## **Demographic Details**

First Name	Gender	
Luke	Male	- 3
Middle Name	Date of Birth	
Travis	1993	ä
Last Name *	Name Suffix	
Babcock		
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 inform	ation)
	Public Information .	
Is this person deceased?		
O Yes O No		
Date Deceased		
Do you have a Nevada Business License in your individual name?		
○ Yes ○ No		
Nevada BIN		
Historical File Number		

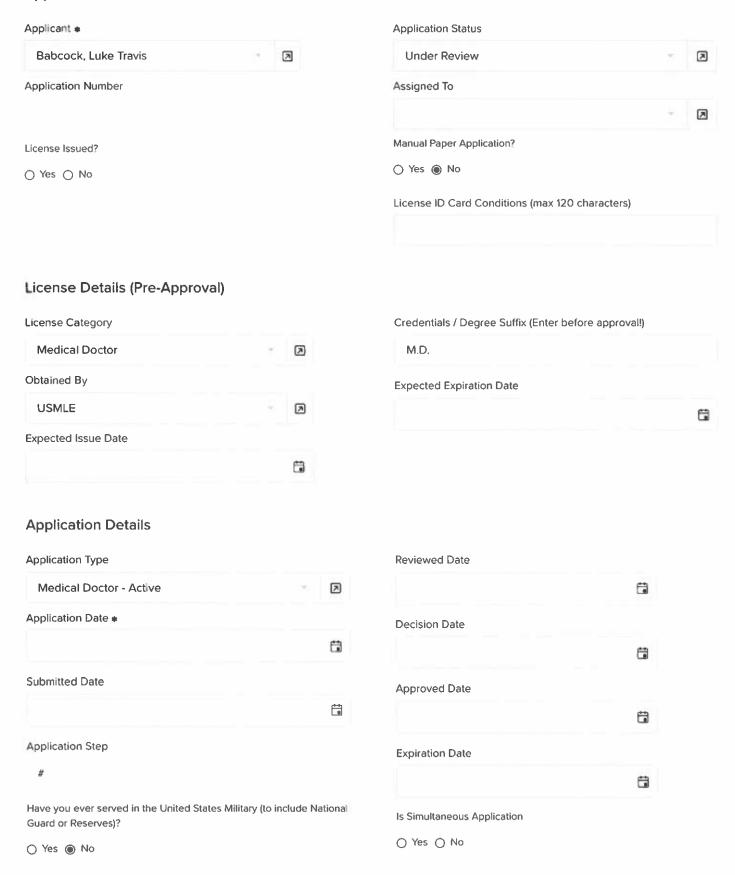
## Military Detail

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
Contact Information	
Primary Phone	Secondary Phone
#	#
Primary Phone Extension	Secondary Phone Extension
Primary E-mail Address	Mail should be directed to
	- A
Cell Phone	Fax
#	*
Public Address	
Street Address	ZIP / Postal Code
2351 N Williamson Blvd #1104	32117
Address Line 2	State / Province
	Florida
City	Country
Daytona Beach	United States
County	ls your physical address different from your mailing address?
Volusia	○ Yes   No
	Public Phone
	# (850) 619-6431

## **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 surviving spouse of a veteran?	
O Yes O No	
Invoices	
Application Invoice	Application Payment Date
<b>7</b>	ä
Licensure Invoice	Licensure Payment Date
- Z	
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.	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.  Per 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 mall address within 30 days after the change.	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.
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	<ul> <li>Yes No</li> <li>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.</li> <li>Yes No</li> </ul>

responses provided to the Board in my application for licensure, and which occurs prior to my being granted licensure to practice medicine

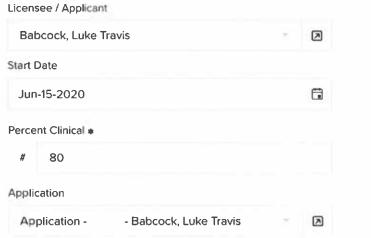
in the state of Nevada.

