PHYSICIAN ASSISTANT
APPLICATION FOR STATUS CHANGE TO ACTIVE STATUS
REGISTRATION FORM FOR THE PERIOD 2023 - 2025
NEVADA STATE BOARD OF MEDICAL EXAMINERS
9600 Gateway Drive, Reno, NV 89521
Phone (775) 688-2559

Date Received by Board

License No._____
File No. _____

(For Board Use Only)

I hereby apply for status change to active status, and enclose the appropriate fee as indicated below:

_____	CHANGE FROM INACTIVE TO ACTIVE STATUS	between 7/1/2023 - 6/30/2024	**$ 400**
_____	CHANGE FROM INACTIVE TO ACTIVE STATUS	between 7/1/2024 - 6/30/2025	**$ 200**

You may pay by cashier's check or money order payable to "NEVADA STATE BOARD OF MEDICAL EXAMINERS," or by credit card. If paying by credit card, please complete the Credit Card Authorization form on the last page of this application. A two-point five percent (2.5%) service fee will be assessed for payment by credit card.

Licensee's Name:
_____

PLEASE NOTE:

NRS 630.255 (4) (5) Inactive licensees: reinstatement.

4. Before resuming the practice of medicine in this State, the inactive registrant must:
   (a) Notify the Board in writing of his or her intent to resume the practice of medicine in this State;
   (b) File an affidavit with the Board describing the activities of the registrant during the period of inactive status;
   (c) Complete the form for registration for active status;
   (d) Pay the applicable fee for biennial registration; and
   (e) Satisfy the Board of his or her competence to practice medicine.
5. If the Board determines that the conduct or competence of the registrant during the period of inactive status would have warranted denial of an application for a license to practice medicine in this State, the Board may refuse to place the registrant on active status.

- Your Status Will Not Be Changed Unless You Answer All Questions On This *Application For Status Change To Active Status Registration* Form.
- You Must Provide Written Explanations For All Questions Answered "Yes."
- All Information You Provide On This Application Is Public Information.

PLEASE TYPE OR PRINT LEGIBLY

1. Active status registration requires the submission of proof of completion of **AMA Category 1** continuing medical education (CME), **completed during the preceding 24-month time period of the date of your submission of this form**. Submit your proof of completion of CME with your completed ***APPLICATION FOR STATUS CHANGE TO ACTIVE STATUS REGISTRATION*** form. A detailed description of the number of continuing medical education hours required for your change of status can be found on page 8 of this application.

2. If your name and/or address have changed, indicate the change in the space provided below. Please be advised, the address you provide below is viewable on the NSBME website and will become your public address. Also, please indicate your current public telephone and fax numbers. Please note: if your name has changed, a copy of the document authorizing your name change (marriage license, divorce decree, etc.) must be included.

Name_____

Street_____

City_____ County_____ State_____ Zip_____

Public Phone Number_____ Public Fax Number_____

Cellular Phone: _____ Private ☐ Public ☐

Email address _____

3. **IF YOU HAVE RETIRED OR MOVED YOUR PRACTICE,** indicate the location of patient records below:

Name_____

Street_____

City_____County_____State_____Zip_____

Phone Number_____

4. **INDICATE BELOW YOUR PRIMARY AND SECONDARY SCOPES OF PRACTICE** using the following codes:

SCOPES OF PRACTICE CODES

1	ADDICTION MEDICINE	41	NEOPLASTIC DISEASES	81	PEDIATRIC, RHEUMATOLOGY
2	ADOLESCENT MEDICINE	42	NEPHROLOGY	82	PEDIATRIC, SURGERY
3	AEROSPACE MEDICINE	43	NEUROLOGY	83	PEDIATRIC, UROLOGY
4	ALLERGY	44	NEURO-OPHTHALMOLOGY	84	PEDIATRICS
5	ALLERGY/IMMUNOLOGY	45	NEUROPATHOLOGY	85	PHYSICAL MEDICINE/REHABILITATION
6	AMBULATORY MEDICINE	46	NEURORADIOLOGY	86	PREVENTIVE MEDICINE
7	ANESTHESIOLOGY	47	NON-CONVENTIONAL MEDICINE	87	PSYCHIATRY
8	BLOODBANKING	48	NUCLEAR MEDICINE	88	PSYCHOANALYSIS
9	BRONCO-ESOPHAGOLOGY	49	NUTRITION	89	PUBLIC HEALTH
10	CARDIOVASCULAR DISEASES	50	OBSTETRICS	90	PSYCHOMATIC MEDICINE
11	CATSCAN/ULTRASOUND	51	OBSTETRICS/GYNECOLOGY	91	PULMONARY DISEASES
12	CHILD NEUROLOGY	52	OCCUPATIONAL MEDICINE	92	RADIOLOGY
13	CHILD PSYCHIATRY	53	ONCOLOGY	93	RADIOLOGY, DIAGNOSTIC
14	CLINICAL PHARMACOLOGY	54	ONCOLOGY, GYNECOLOGICAL	94	RADIOLOGY, INTERVENTIONAL
15	CRITICAL CARE	55	ONCOLOGY, HEMATOLOGY	95	RADIOLOGY, NUCLEAR
16	DERMATOLOGY	56	ONCOLOGY, RADIATION	96	RADIOLOGY, THERAPEUTIC
17	DERMATOPATHOLOGY	57	ONCOLOGY, SURGICAL	97	RADIOLOGY, VASCULAR
18	EMERGENCY MEDICINE	58	OPHTHALMOLOGY	98	RHEUMATOLOGY
19	ENDOCRINOLOGY	59	OTOLARYNGOLOGY	99	RHINOLOGY
20	FAMILY PRACTICE	60	OTOLOGY	100	SLEEP DISORDERS
21	GASTROENTEROLOGY	61	PAIN MANAGEMENT	101	SPORTS MEDICINE
22	GENERAL PRACTICE	62	PATHOLOGY	102	SURGERY, ABDOMINAL
23	GERIATRIC PSYCHIATRY	63	PATHOLOGY, ANATOMIC	103	SURGERY, CARDIOTHORACIC
24	GERIATRICS	64	PATHOLOGY, CLINICAL	104	SURGERY, CARDIOVASCULAR
25	GYNECOLOGY	65	PATHOLOGY, FORENSIC	105	SURGERY, COLON/RECTAL
26	HAIR TRANSPLANTATION	66	PEDIATRIC, ALLERGY	106	SURGERY, GENERAL
27	HEMATOLOGY	67	PEDIATRIC, CARDIOLOGY	107	SURGERY, HAND
28	HOMEOPATHY	68	PEDIATRIC, CRITICAL CARE	108	SURGERY, HEAD/NECK
29	HYPNOSIS	69	PEDIATRIC, EMERGENCY MEDICINE	109	SURGERY, MAXILLOFACIAL
30	IMMUNOLOGY	70	PEDIATRIC, ENDOCRINOLOGY	110	SURGERY, NEUROLOGICAL
31	INFECTIOUS DISEASES	71	PEDIATRIC, GASTROENTEROLOGY	111	SURGERY, ORTHOPEDIC
32	INFERTILITY	72	PEDIATRIC, HEMATOLOGY/ONCOLOGY	112	SURGERY, PLASTIC
33	INTERNAL MEDICINE	73	PEDIATRIC, INFECTIOUS DISEASES	113	SURGERY, THORACIC
34	LARYNGOLOGY	74	PEDIATRIC, INTENSIVIST	114	SURGERY, TRANSPLANT
35	LEGAL MEDICINE	75	PEDIATRIC, NEPHROLOGY	115	SURGERY, TRAUMATIC
36	MATERNAL/FETAL MEDICINE	76	PEDIATRIC, NEUROLOGY	116	SURGERY, UROLOGIC
37	MEDICAL ACUPUNCTURE	77	PEDIATRIC, OPHTHALMOLOGY	117	SURGERY, VASCULAR
38	MEDICAL ETHICS	78	PEDIATRIC, PHYSIATRY	118	TOXICOLOGY
39	MEDICAL GENETICS	79	PEDIATRIC, PULMONARY	119	URGENT CARE
40	NEO/PERINATAL MEDICINE	80	PEDIATRIC, RADIOLOGY	120	UROLOGY

Code **Code**

Primary Scope of Practice _____ **Secondary Scope of Practice** _____

Other States of Current or Previous Licensure:

List state licenses YOU HOLD OR HAVE HELD to practice medicine in any state, territory or country with the exception of training licenses.

