# **Demographic Details**

First Name	Gender		
Nazih	Male	-	2
Middle Name	Date of Birth		
Michel	1945		
Last Name *	Name Suffix		
Haddad			
Previous Name(s)	City of Birth		
Social Security Number	Place of Birth		
Tax Identification Number	Weight (in Ibs)		
Height	Eye Color		
Hair Color	Comments (non-public information)  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			

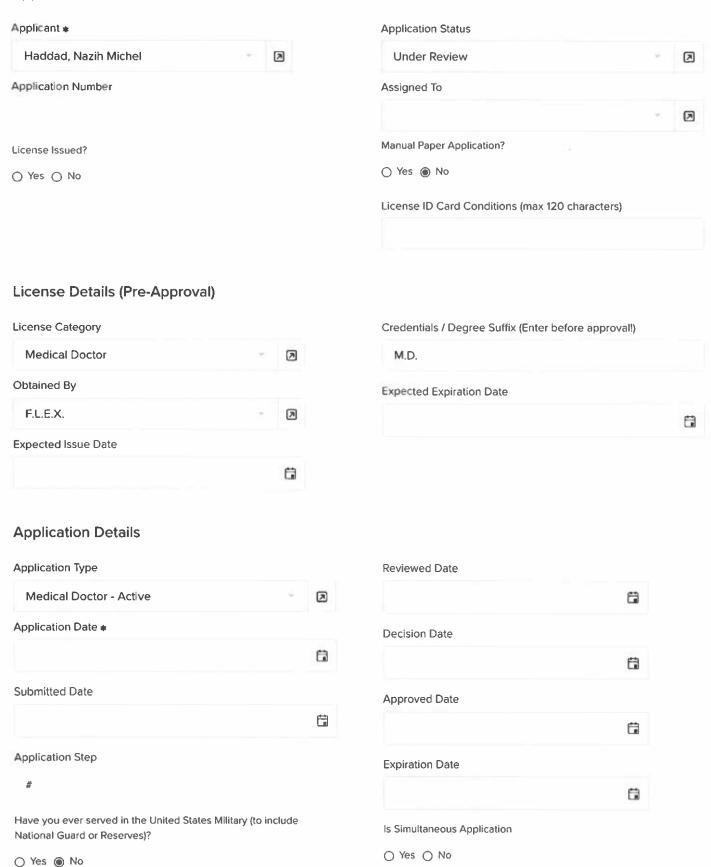
# Military Detail

Have you ever served in the United States Military (to include National States Milita	onal Guard or Reserves)?		
○ Yes ⑥ No			
Discipline / SPL			
Disciplinary Action?	SPL?		
○ Yes ○ No	○ Yes ○ No		
	Date of SPL Issuance		
		Ei	
Contact Information			
Primary Phone	Secondary Phone		
#	#		
Primary Phone Extension	Secondary Phone Extension		
Primary E-mail Address	Mail should be directed to		
		Ÿ	Ø
Cell Phone	Fax		
#	#		
Public Address			
Street Address	ZIP / Postal Code		
2340 E White Lantern Lane	92867		
Address Line 2	State / Province		
	California		
City	Country		
Orange	United States	. 4	7
County	Is your physical address different from your mailing	address?	
Orange	○ Yes ⑥ No		
	Public Phone		
	# (714) 606-6261		

# **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?	
○ Yes ○ No	
Invoices	
Application Invoice	Application Payment Date
- A	
Licensure Invoice	Licensure Payment Date
7	G
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.	l 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 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	<ul> <li>Yes  No</li> <li>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.</li> <li>Yes  No</li> </ul>

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

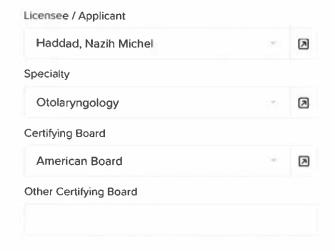
medicine in the state of Nevada.