Yes ○ No

#### Activities

Licensee / Applicant	Ŧ	Name of Organization / Institution	Ţ	Start Date	7	End Date	▼	Percent Clinical	
Luke Babcock		Halifax Health Family Medicine Program		Jun-15-2020		\$ep-01-2023		80	

### **Application Activity Details**





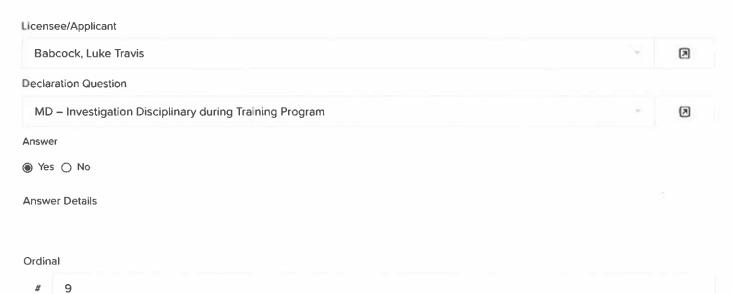
#### **Location Details**



#### Declarations

Ordinal † T	Licensee/Applicant	Declaration Question	Ŧ	Answer	T	Answer Details
1	Luke Babcock	MD, PA — Q1 — Medical Condition Impair Safe Practice		No		
2	Luke Babcock	MD, PA – Q2 – Medical Condition Field of Practice		No		
3	Luke Babcock	MD, PA – Q3 – Chemical Substances Impair Safe Practice		No		
4	Luke 8abcock	MD, PA, LL = O4 - Performance of Public Service Requirement		No		
5	Luke Babcock	ALL – Q5 – Named Defendant Respond to Legal Action		No		
6	Luke Babcock	ALL = Q6 = Malpractice Claim Paid		No		
7	Luke Babcock	ALL – Q7 – Arrest Question		No		
8	Luke Bebcock	MD, Previously applied for licensure in Nevada.		No		
9	Babcock, Luke Travis	MD – Investigation Disciplinary during Training Program		Yes		
10	Luke Bebcock	MD = Q8 = Denied License / Permission to Practice Medicine		No		
11	Luke Babcock	MD – Q9 – Medical License Revoked		No		
12	Luke Beboock	MD = Q11 - Voluntarily Surrendered a License		No		
13	Luke Babcock	MD – Q12 – Denied Membership		No		
14	Luke Babcock	MD = Q13 = Investigation = Respond To/Notify Of		No		
15	Luke Babcock	MD, PA - Q10 - Controlled Substance Registration		No		
16	Luke Babcock	MD. PA. CCP, Hospital Privileges Denied, Suspended.		No		

#### **Declaration**



#### **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?

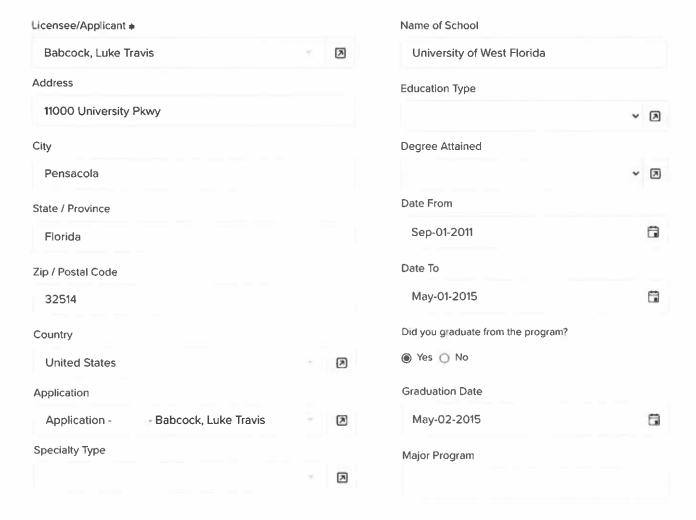
#### Related To



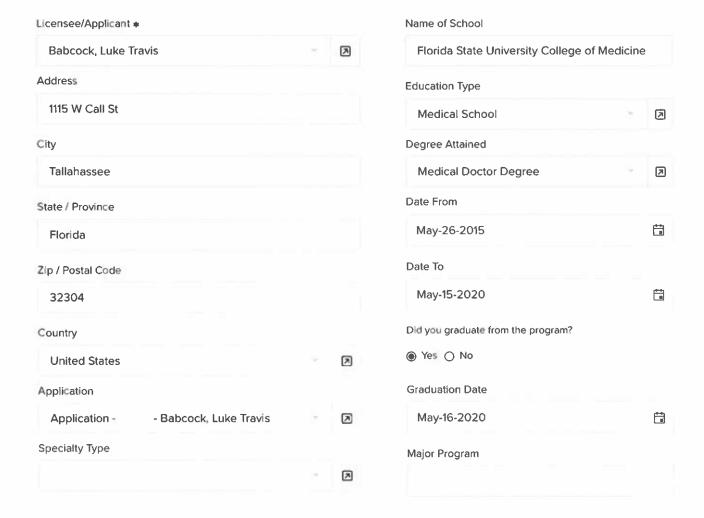
#### Education

Licensee/Applicant	Ŧ	Education Type	7	Name of School	т	Degree Attained	Ŧ	Date From	т	Date To †	T	Graduation Date
Babcock, Luke Travis		College/University		University of West Florida		Bachelor of Science		Sep-01-2011		May-01-2015		May-02-2015
Babcock, Luke Travis		Medical School		Florida State University College of Medicine		Medical Doctor Degree		May-26-2015		May-15-2020		May-16-2020

