AGENDA ITEM 19(c)

Uniform Application for Licensure

Application ID: 296591
FID: 215809724

License Requested: MD
License Type: Permanent Medical License
Submitted to: Nevada State Board of Medical Examiners
Submission Date: 3/17/2020 7:48 PM

Practitioner Name

Okpara, Izuchukwu Daniel

Contact Information

Address

Public Access	Board Contact	Type	Address
Yes	Yes	Home	Santa Clarita, CA 91350 UNITED STATES

Phone

Public Access	Board Contact	Type	Phone Number	Phone Extension
Yes	Yes	Mobile		

Email

Public Access	Board Contact	Email
No	No	
Yes	Yes	

Identification

USMLE Number	SSN	Birth Date	Birth Place	Gender	NPI	Practitioner Type	US Citizen
52340742		/1986	NIGERIA	M		MD	Yes

Medical School

Medical School Name	Address	Start Date	End Date	Graduation Date	Degree Code
University of Texas Medical School at Galveston	301 University Boulevard Galveston, TX 77555 UNITED STATES	08/27/2007	05/27/2011	06/04/2011	MD

Fifth Pathway

None Reported

ECFMG

Certificate Number	Issue Date
None Reported	

Postgraduate Training

Hospital Name:	**Baylor College of Medicine Program** Houston, TX UNITED STATES	**Program Code:**	ACGME 4404821334
		Attendance Dates:	
Institution:	Baylor College of Medicine	**Start Date:**	07/11/2011
Training Specialty:	Surgery	**End Date:**	07/10/2012
		Program Type:	Internship
Training Status:	Completed		
Clinical %:	100	**Administrative %:**	0

Hospital Name:	**Los Angeles County-Harbor-UCLA Medical Center Program** Torrance, CA UNITED STATES	**Program Code:**	ACGME 4400521056
		Attendance Dates:	
Institution:	Los Angeles County-Harbor-UCLA Medical Center	**Start Date:**	07/01/2012
Training Specialty:	Surgery	**End Date:**	06/30/2013
		Program Type:	Residency
Training Status:	Completed		
Clinical %:	100	**Administrative %:**	0

Examination History

Exam	State	Last Attempt	Pass/Fail	Number Of Attempts
USMLE Step 1 Examination		06/15/2009	Pass	1
USMLE Step 2 CK Examination		08/23/2010	Pass	1
USMLE Step 2 CS Examination		09/21/2010	Pass	1
USMLE Step 3 Examination		06/18/2012	Pass	1

State Licensure History

MD, DO, PA License History

License Entity	Licensing State	License Number	Issue Date	Expiration Date	License Type	License Status
Medical Board of California	CA	A-126340	07/01/2013	07/31/2021	Full	Active
Texas Medical Board	TX	BP10039790	07/11/2011	07/10/2012	Training	Terminated
Texas Medical Board	TX	R0292	09/30/2016	11/30/2020	Full	Active

Physician Reported License History

Practitioner License Type	Licensing State	License Number	Issue Date	Expiration Date	Type	License Status

None Reported

Chronology of Activity Type

Practice/Emp/ Desc:	**University of Texas Medical School at Galveston**	**Chronology Type:**	Medical Education

Address: Galveston, TX
US

Position/Dept:

Clinical %:

Admin %:

Attendance Dates:

From: 08/27/2007 to 05/27/2011

Employment: Staff Privileges: Affiliation:

Practice/Emp/ Desc: Vacation

Chronology Type: Vacation

Address:

Position/Dept:

Clinical %: 0

Admin %: 0

Attendance Dates:

From: 06/01/2011 to 07/01/2011

Employment: Staff Privileges: Affiliation:

Practice/Emp/ Desc: Baylor College of Medicine Program

Chronology Type: Accredited Training

Address: Houston, TX
US

Position/Dept:

Clinical %: 100

Admin %: 0

Attendance Dates:

From: 07/11/2011 to 07/10/2012

Employment: Staff Privileges: Affiliation:

Practice/Emp/ Desc: Los Angeles County-Harbor-UCLA Medical Center Program

Chronology Type: Accredited Training

Address: Torrance, CA
US

Position/Dept:

Clinical %: 100

Admin %: 0

Attendance Dates:

From: 07/01/2012 to 06/30/2013

Employment: Staff Privileges: Affiliation:

Practice/Emp/ Desc: Seeking Employment

Chronology Type: Seeking Employmen t

Address:

Position/Dept:

Clinical %: 0

Admin %: 0

Attendance Dates:

From: 07/01/2013 to 09/01/2013

Employment: Staff Privileges: Affiliation:

Practice/Emp/ Desc: Wound Care Surgeons

Chronology Type: Work

Address:	7301 Topanga Canyon Blvd #330 Canoga Park, CA 91303 US	**Attendance Dates:**	
Position/Dept:	Contracted Wound Care Physician - Wound Care	**From:**	09/01/2013 to 02/01/2017
Clinical %:	100		
Admin %:	0		

Employment: • **Staff Privileges:** **Affiliation:**

Practice/Emp/ Desc:	**Omni Wound Physicians**	**Chronology Type:**	Work
Address:	27674 Newhall Ranch Road Suite C85 Valencia, California, CA 91355 US	**Attendance Dates:**	
Position/Dept:	Medical Director - Wound Care	**From:**	03/01/2017 to In Progress
Clinical %:	80		
Admin %:	20		

Employment: • **Staff Privileges:** **Affiliation:**

Malpractice

None Reported

ADDENDUM 3 – ADDITIONAL PHYSICIAN INFORMATION

CITIZENSHIP AND IDENTIFICATION

U.S. Citizen: Yes ☑ No ☐ Social Security Number: _____

Non U.S. Citizen: Yes ☐ No ☐ Social Security Number: _____ or

Individual Taxpayer Identification Number (ITIN): _____

Visa ☐ Indicate Visa Type: _____ Applying for Visa: Yes ☐ No ☐

For the items below, please provide your USCIS number.

Conditional Resident ☐ _____ Permanent Resident ☐ _____

Employment Authorization ☐ _____ Asylee ☐ _____

Color of Eyes: _____ Color of Hair: _____ Height: ___ Weight: _____

EXAMINATION SCORES

List all licensure examinations you have taken, whether U.S. or International, on the Examination History tab of the online Uniform Application. Also list below the score you received on each exam taken. INCLUDE ALL INFORMATION PERTAINING TO ANY AND ALL FAILED ATTEMPTS.

Examination Name	Date Taken	Score Received
USMLE Step 1	06/15/2009	Pass - 217
USMLE Step 2 CK	08/23/2010	Pass - 223
USMLE Step 2 CS	09/21/2010	Pass
USMLE Step 3	06/18/2012	Pass

Examination Name	Date Taken	Score Received

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SPECIALTY CERTIFICATION

Scope of Practice/Specialty(ies): General Surgery (not BE or BC), Wound Care

List any and all certifications and re-certifications by a Board or Sub-Board recognized by the **American Board of Medical Specialties.** INCLUDE ALL INFORMATION PERTAINING TO ANY AND ALL FAILED ATTEMPTS.

Board / Specialty Board	If you are Lifetime Board Certified, indicate "Lifetime"	Certification #	Dates of Certification/ Recertification (MM/YY)
~~American Board of Wound Healing~~	(Not recognized by ABMS)		07/19

If you hold "lifetime or historical" ABMS Board Certification, please provide a notarized statement agreeing to maintain Board Certification for the duration of your licensure in the state of Nevada.

ADDENDUM 4 – ATTESTATION QUESTIONS

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 THIS ADDENDUM.

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? If "Yes," attach an explanation on a separate sheet.	Yes ☐ No ☑ N/A ☐
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? If "Yes," attach an explanation on a separate sheet.	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? If "Yes," attach an explanation on a separate sheet.	Yes ☐ No ☑
4.	Have you failed to initiate the performance of public service within one year after the date the public service is required to begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local government for your medical education? If "Yes," attach an explanation on a separate sheet.	Yes ☐ No ☑
5a.	Have you EVER 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? If "Yes," please describe in the space provided on the Malpractice Liability Claims Information page within the online Uniform Application. Also complete addendum 5.	Yes ☐ No ☑
5b.	Have you EVER had a professional liability, malpractice, claim paid on your behalf, or paid such a claim yourself including any military tort claims if applicable? If "Yes," please describe in the space provided on the Malpractice Liability Claims Information page within the online Uniform Application. Also complete addenda 5 and 6.	Yes ☐ No ☑
6.	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 an explanation on a separate sheet.	Yes ☐ No ☑
7.	Have you previously applied for medical licensure in Nevada (including in a Residency program)? If "Yes," attach an explanation on a separate sheet.	Yes ☐ No ☑
8.	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? If "Yes," attach an explanation on a separate sheet.	Yes ☐ No ☑

9. Have you EVER been denied a license, permission to practice medicine or any other healing art, or permission to take an examination to practice medicine or any other healing art in any state, country or U.S. territory? If "Yes," attach an explanation on a separate sheet. Yes ☐ No ☑