Yes ○ No

# **Board Certifications**

Licensee / Applicant	Ŧ	Certifying Board	Ŧ	Other Certifying Board	7	Specialty	Y	Initial Certification Date	<b>T</b>	Recertification Date
Haddad, Nazih M		American Board		N/A		Otolaryngology		Oct-29-1976		N/A

# **Board Certification Details**





### Connected Record

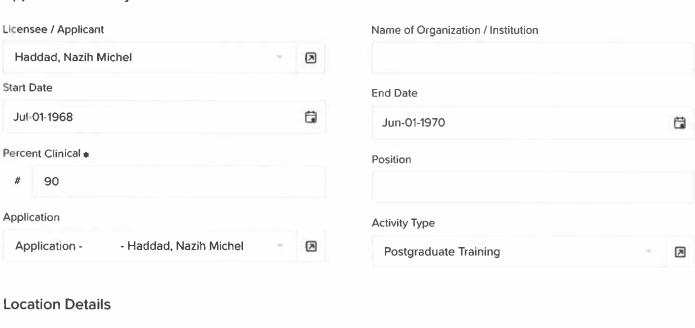
### Application



# Activities

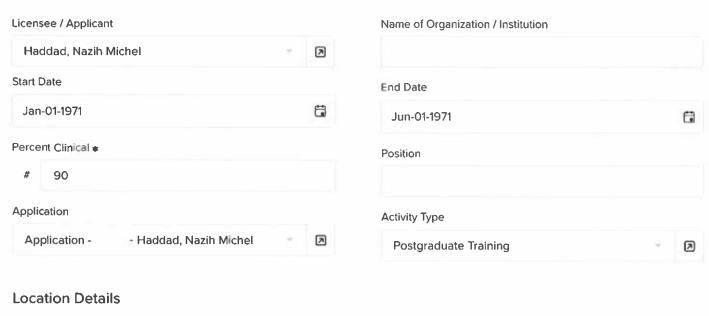
Licensee / Applicant	T	Name of Organization / Institution	T	Start Date †	7	End Date	₹	Percent Clinical
Haddad, Nazih Michel		N/A		Jul-01-1968		Jun-01-1970		90
Haddad, Nazih Michel		N/A		Jan-01-1971		Jun-Q1-1971		90
Haddad, Nazih Michel		N/A		Jan-01-1977		Jan-01-1980		90

# **Application Activity Details**



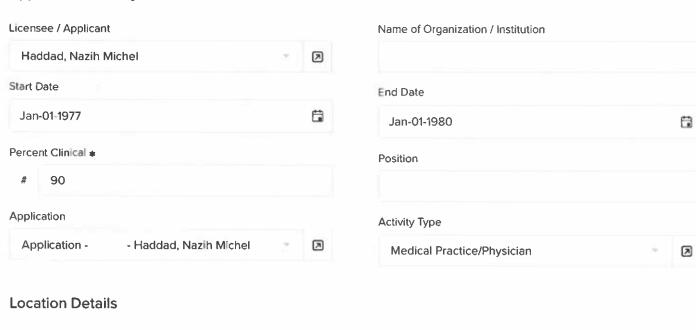


# **Application Activity Details**





# **Application Activity Details**



Street Address 1	Country	
	United States	· 2
City	State / Province	
New York	New York	
	Zip / Postal Code	