#### **Education Details**

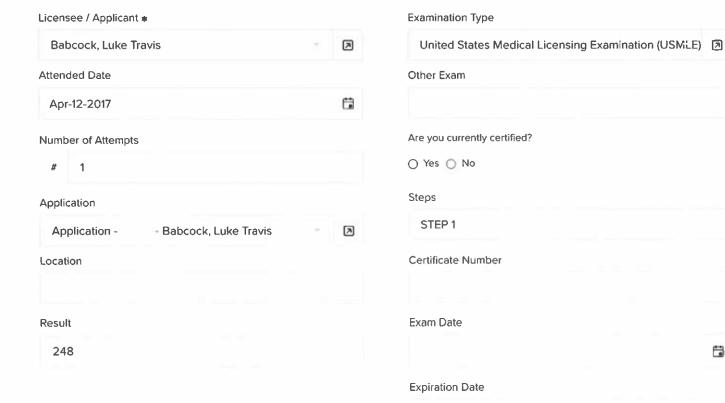


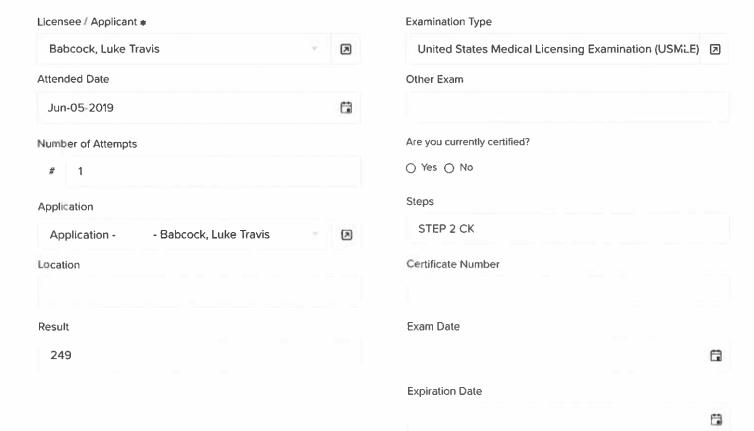
#### **Education Details**

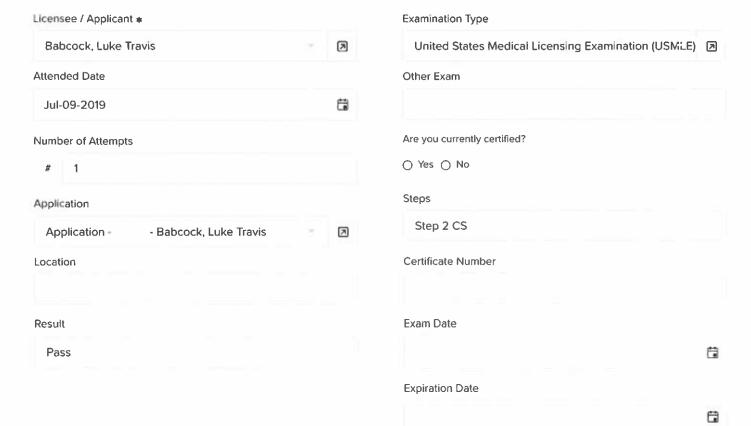


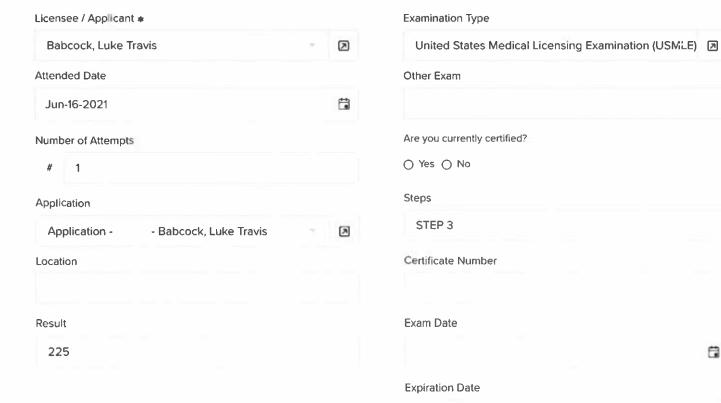
#### Examinations

Licensee / Applicant	Ŧ	Examination Type	T	Attended Date †
Babcock, Luke Travis		United States Medical Licensing Examination (USMLE)		Apr-12-2017
Babcock, Luke Travis		United States Medical Licensing Examination (USMLE)		Jun-05-2019
Babcock, Luke Travis		United States Medical Licensing Examination (USMLE)		Jul-09-2019
Babcock, Luke Travis		United States Medical Licensing Examination (USMLE)		Jun-16-2021





