Demographic Details

| First Name | Gender | | |
|--|-----------------------------|---------|---|
| Logan | Male | - | Ø |
| Middle Name | Date of Birth | | |
| Paul | 1984 | 1 | |
| Last Name ★ | Name Suffix | | |
| Marcus | | | |
| 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 | nation) | |
| | 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 ⑥ 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 | |
| | · | 7 |
| Cell Phone | Fax | |
| # | # | |
| | | |
| Public Address | | |
| Street Address | ZIP / Postal Code | |
| 1580 Himmel Ave | 94061 | |
| Address Line 2 | State / Province | |
| | California | |
| City | Country | |
| Redwood City | United States | 7 |
| County | Is your physical address different from your mailing address? | |
| CA | ○ Yes No | |
| | Public Phone | |
| | # (619) 841-8367 | |

Mailing Address

| Street Address | City (Mailing) | |
|-----------------------------|----------------------------|---|
| Address Line 2 | State / Province (Mailing) | |
| ZIP / Postal Code (Mailing) | County (Mailing) | |
| | | 7 |
| | County (Mailing) | |
| | | |

Application Status

| Applicant * | | | Application Status | | |
|---|----------------------|---|--|-------|---|
| Marcus, Logan Paul | - 3 | | Pending Review by the Board | * | A |
| Application Number | | | Assigned To | | |
| | | | | 7 | Z |
| License Issued? | | | Manual Paper Application? | | |
| ○ Yes ○ No | | | ○ Yes 	 No | | |
| | | | License ID Card Conditions (max 120 characters | 5) | |
| | | | | | |
| | | | | | |
| License Details (Pre-Approval) | | | | | |
| License Category | | | Credentials / Degree Suffix (Enter before approv | /al!) | |
| Medical Doctor | 7 | | M.D. | | |
| Obtained By | | | Expected Expiration Date | | |
| USMLE | 7 | | | | |
| Expected Issue Date | | | | | |
| | ä | | | | |
| Application Details | | | | | |
| Application Type | | | Reviewed Date | | |
| Medical Doctor - Endorsement | | 2 | | | |
| Application Date * | | | Decision Date | | |
| | | | | | |
| Submitted Date | | | Approved Date | | |
| | | | | | |
| Application Step | | | Expiration Date | | • |
| # | | | | | |
| Have you ever served in the United States M | Military (to include | | Is Simultaneous Application | | |
| National Guard or Reserves)? O Yes No | | | ○ Yes ○ No | | |
| O les (No | | | | | |

| Are you the spouse of an active duty member or surviving spouse of a veteran? | |
|---|---|
| ○ Yes ○ No | |
| Invoices | |
| Application Invoice | Application Payment Date |
| 7 | |
| Licensure Invoice | Licensure Payment Date |
| ~ D | |
| 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. 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. |
| 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. | 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 ficensure in Nevada. 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 | In consideration for processing my application I, the undersigned, whose name and signature voluntarily appears below; do hereby an irrevocably agree to the Civil Applicant Waiver. |

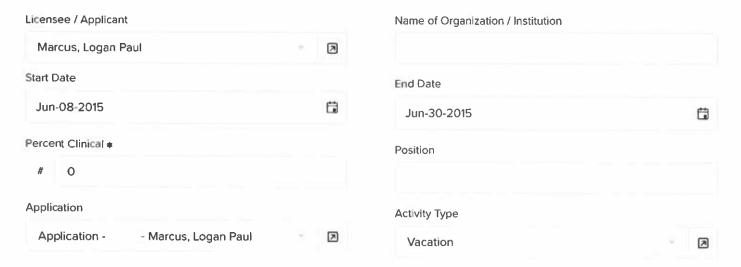
will be denied. I am responsible to keep the Board informed of any circumstance or event that would require a change to my initial responses provided to the Board in my application for licensure, and which occurs prior to my being granted licensure to practice

medicine in the state of Nevada.