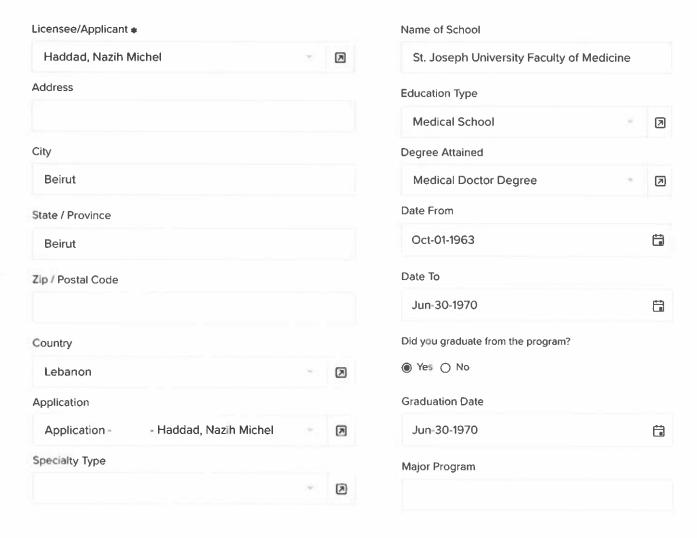
# Declarations

Ordinal †	•	Licensee/Applicant	•	Declaration Question	7	r	Answer	•	Answer Details
12		Nazih Haddad		MD, PA - Q1 - Medical Condition Impair Safe Practice			No		
2		Nazih Haddad		MD, PA - Q2 - Medical Condition Field of Practice			No		
3		Nazih Haddad		MD. PA – Q3 – Chemical Substances Impair Safe Practice			No		
4		Nazih Haddad		MD, PA, LL – Q4 – Performance of Public Service Requirement			No		
5		Haddad, Nazıh Michel		ALL – Q5 – Named Defendant Respond to Legal Action			No		
6		Haddad, Nazıh Michel		ALL – Q6 – Malpractice Claim Paid			No		
7		Nazh Haddad		ALL = Q7 — Arrest Question			No		
8		Nozih Hadded		MD, Previously applied for licensure in Nevada,			No		
9		Haddad, Nazih M		MD – Investigation Disciplinary during Training Program			No		
10		Nazih Hedded		MD – O8 – Denied License / Permission to Practice Medicine			No		
11		Nazih Hedded		MD – Q9 – Médical License Revoked			No		
12		Haddad, Nazih M		MD – Q11 – Veluntarily Surrendered a License			No		
13		Nazih Hadded		MD = Q12 = Denied Membership			No		
14		Haddad, Nazih Michel		MD – Q13 – Investigation – Respond To/Notify Of			No		
15		Nazih Hadded		MD. PA = Q10 - Controlled Substance Registration			No		
16		Nazin Haddad		MD. PA, CCP, Hospital Privileges Denied. Suspended			No		

# Education

Licensee/Applicant	T	Education Type	۲	Name of School	T	Degree Attained	т	Date From	T	Date To †	7	Graduation Date
Haddad, Nazih Michel		Medical School		St. Joseph University Faculty of Medicine		Medical Doctor Degree		Oc1-01-1963		Jun-30-1970		Jun-30-1970

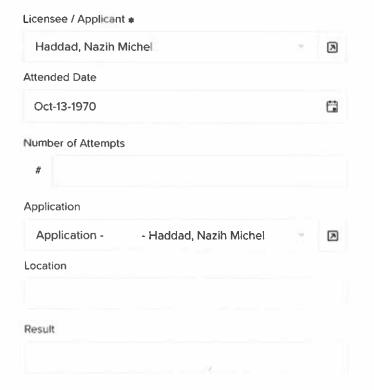
### **Education Details**



### Examinations

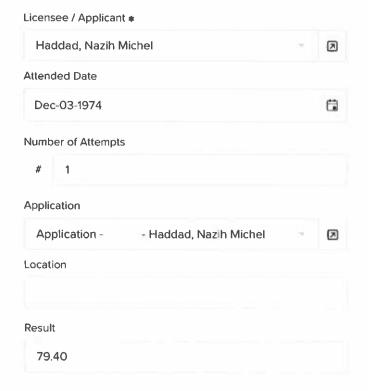
Licensee / Applicant	Examination Type	T	Attended Date
Haddad, Nazih Michel	ECFMG		Oct-13-1970
Haddad, Nazih Michel	Federation Licensing Examination (FLEX)		Dec-03-1974