State/Territory/Country	License #	Date of Issuance	Dates of Practice From (Mo./Yr.)	To (Mo./Yr.)

(If more space is needed, attach a separate sheet.)

Questions:

All of the following questions refer to the time period since your last renewal

In the event that your status was not changed to Inactive during a renewal, all questions refer to the time period within the last 24 months prior to your submission of this form.

For the purposes of the following questions, these phrases or words have these meanings:

"Ability to practice medicine" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments;

2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and

3. The physical capability to perform medical tasks such as physician examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental or psychological condition or disorder.

"Chemical substances" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction.

For all "yes" responses to the following questions, you must submit your written explanation(s) on a separate sheet attached to your completed *Application for Status Change to Active Status Registration* form.

1. Do you currently have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? _____Yes _____No

2. If you currently have a medical condition which in any way impairs or limits your ability to practice medicine, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, the manner in which you have chosen to practice, or by any other reasonable accommodation? _____Yes _____No _____N/A

3. If you currently use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety? _____Yes _____No _____N/A

4. Are you currently certified by the National Commission on Certification of Physician Assistants? _____Yes _____No

Questions (continued): **The following questions refer to the time period since your last renewal OR within the last 24 months prior to your submission of this form.**

Malpractice Questions:

5. Have you been named as a defendant, or been requested to respond as a defendant, to a legal action involving professional liability, or malpractice, including any military tort claims if applicable? _____Yes _____No

6. Have you had a professional liability, malpractice, claim paid on your behalf, or paid such a claim yourself including any military tort claims if applicable? _____Yes _____No

Malpractice Explanation(s):

List of all claims or suits for medical malpractice made against you. A claim is any formal or informal demand for payment to any person or organization. If have not answered "yes" to questions #5 and/or #6 and do not have any such claims or suits, this section will be left blank. If you have more than 1 claim, make a copy or copies of this page and submit all explanations with your application for licensure.

Name of patient involved:

In which state did the action take place?

Case number (if applicable):

Which court?
(If settled before initiation of civil action, state here.)

Current status of claim:

☐ Open ☐ Closed (settled or judgment) ☐ Dismissed (no money paid out) ☐ Other

Date claim was closed/settled or dismissed: _____
Month/Year

Amount of judgment or settlement $

Month and year of event precipitating claim:

Month and year of lawsuit:

Insurance carrier at time:

What is/was your status? ☐ Primary defendant ☐ Co-defendant ☐ Other

Please provide specifics in reference to the adverse event including the allegations and your role in the event:

Questions (continued): **The following questions refer to the time period since your last renewal OR within the last 24 months prior to your submission of this form.**

7. Have you ever been arrested, investigated for, charged with, convicted of, or pled guilty or nolo contendere to any offense or violation of any federal (including the Uniform Code of Military Justice), state or local law, or the laws of any foreign country, which is a misdemeanor, gross misdemeanor, felony, violation of the Uniform Code of Military Justice, or synonymous thereto in a foreign jurisdiction, excluding any minor traffic offense (driving or being in control of a motor vehicle while under the influence of a chemical substance, including alcohol, is not considered a minor traffic offense), or for any offense which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? *Please note that you MUST disclose ANY investigation or arrest, including those where the final disposition was dismissal, or expungement. (If "Yes," attach explanation on separate sheet.)

_____Yes _____No

8. Have you been denied a license or certificate to practice as a physician assistant, or any other healing art, or permission to take an examination to practice as a physician assistant or any other healing art in any state, country or U.S. territory?

_____Yes _____No

9. Have you had a physician assistant license or certificate, or license or certificate to practice in any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory? _____Yes _____No

10. Have you voluntarily surrendered a license or certificate to practice as a physician assistant, or in any other healing art in any state, country or U.S. territory in lieu of any disciplinary action? _____Yes _____No

11. Have you ever been denied membership, been asked to resign or expelled from a medical society or other professional medical organization? _____Yes _____No

12. Have you ever been: a) asked to respond to an investigation; b) notified that you were under investigation for; c) investigated for; d) charged with; or e) convicted of any violation of a statute, rule or regulation governing your practice as a physician assistant by any medical licensing board, hospital, medical society, governmental entity or agency other than the Nevada State Board of Medical Examiners? _____Yes _____No

13. Have you ever surrendered your state or federal controlled substance registration or had it revoked or restricted in any way?