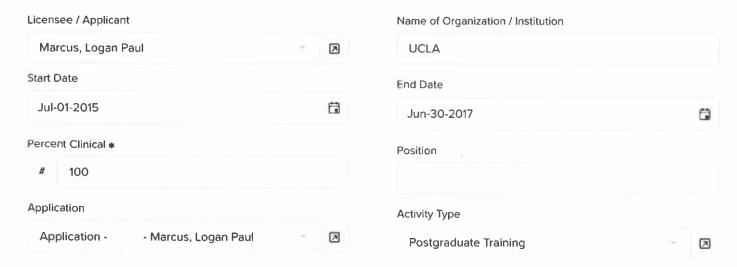
Yes ○ No

Activities

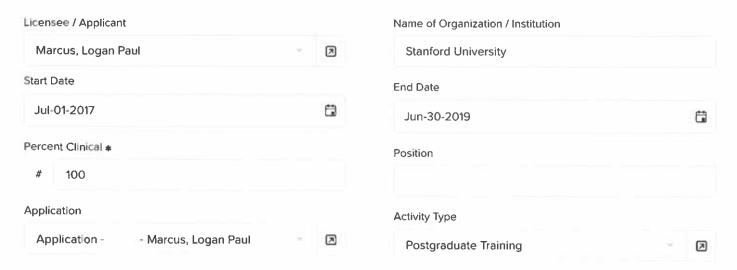
| Licensee / Applicant | Ŧ | Name of Organization / Institution | r | Start Date † | r | End Date | T | Percent Clinical | T |
|----------------------|---|------------------------------------|---|--------------|---|-------------|---|------------------|---|
| Marcus, Logan Paul | | N/A | | Jun-08-2015 | | Jun-30-2015 | | 0 | |
| Marcus, Logan Paul | | UCLA | | Jul-01-2015 | | Jun-30-2017 | | 100 | |
| Marcus, Logan Paul | | Stanford University | | Jul-04-2017 | | Jun-30-2019 | | 100 | |
| Marcus, Logan Paul | | NA | | Jul-01-2019 | | Sep-22-2019 | | 0 | |
| Marcus, Logan Paul | | Concentra | | 5ep-23-2019 | | May-30-2023 | | 100 | |



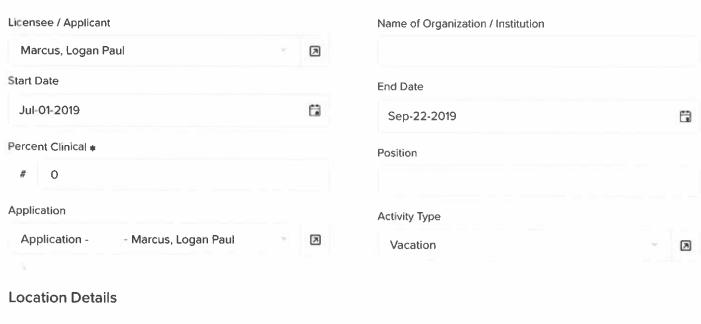




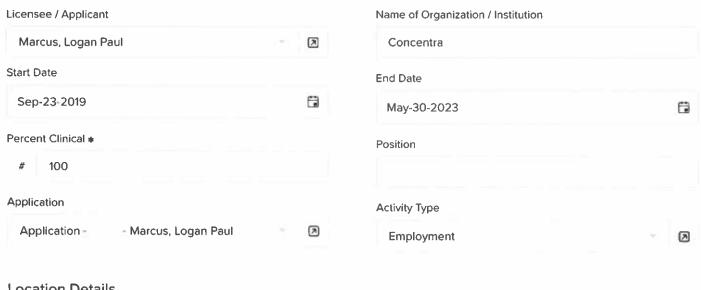








| Street Address 1 | Country | | |
|------------------|-------------------|---|--|
| | United States | 2 | |
| City | State / Province | | |
| Redwood City | California | | |
| | Zip / Postal Code | | |
| | 94061 | | |