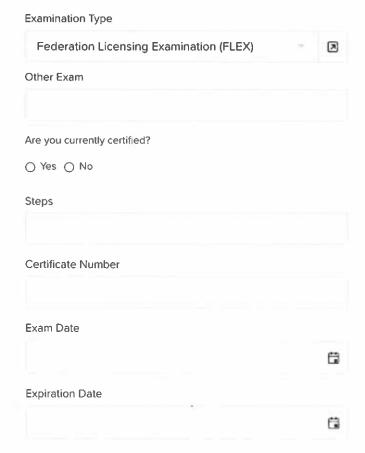
# **Examination Details**



ECFMG	7
Other Exam	
Are you currently certified?	
Yes ○ No	
Steps	
Certificate Number	
Exam Date	
	ä
Expiration Date	

### **Examination Details**

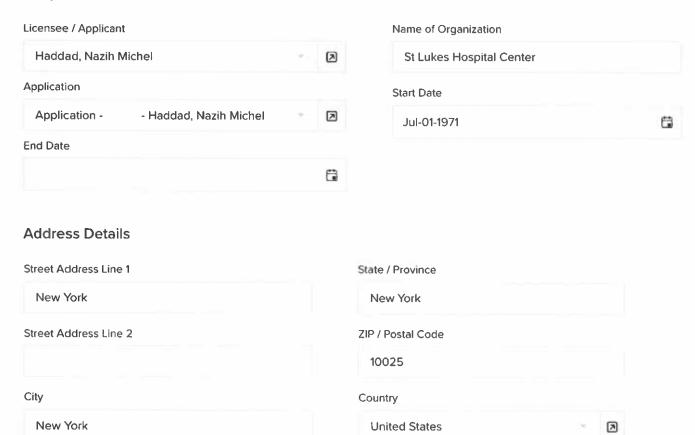




# Hospitals

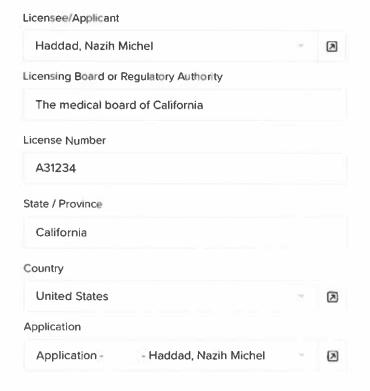
Licensee / Applicant	▼ Name of Organization	▼ Start Date	▼ End Date
Nazih Haddad	St Lukes Hospital Center	Jul-01-1971	N/A

