Applicant: *If you answered affirmatively with regard to any type of hospital investigation or violation and/or have had staff privileges denied,suspended, limited, revoked or not renewed by a hospital and/or if you resigned from any medical staff position in lieu of disciplinary action, submit this form to all hospitals where you have had privileges within the past 10 years. If more than one hospital or surgery center, photocopies of the blank form may be made and used.*
(Please note: do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department of staff meetings or maintaining required malpractice insurance)

FORM 5

NEVADA STATE BOARD OF MEDICAL EXAMINERS
VERIFICATION OF HOSPITAL OR SURGERY CENTER PRIVILEGES

Attn: Medical Staff Office

Hospital: _____

Address: _____

_____

obtain a medical license in Nevada. The applicant has indicated that he/she holds or has held staff privileges at your hospital. In order that the processing of the application may be completed, we ask that you provide us with the information requested below.

Hospital Chief-of-Staff or Administrator:

The above named applicant submitted an application to

Applicant's Name: _____

Applicant's DOB: _____

Specialty: _____

Affiliation dates: _____

1. What privileges are/were extended to the applicant?

_____

2. Dates of hospital privileges: From_____ To_____
Month / Year Month / Year

3. Have staff privileges ever been limited, restricted, suspended or revoked? No ☐ Yes ☐

If Yes, please explain: _____

_____

4. Is there any derogatory information on file? No ☐ Yes ☐ If Yes, please explain:

_____

_____

5. Do your records indicate applicant having privileges at any other hospitals in your area? No ☐ Yes ☐

If Yes, please list hospitals and/or attach a list.

_____

_____

_____
Signature of Hospital Chief-of-Staff or Administrator

_____
Printed Name, Title, and Date

Phone #: _____

Fax #: _____

Email: _____

Please return completed form to:

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

RELEASE

I hereby authorize the above named institution to release any information, files, or records required by the Nevada State Board of Medical Examiners for licensure in the state of Nevada.

_____
Medical Doctor (applicant) signature and date

State of _____ County of _____

Subscribed and sworn to before me this _____ day of

_____, 20_____.

Notary Public for the State of _____

My Commission Expires: _____

Residing at: _____
City State

_____
Signature of Notary

Hospital Administrator: *If you have questions, you may contact the Nevada Board at (775) 688-2559.*