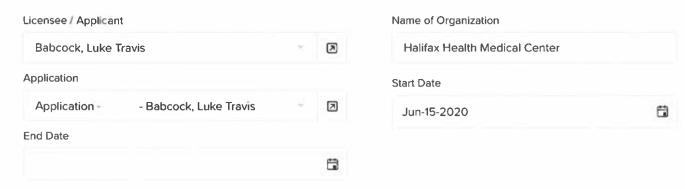




## Hospitals

Licensee / Applicant	T	Name of Organization	Ŧ	Start Date	т	End Date
Luke Babcock		Halifax Health Medical Center		Jun-15-2020		N/A

## **Hospital Details**



#### **Address Details**



## Other Licenses

Licensee/Applicant	T	License Number	T	License Type	7	Issue Date †	Ŧ	Expiration Date	T	State / Province	
Luke Babcock		ME 154036		N/A		Dec-07-2021		Jan 31-2024		Florida	

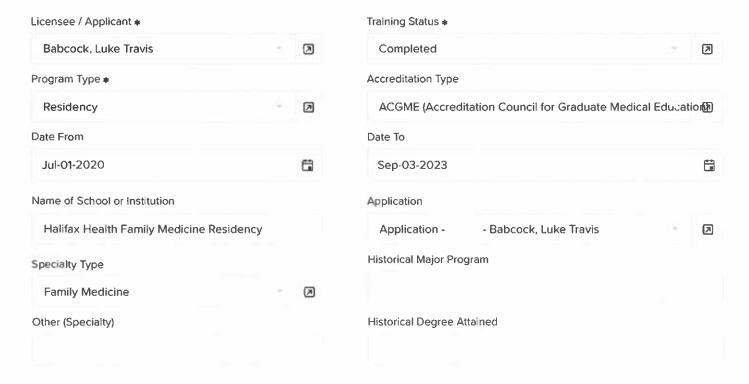
#### Other License Details

Licensee/Applicant		License Type	
Babcock, Luke Travis	7		
Licensing Board or Regulatory Authority		License Status	
Florida Department of Health		CLEAR/ACTIVE	
License Number		Issue Date	
ME 154036		Dec-07-2021	G
State / Province		Expiration Date	
Florida		Jan-31-2024	
Country		Notes	
United States	<b>D</b>		
Application			
Application Babcock, Luke Travis	<b>a</b>		

## Postgraduate Training

Licensee / Applicant	Name of School or Institution	7	Specialty Type	T	Date From	т	Date To †	۲	Program Type
Babcock, Luke Travis	Halifax Health Family Medicine Residency		Family Medicine		Jul-01-2020		Sep-03-2023		Residency

#### Postgraduate Training Details



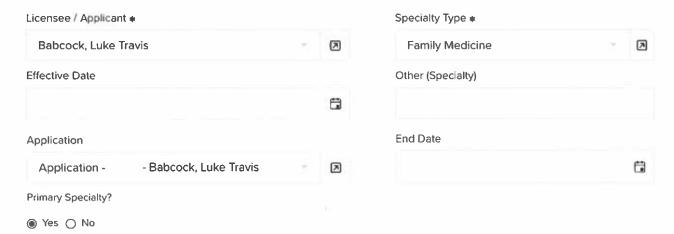
#### **Location Details**



Specialties

Licensee / Applicant	▼ Specialty Type	Primary Specialty?	▼ Effective Date	▼ End Date	
Luke Babcock	Family Medicine	Yes	N/A	N/A	

## **Specialty Details**



## RECEIVED

AUG 0 8 2023

## 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 your 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.

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I have read this responsibili application for medical lice.			nderstand	that I ald	one am a	ccountable for d	completing my
Print your name	Ke Bu	2000	k				
Sign your name							
Dato	1.3						
Note: It is your responsibility a change to your initial resources prior to you being g	sponses pro	vidod ti	o the Boa	ard in you	ur applica	ation for licensu	t would require ire, and which



