ø

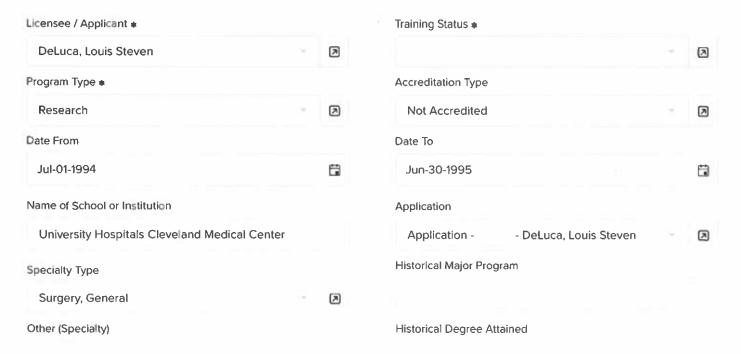


Postgraduate Training

Licensee / Applicant	T	Name of School or Institution	Specialty Type	Ŧ	Date From	•	Date To †	T	Program Type
DeLuca, Louis Steven		University Hospitals Cleveland Medical Center	Surgery,General		Jul 01 1992		Jun-30-1994		Internship/Residency
DeLuca, Louis Steven		University Hospitals Cleveland Medical Center	Surgery, General		Jul-01-1994		Jun-30-1995		Research
DeLuca, Louis Steven		University Hospitals Cleveland Medical Center	Surgery, General		Jul-01-1995		Jun-30-1996		Residency
DeLuca, Louis Steven		USF Morsani College of Medicine	Surgery, Plastic		Jul-01-1996		Jul-31-1999		Residency

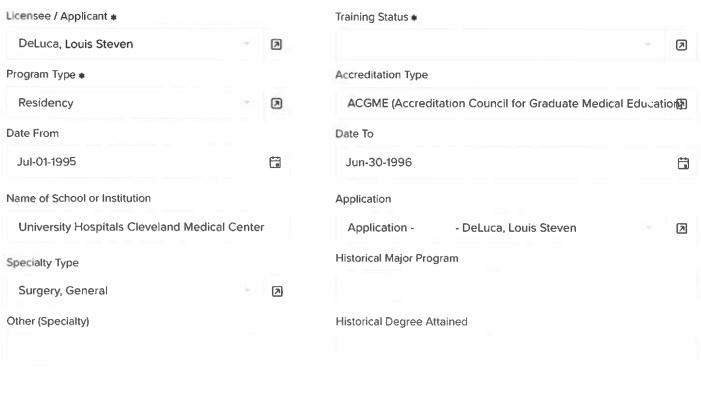






Location Details





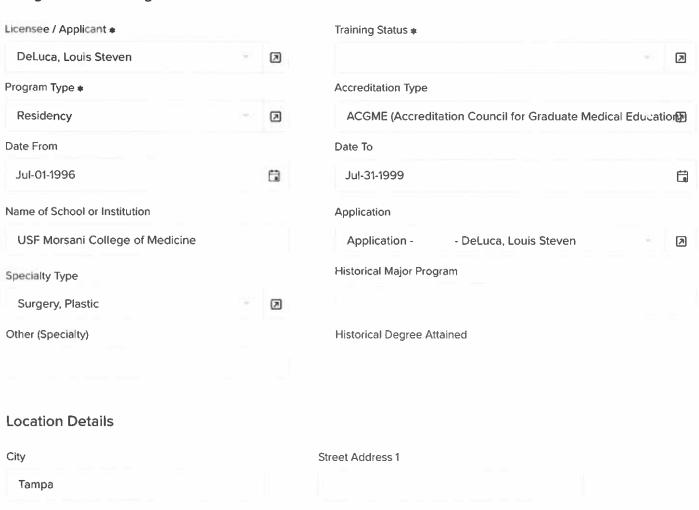
Location Details

City		Street Address 1
Cleveland		
State / Province		Tin / Doctol Code
		Zip / Postal Code
Ohio		
County		Country
	2	2

State / Province

Florida

County



Zip / Postal Code

75

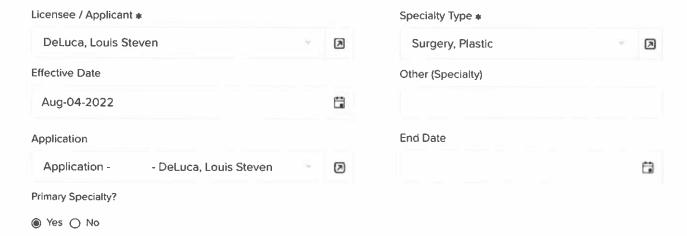
Country

Z

Specialties

Licensee / Applicant	7	Specialty Type	Primary Specialty?	T	Effective Date	T	End Date	
DeLuca, Louis N/A		Surgery, Plastic	Yes		Aug-04-2022		N/A	

Specialty Details



DEC 0 5 2022

NEVADA STATE BOARD OF MEDICAL EXAMINERS

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.

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 Long DELuca
Sign your name
Date 11/05/2000

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.