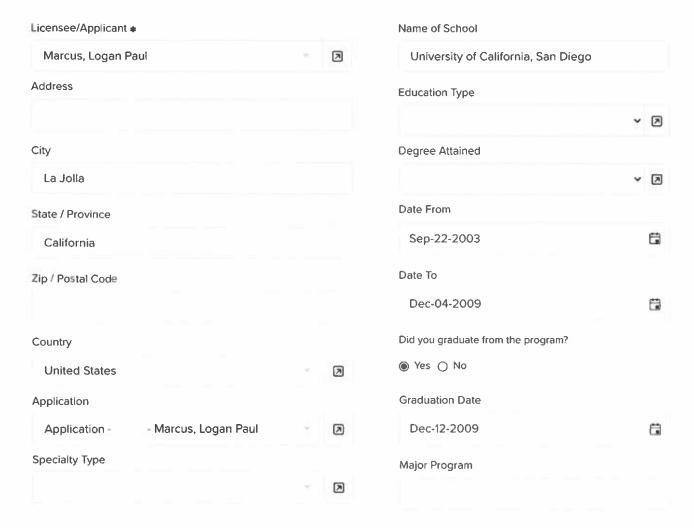
Declarations

| Ordinal † | ۳ | Licensee/Applicant | • | Declaration Question | * | Answer | ₹ | Answer Details |
|-----------|---|--------------------|---|---|---|--------|---|----------------|
| 19 | | Logan Marcus | | MD. PA - Q1 - Medical Condition Impair Safe Practice | | No | | |
| 2 | | Logan Marcus | | MD, PA – Q2 – Medical Condition Field of Practice | | No | | |
| 3 | | Logan Marcus | | MD_PA = Q3 = Chemical Substances Impair Safe Practice | | No | | |
| 4 | | Logan Marcus | | MD, PA, LL = Q4 - Performance of Public Service Requirement | | No | | |
| 5 | | Logan Marcus | | ALL – Q5 – Named Defendant Respond to Legal Action | | No | | |
| 6 | | Logan Marcus | | ALL ~ O6 ~ Malpractice Claim Paid | | No | | |
| 7 | | Marcus, Logan Paul | | ALL – Q7 – Arrest Question | | No | | |
| 8 | | Logan Marcus | | MD, Previously applied for licensure in Nevada. | | No | | |
| 9 | | Marcus, Logan Paul | | MD ~ Investigation Disciplinary during Training Program | | No | | |
| 10 | | Logan Marcus | | MD – Q8 – Denied License / Permission to Practice Medicine | | No | | |
| n | | Logan Marcus | | MD – Q9 – Medical License Revoked | | No | | |
| 12 | | Logan Marcus | | MD – QM – Voluntarily Surrendered a License | | No | | |
| 13 | | Logan Marcus | | MD – Q12 – Denied Membership | | No | | |
| 14 | | Marcus, Logan Paul | | MD - Q13 - Investigation - Respond To/Notify Of | | No | | |
| 15 | | Logan Marcus | | MD, PA – Q10 – Controlled Substance Registration | | No | | |
| 16 | | Logan Marcus | | MD, PA, CCP, Hospital Privileges Denied, Suspended. | | No | | |

Education

| Licensee/Applicant | Education Type | Name of School | Degree Attained | Date From 🍸 | Date To † ▼ | Graduation Date |
|--------------------|--------------------|--|-----------------------|-------------|-------------|-----------------|
| Logan Marcus | College/University | University of California, San Diego | Bachelor of Science | Sep-22-2003 | Dec-04-2009 | Dec-12-2009 |
| Lugan Marcus | Graduate | Georgetown University | Master of Science | Jul-12-2010 | Jun-24-2011 | Aug-31-2011 |
| Marcus, Logan Paul | Medical School | University of California, San Diego School of Medicine | Medical Doctor Degree | Sep-06-2011 | Jun-07-2015 | Jun-07-2015 |

Education Details



Education Details

| Licensee/Applicant * | | Name of School | | |
|--------------------------------|---|------------------------------------|-----|---|
| Marcus, Logan Paul | | Georgetown University | | |
| Address | | Education Type | | |
| 3900 Reservoir Rd NW | | Graduate | · 2 | 9 |
| City | | Degree Attained | | |
| Washington | | Master of Science | - 2 | 9 |
| State / Province | | Date From | | |
| District of Columbia | | Jul-12-2010 | | ì |
| Zip / Postal Code | | Date To | | |
| 20007 | | Jun-24-2011 | Ċ. | 1 |
| Country | | Did you graduate from the program? | | |
| United States | 7 | Yes ○ No | | |
| Application | | Graduation Date | | |
| Application Marcus, Logan Paul | 7 | Aug-31-2011 | G | 3 |
| Specialty Type | | Major Program | | |
| | | | | |
| | | | | |

Education Details

| Licensee/Applicant * | | Name of School | |
|--------------------------------|---|---|------|
| Marcus, Logan Paul | 7 | University of California, San Diego School of M | |
| Address | | Education Type | |
| | | Medical School | 7 |
| City | | Degree Attained | |
| La Jolla | | Medical Doctor Degree | 7 |
| State / Province | | Date From | |
| California | | Sep-06-2011 | |
| Zip / Postal Code | | Date To | |
| 92093 | | Jun-07-2015 | |
| Country | | Did you graduate from the program? | |
| United States | 7 | Yes ○ No | |
| Application | | Graduation Date | |
| Application Marcus, Logan Paul | 2 | Jun-07-2015 | in a |
| Specialty Type | | Major Program | |
| | 7 | | |