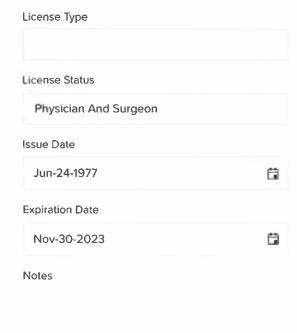
# **Hospital Details**

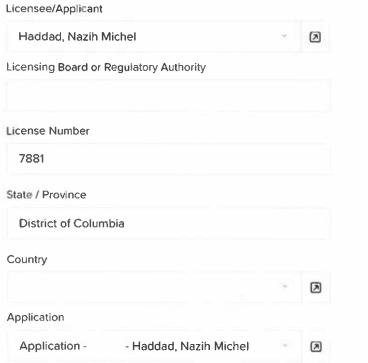


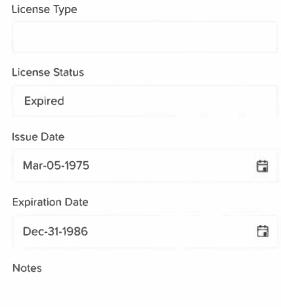
# Other Licenses

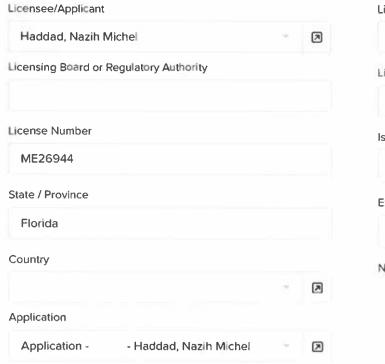
Licensee/Applicant	T	License Number	T	License Type	*	Issue Date	7	Expiration Date	<b>T</b>	State / Province †	
Haddad Nazih Michel		A31234		N/A		Jun-24-1977		Nov-30-2023		California	
Haddad, Nazih Michel		7881		N/A		Mar-05-1975		Dec-31-1986		District of Columbia	
Haddad, Nazih Michel		MF26944		N/A		Sep-17-1976		N/A		Florida	
Haddad, Nazih Michel		54180		N/A		May-15-1985		Nov-11-1991		Massachusetts	

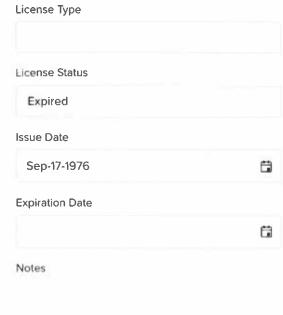


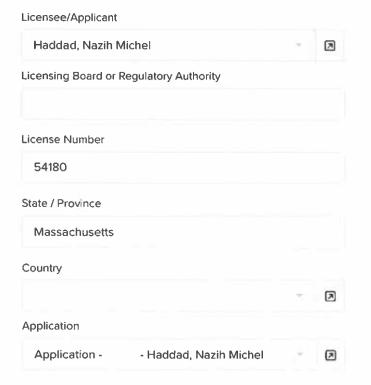


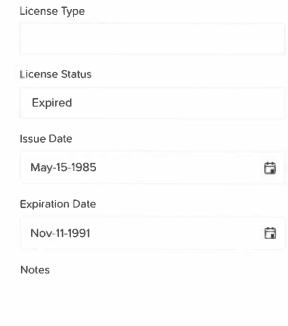












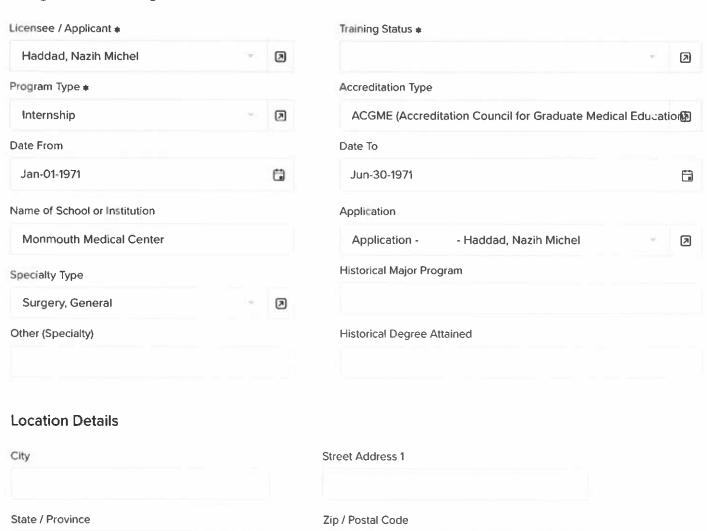
# Postgraduate Training

Licensee / Applicant	Name of School or Institution	Specialty Type	Date From 7	Date To †	T	Program Type
Haddad, Nazih Michel	Monmouth Medical Center	Surgery General	Jan-01-1971	Jun-30-1971		Internship
Haddad, Nazih Michel	St. Luke's Hospital Center	Surgery, General	Jul-01-1971	Jun-30-1972		Internship
Haddad, Nazih Michel	Thomas Jefferson University Hospital	Otolaryngology Head & Neck Surgery	Jul-01-1972	Jul-01-1975		Residency