_____Yes _____No

14. List all hospitals where you have had staff privileges denied, suspended, limited, revoked or not renewed by the hospital. List any (all) resignations from any medical staff in lieu of disciplinary or administrative action. (Please Note: Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance).

Hospital	Mailing Address	Type of Action	Dates of Action From (Mo./Yr.)	To (Mo./Yr.)

(If more space is needed, attach a separate sheet.)

Attestations/Affirmations:

CHILD SUPPORT STATEMENT

I UNDERSTAND THAT THIS *APPLICATION FOR STATUS CHANGE TO ACTIVE STATUS REGISTRATION* WILL BE DENIED IF I HAVE NOT PLACED A CHECK MARK NEXT TO (a), (b), OR (c) UNDER THE CHILD SUPPORT STATEMENT SECTION.

Please place a check mark next to one of the following statements:

_____ (a) I am not subject to a court order for the support of a child;

_____ (b) I am subject to a court order for the support of one or more children and am in compliance with the order or am in compliance with a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order; **OR**

_____ (c) I am subject to a court order for the support of one or more children and am NOT in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

ATTESTATION REGARDING THE REPORTING OF THE ABUSE OR NEGLECT OF A CHILD

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**

www.leg.state.nv.us/NRS/NRS-432B.html#NRS432BSec220

SAFE INJECTION PRACTICE ATTESTATION

ATTESTATION TO KNOWLEDGE OF AND COMPLIANCE WITH THE GUIDELINES OF THE CENTERS FOR DISEASE CONTROL AND PREVENTION FOR APPLICANT PHYSICIANS

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. _____**Yes** _____**No**

http://www.cdc.gov/injectionsafety/IP07_standardPrecaution.html

MILITARY SERVICE ATTESTATION

1-Have you ever served in the United States Military (to include National Guard or Reserves)? _____Yes _____No
If your answer is "No", you do not have to complete the remaining questions for the Military Service Attestation.

2-If yes, which branch of service did you serve?
- ☐ Air Force
- ☐ Army
- ☐ Navy
- ☐ Marine Corps
- ☐ Coast Guard

3-Military occupation specialty or specialties?
- ☐ Administration or Personnel
- ☐ Aviation
- ☐ Civil Engineering
- ☐ Communications
- ☐ Infantry or Armor
- ☐ Legal or Chaplin Corps
- ☐ Logistics or Supply
- ☐ Maintenance
- ☐ Medical Services
- ☐ Security Forces or Military Police
- ☐ Other

4&5-Dates of service in the Military:
4-From: _____/_____/_____ (DD / MM / YYYY) **5-To:** _____/_____/_____ (DD / MM / YYYY)

6-Are you still serving? _____Yes _____ No

7-Have you ever served on active duty in the Armed Forces of the United States? _____Yes _____No

8-Have you ever been assigned to duty for a minimum of 6 continuous years in the National Guard or a reserve component of the Armed Forces of the United States? _____Yes _____No

9-Have you ever served the Commissioned Corps of the United States Public Health Service or the Commissioned Corps of the National Oceanic and Atmospheric Administration of the United States in the capacity of a commissioned officer while on active duty in defense of the United States? _____Yes _____No

10-If the answer to question(s) 7, 8 and/or 9 is "yes," did you separate from such service under conditions other than dishonorable? (Unless you were dishonorably discharged, your answer should be "Yes.")
_____Yes _____No _____N/A

APPLICATION AFFIRMATION

I, _____,
(Print your full name)

being duly sworn, depose and say: That 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 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.

_____ _____
Signature of applicant **Date**

(NOTARY SEAL)

State of _____ County of _____
Subscribed and sworn to before me this _____ day of
_____, 2_____
My Commission Expires: _____
Residing at: _____
City State

_____
Signature of Notary

Continuing Education:

CONTINUING MEDICAL EDUCATION (CME) STATEMENT:

Note: *If you have previously submitted proof of 4 hours AMA Category 1 continuing medical education regarding bioterrorism or relating to medical consequences of act of terrorism involving use of weapon of mass destruction, you will not be responsible to do so again. For your information, this requirement became effective October 2003.*

Please place a check mark next to one of the following statements:

_____ (a) I was initially licensed in Nevada prior to or during the time period July 1, 2023 through December 31, 2023 and completed a minimum of 44 hours of AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics or pain management and/or addiction care, 20 hours of which were in my scope of practice or specialty and 4 of which were in bio-terrorism/weapons of mass destruction *(if applicable)*;

_____ (b) I was initially licensed in Nevada during the time period January 1, 2023 through June 30, 2023, the second six months of the past biennial period, and completed a minimum of 34 hours of AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics or pain management and/or addiction care, 20 hours of which were in my scope of practice or specialty and 4 of which were in bio-terrorism/weapons of mass destruction *(if applicable)*;

_____ (c) I was initially licensed in Nevada during the time period July 1, 2023 through December 31, 2023, the third six months of the past biennial period, and completed a minimum of 24 hours of AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics or pain management and/or addiction care, 18 hours of which were in my scope of practice or specialty and 4 of which were in bio-terrorism/weapons of mass destruction *(if applicable)*;

_____ (d) I was initially licensed in Nevada during the time period January 1, 2024 through June 30, 2024, the fourth six months of the past biennial period, and completed a minimum of 14 hours of AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics or pain management and/or addiction care, 8 hours of which were in my scope of practice or specialty and 4 of which were in bio-terrorism/weapons of mass destruction *(if applicable).*

Attach copies of proof of your completion of continuing medical education (CME) hours

Your copies of proof of CME or training completion will not be returned to you.

END OF PHYSICIAN ASSISTANT STATUS CHANGE APPLICATION

CHECKLIST FOR STATUS CHANGE APPLICATION
REQUESTING CHANGE FROM INACTIVE TO ACTIVE STATUS

_____	a.	**APPLICATION** ☐ Properly completed and signed application ☐ Appropriate explanations and copies of all pertinent documentation must be attached for any affirmative responses to questions 1 through 14, on pages 3 - 5
_____	b.	**FEES** • Proper payment of registration fee payable either by: o Cashier's check made payable to Nevada State Board of Medical Examiners (NSBME); o Money order made payable to Nevada State Board of Medical Examiners (NSBME); o Credit card – acceptable with signed credit card authorization form; [an additional 2.5% service fee will be charged for credit card payment]
_____	c.	**CONTINUING MEDICAL EDUCATION** • Proof of completion of AMA Category 1 continuing medical education (CME) completed during the preceding 24-month time period of the date of submission of this application for Status Change. Refer to page 8 for a detailed summarization of your continuing education requirement.
_____	d.	**ADDITIONAL REQUIREMENTS** ☐ A signed statement notifying the Board of your intent to resume the practice of medicine in the state of Nevada. ☐ A Notarized sworn affidavit to the Board describing your activities during your Inactive status.
_____	e.	**SELF-QUERY VERIFICATION** • National Practitioner Data Bank (NPDB); The NPDB will send the report directly to you and you will forward the final report to the board office; The request form for the National Practitioner Data Bank (NPDB) is available at http://www.npdb.hrsa.gov. Click on 'Self-Query' for Healthcare Professionals on the right side of the page and follow the instructions provided. If you require additional information, please call the NPDB at (800) 767-6732. Once you have received the final report or self-query response from the NPDB, forward a copy of this report to the Board office either by mail, fax or email.

CREDIT CARD AUTHORIZATION FORM

If mailing or faxing this page separately from the application, please mail to:
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521
or fax to:
775-688-2321

***Please type or print legibly*.**

Name of Applicant: _____

Method of Payment: ☐ MasterCard ☐ Visa ☐ American Express ☐ Discover

Name on Credit Card: _____

Business Name (if applicable): _____

Credit Card Billing Address:

_____

_____

_____

Phone Number: _____

Credit Card Number: _____

Expiration Date: _____ / _____ Credit Card Verification Code: CVC: _____
(MM) (YYYY) (Three or four digit code found on the front or back of the card)

For security of your financial information, please do not email this form to the Board; emailed forms will not be accepted.

I authorize the Nevada State Board of Medical Examiners to charge the above credit card for a one-time payment in the amount of $ _____.

Printed Name: _____

Authorized Signature: _____ Date: _____

Email Address for receipt: _____

Disclosure: By continuing, you will be charged a non-refundable card payment-processing fee of 2.5% for debit and credit cards by our payment processor. If you do not wish to pay the fee, you can select another payment option.