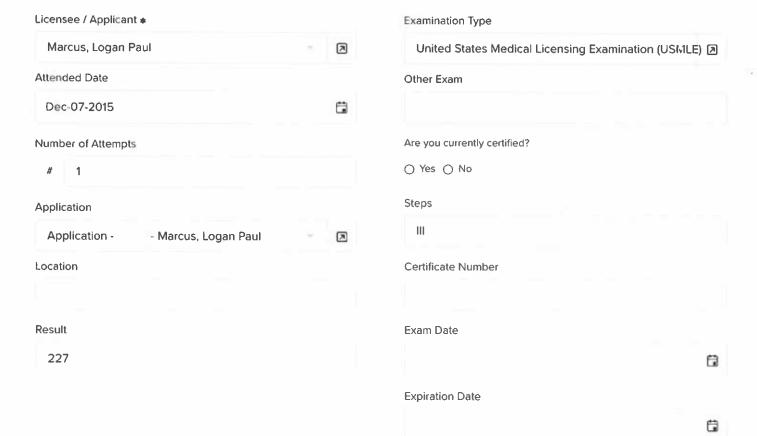
Examinations

| _ | | | | |
|----------------------|----|---|---|-----------------|
| Licensee / Applicant | T | Examination Type | • | Attended Date † |
| Marcus, Logan Paul | | United States Medical Ucensing Examination (USMLE) | | Apr-11-2013 |
| Marcus, Logan Paul | | United States Medical Licensing Examination (USMLE) | | May-19-2014 |
| Marcus, Logan Paul | | United States Medical Licensing Examination (USMLE) | | Oct-06-2014 |
| Marcus, Logan Paul | 10 | United States Medical Licensing Examination (USMLE) | | Dec-07-2015 |

Licensee / Applicant * **Examination Type** Marcus, Logan Paul 2 United States Medical Licensing Examination (USMLE) Attended Date Other Exam Apr-11-2013 Are you currently certified? **Number of Attempts** ○ Yes ○ No Steps **Application** Application -- Marcus, Logan Paul 2 Location Certificate Number Result Exam Date 254 **Expiration Date**

| Licensee / Applicant * | | Examination Type | | |
|--------------------------------|-----|---|--|--|
| Marcus, Logan Paul | 7 | United States Medical Licensing Examination (USMLE) 3 | | |
| Attended Date | | Other Exam | | |
| May-19-2014 | | | | |
| Number of Attempts | | Are you currently certified? | | |
| # 1 | | ○ Yes ○ No | | |
| Application | | Steps | | |
| Application Marcus, Logan Paul | - 7 | II CK | | |
| Location | | Certificate Number | | |
| | | | | |
| Result | | Exam Date | | |
| 250 | | | | |
| | | Expiration Date | | |
| | | Fa | | |

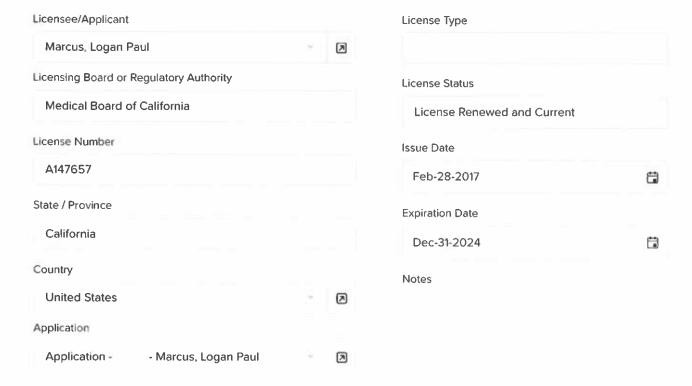
| Licensee / Applicant * | | Examination Type |
|--------------------------------|---|---|
| Marcus, Logan Paul | 2 | United States Medical Licensing Examination (USMLE) |
| Attended Date | | Other Exam |
| Oct-06-2014 | | |
| Number of Attempts | | Are you currently certified? |
| # 1 | | ○ Yes ○ No |
| Application | | Steps |
| Application Marcus, Logan Paul | 7 | 2 CS |
| Location | | Certificate Number |
| Result | | Exam Date |
| Pass | | |
| | | Expiration Date |
| | | E |



Other Licenses

| Licensee/Applicant | T | License Number | Y | License Type | T | Issue Date | T | Expiration Date | 7 | State / Province |
|--------------------|---|----------------|---|--------------|---|-------------|---|-----------------|---|------------------|
| Logan Marcus | | A147657 | | N/A | | Feb-28-2017 | | Dec-31-2024 | | California |