# Postgraduate Training Details

**New Jersey** 

County

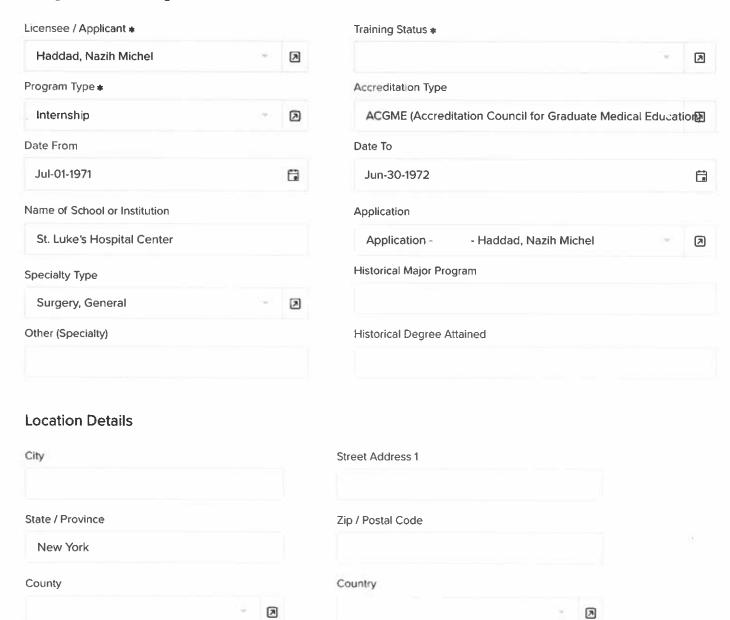


Country

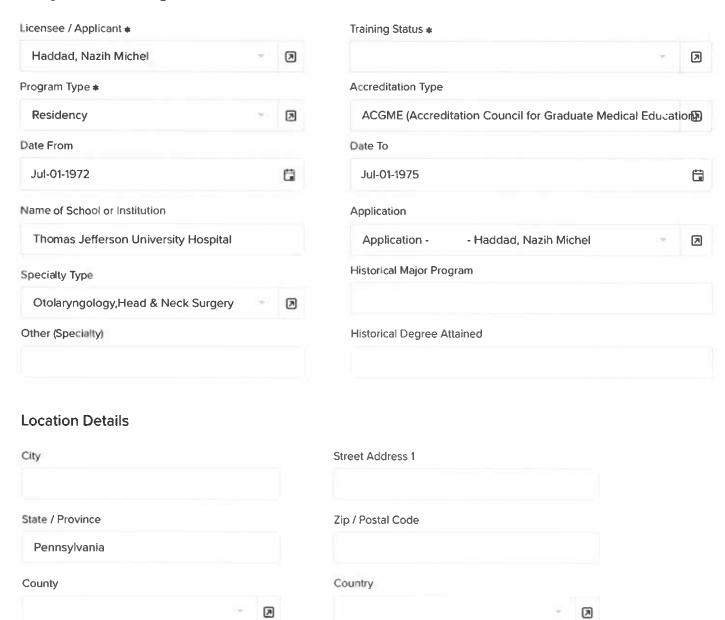
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# Postgraduate Training Details



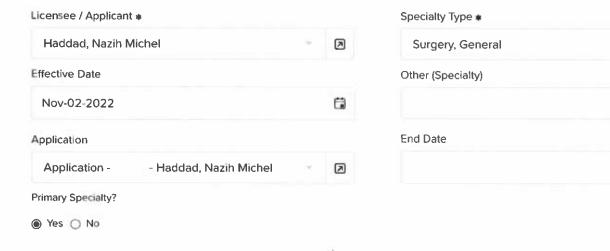
# **Postgraduate Training Details**



# Specialties

Licensee / Applicant	т	Specialty Type	7	Primary Specialty?	T	Effective Date	*	End Date
Haddad, Nazih M		Surgery, General		Yes		Nov-02-2022		N/A

# **Specialty Details**



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# JAN 23 2023

# RESPONSIBILITY STATEMENT

ATTENTION APPLICANT!

NEVADA STATE BOARD OF MEDICAL EXAMINERS

# 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

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.