10. Have you EVER had a medical license or license to practice any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory? If "Yes," attach an explanation on a separate sheet. Yes ☐ No ☑

11. Have you EVER voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory? If "Yes," attach an explanation on a separate sheet. Yes ☐ No ☑

12. Have you EVER been denied membership, asked to resign, or expelled from a medical society or other professional medical organization? If "Yes," attach an explanation on a separate sheet. Yes ☐ No ☑

13. 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 by any medical licensing board, hospital, medical society, governmental entity or agency other than the Nevada State Board of Medical Examiners? If "Yes," attach an explanation on a separate sheet. Yes ☐ No ☑

14. Have you EVER surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? If "Yes," attach an explanation on a separate sheet. Yes ☐ No ☑

15. 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 departmental or staff meetings, or maintain required malpractice insurance.)

Hospital	Mailing Address	Type of Action	Dates of Action

CHILD SUPPORT STATEMENT

The law of the state of Nevada requires that all applicants for issuance of a license be required to provide the following information concerning the support of a child. You are advised that this question is part of your application, your response is given under oath, and any response hereto which is false, fraudulent, misleading, inaccurate or incomplete, may result in your application being denied. You must mark one of the following responses, and failure to mark one of the responses may result in denial of your application.

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

Yes ☑ No ☐ I attest and affirm that I am aware and understand the reporting requirements found in Nevada Revised Statute 432B.220 regarding the abuse or neglect of a child.
http://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

Yes ☑ No ☐ 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.
http://www.cdc.gov/injectionsafety/IP07_standardPrecaution.html

COMMUNICATIONS AFFIRMATION

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 hereby agree that as a condition of obtaining or maintaining licensure with the Board, 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, and that the failure to do so may subject me to a fine or disciplinary action as allowed in NRS 630.244.

Printed Name of Applicant/Licensee: IZUCHUKWU OKPARA

Signature of Applicant/Licensee: _____ Email Address: _____

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.

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2-If yes, which branch of service did you serve? N/A

- ☐ Air Force
- ☐ Army
- ☐ Navy
- ☐ Marine Corps
- ☐ Coast Guard

3-Military occupation specialty or specialties? N/A

- ☐ 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: N/A

4-From: ____/____/____ (DD / MM / YYYY) 5-To: ____/____/____ (DD / MM / YYYY)

6-Are you still serving? __Yes ___No N/A

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, Izuchukwu Okpara,
(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 — 03/18/2020 Date

State of CA County of Los Angeles

Subscribed and sworn to before me this 18 day of MARCH, 2020

Notary Public for the State of CALIFORNIA

My Commission Expires: APRIL 17, 2020

Residing at: LOS ANGELES (City) CA (State)

Signature of Notary

DAE JUNG AHN
Commission No. 2149316
NOTARY PUBLIC-CALIFORNIA
LOS ANGELES COUNTY
My Comm Expires APRIL 17, 2020
NOTARY SEAL

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

ADDENDUM 8 – REQUEST FOR LICENSURE BY ENDORSEMENT

(ENDORSEMENT IS NOT THE SAME AS RECIPROCITY)

State your Name, and fill in the state, territory, or District of Columbia in which licensed:

I, Izuchukwu Okpara, being first duly sworn, do hereby swear or affirm under the penalties of perjury that the statements contained herein are true and correct to the best of my knowledge.

That I am now, and have been continuously, licensed to practice medicine by the licensing agency of

Medical Board of Texas (State, territory, or District of Columbia), since 12/01/2016 (month / day / year).

That I have never had a license to practice any type of medicine in any jurisdiction, country, state, territory, or District of Columbia, revoked for gross medical negligence.

That I am the person named in the license to practice medicine in Texas (state, territory, or District of Columbia),

and that said license to practice medicine was obtained by me without fraud or misrepresentation or any mistake of which I am aware, and that all information contained in this application for licensure by Endorsement, and any accompanying materials, are complete and correct.

DATED this 18th day of March, 2020.

Signature: _____

Typed or Printed Name: Izuchukwu Okpara

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DAE JUNG AHN
Commission No. 2149316
NOTARY PUBLIC-CALIFORNIA
LOS ANGELES COUNTY
My Comm. Expires APRIL 17, 2020
(NOTARY SEAL)

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of CA County of LOS ANGELES

Subscribed and sworn to before me this 18th day of MARCH, 2020.

Notary Public for the State of CALIFORNIA

My Commission Expires: APRIL 17, 2020

Residing at: LOS ANGELES (City) CA (State)

_____
Signature of Notary

Please return completed form to
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521