Other License Details



Postgraduate Training

| Licensee / Applicant T | Name of School or Institution | Specialty Type | • | Date From | • | Date To † | • | Program Type |
|------------------------|---|-----------------------|---|-------------|---|-------------|---|----------------------|
| Marcus, Logan Paul | University of California, Los Angeles David Geffen School of Medicine | Surgery Neurological | | Jun-24-2015 | | Jun-30-2017 | | Internship/Residency |
| Marcus, Logan Paul | Stamford Health Care-Stanford University Program | Oncology Radiation | | Jul-01-2017 | | Jun-30-2019 | | Residency |
| Marcus, Logan Paul | University of Pennsylvania Health System Program | Occupational Medicine | | Jul-01-2022 | | Jun-30-2024 | | Residency |

Postgraduate Training Details

County

| Licensee / Applicant ★ | | Training Status * | |
|---------------------------------------|--------------|---|--------------|
| Marcus, Logan Paul | 7 | | 7 |
| Program Type * | | Accreditation Type | |
| Internship/Residency | 7 | ACGME (Accreditation Council for Graduate Medical I | Education 19 |
| Date From | | Date To | |
| Jun-24-2015 | | Jun-30-2017 | |
| Name of School or Institution | | Application | |
| University of California, Los Angeles | David Geffer | Application Marcus, Logan Paul | A |
| Specialty Type | | Historical Major Program | |
| Surgery, Neurological | · 2 | | |
| Other (Specialty) | | Historical Degree Attained | |
| | | | |
| Location Details | | | |
| City | | Street Address 1 | |
| State / Province | | Zip / Postal Code | |
| California | | | |

Country

7

- 🗷

Postgraduate Training Details

State / Province

California

County

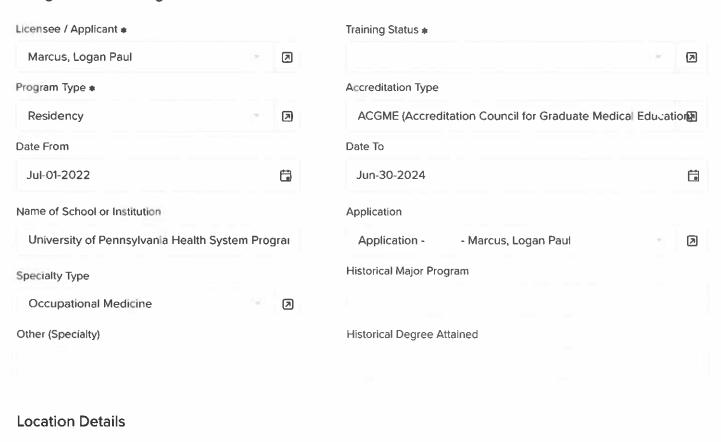
| Licensee / Applicant * | | Training Status * | |
|--|----------|--|------------------|
| Marcus, Logan Paul | 2 | | 7 |
| Program Type * | | Accreditation Type | |
| Residency | | ACGME (Accreditation Council for Graduate Me | edical Education |
| Date From | | Date To | |
| Jul-01-2017 | | Jun-30-2019 | |
| Name of School or Institution | | Application | |
| Stanford Health Care-Stanford University Prograi | | Application Marcus, Logan Paul | 7 |
| Specialty Type | | Historical Major Program | |
| Oncology,Radiation | 7 | | |
| Other (Specialty) | | Historical Degree Attained | |
| | | | |
| Location Details | | | |
| City | | Street Address 1 | |
| | | | |

Zip / Postal Code

A

Country

Postgraduate Training Details



| City | | Street Address 1 | |
|------------------|-------------|-------------------|----------|
| | | | |
| State / Province | | Zip / Postal Code | |
| Pennsylvania | | | |
| County | | Country | |
| | > | | A |

Specialties

| Licensee / Applicant | т | Specialty Type | 7 | Primary Specialty? | T | Effective Date | т | End Date | |
|----------------------|---|-----------------------|---|--------------------|---|----------------|---|----------|--|
| Logen Mercus | | Occupational Medicine | | Yes | | Sep-23-2019 | | N/A | |

Specialty Details

| Licensee / Applicant * | | Specialty Type * | |
|--------------------------------|---|-----------------------|----------|
| Marcus, Logan Paul | 7 | Occupational Medicine | 7 |
| Effective Date | | Other (Specialty) | |
| Sep-23-2019 | | | |
| Application | | End Date | |
| Application Marcus, Logan Paul | 7 | | □ |
| Primary Specialty? | | | |
| Yes ○ No | | | |

JUL 28 2023

ATTENTION APPLICANT!

NEVADA STATE BOARD OF MEDICAL EXAMINERS

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.

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 _ | Logen P. Mary | |
|-------------------|---------------|--|
| Sign your name _ | J | |
| Date | 7/21/25 | |

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.

