AGENDA ITEM 21(a)

Uniform Application for Licensure

Application ID: 286566
FID: 201993433

License Requested: MD
License Type: Permanent Medical License
Submitted to: Nevada State Board of Medical Examiners
Submission Date: 1/28/2020 4:19 PM

Practitioner Name

Swaine, Kent Alan

Contact Information

Address

Public Access	Board Contact	Type	Address
Yes	Yes	Home	24915 Ironwood Drive Valencia, CA 91355 UNITED STATES

Phone

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

Email

Public Access	Board Contact	Email
Yes	Yes	

Identification

USMLE Number	SSN	Birth Date	Birth Place	Gender	NPI	Practitioner Type	US Citizen
05537444		/1964	CA UNITED STATES	M		MD	Yes

Medical School

Medical School Name	Address	Start Date	End Date	Graduation Date	Degree Code
Ross University	School of Medicine PO BOX 266 Roseau, 04 DOMINICA	06/05/1994	06/05/1998	06/05/1998	MD

Fifth Pathway

None Reported

ECFMG

Certificate Number	Issue Date
05537444	06/22/1998

Postgraduate Training

Hospital Name: JFK Medical Center Program
Edison, NJ UNITED STATES

Program Code: ACGME 1203311190

Attendance Dates:

Institution: JFK Medical Center

Start Date: 07/01/1998

Training Specialty: Family Medicine

End Date: 07/01/2001

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		06/11/1996	Pass	1
USMLE Step 2 CK Examination		08/26/1997	Pass	1
USMLE Step 3 Examination		12/12/2000	Pass	1
SPEX	NV	01/15/2020	Pass	1

State Licensure History

MD, DO, PA License History

License Entity	Licensing State	License Number	Issue Date	Expiration Date	License Type	License Status
Nevada State Board of Medical Examiners	NV	13917	06/10/2011	06/30/2015	Full	Expired
Nevada State Board of Medical Examiners	NV	9815	07/01/2001	10/14/2008	Full	Revoked
Hawaii Medical Board	HI	MD-11389	02/22/2001	01/31/2002		Expired

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: Ross University

Chronology Type: Medical Education

Address: Roseau, 04
DM

Attendance Dates:

Position/Dept:

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From: 06/05/1994 to 06/05/1998

Clinical %:

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Admin %:

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

Practice/Emp/ Desc: JFK Medical Center Program

Chronology Type: Accredited Training

Address: Edison, NJ
US

Attendance Dates:

Position/Dept:

From: 07/01/1998 to 07/01/2001

Clinical %: 100

Admin %: 0

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

Practice/Emp/ Desc: **Comprehensive Primary Care**

Chronology Type: Work

Address: 3201 South Maryland Parkway Suite 220
Las Vegas, NV 89101
US

Attendance Dates:

Position/Dept: Family Medicine Physician - Primary care outpatient

From: 08/01/2001 to 11/15/2002

Clinical %: 80

Admin %: 20

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

Practice/Emp/ Desc: **Self Employed Physician**

Chronology Type: Work

Address: 416 Windsor Castle Court
Las Vegas, NV 89138
US

Attendance Dates:

Position/Dept: Inpatient and outpatient family medicine physician - Primary care

From: 11/15/2002 to 06/30/2007

Clinical %: 90

Admin %: 10

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

Practice/Emp/ Desc: **N/A**

Chronology Type: Health Issue

Address:

Attendance Dates:

Position/Dept:

From: 07/01/2007 to 10/31/2009

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Clinical %: 0

Admin %: 0

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

Practice/Emp/ Desc: **Nevada Heart and Vascular Center**

Chronology Type: Work

Address: 5380 South Rainbow Blvd. Suite 226
Las Vegas, NV 89118
US

Attendance Dates:

Position/Dept: Employee - Outpatient clinical setting

From: 11/01/2009 to 08/15/2011

Clinical %: 50

Admin %: 50

Employment:	Staff Privileges:	Affiliation:

Practice/Emp/ Desc: Diagnostic Center of Medicine

Chronology Type: Work

Address: 5280 South Rainbow Blvd. Suite 120
Las Vegas, NV 89118
US

Attendance Dates:

Position/Dept: Family Medicine Physician - Primary Care clinical setting

From: 09/01/2011 to 01/31/2014

Clinical %: 80

Admin %: 20

Employment:	Staff Privileges:	Affiliation:

Practice/Emp/ Desc: N/A

Chronology Type: Health Issue

Address:

Attendance Dates:

Position/Dept:

From: 02/01/2014 to 09/30/2016

Clinical %: 0

Admin %: 0

Employment:	Staff Privileges:	Affiliation:

Practice/Emp/ Desc: Rosati's

Chronology Type: Work

Address: 8001 North Durango Drive Unit 110
Las Vegas, NV 89143
US

Attendance Dates:

Position/Dept: employee - restaurant

From: 10/15/2016 to 08/01/2017

Clinical %: 0

Admin %: 100

Employment:	Staff Privileges:	Affiliation:

Practice/Emp/ Desc: N/A

Chronology Type: Health Issue

Address:

Attendance Dates:

Position/Dept:

From: 08/01/2017 to 02/01/2018

Clinical %: 0

Admin %: 0

Employment:	Staff Privileges:	Affiliation:

Practice/Emp/ Desc: Aloha Home Health Care

Chronology Type: Work

Address: 3160 South Valley View Boulevard
Unit 205
Las Vegas, NV 89102
US

Attendance Dates:

Position/Dept: marketing liaison - marketing

From: 03/01/2018 to 05/31/2019

Clinical %: 0

Admin %: 100

Employment:	Staff Privileges:	Affiliation:

Practice/Emp/ Desc:	N/A	Chronology Type:	Seeking Employment
	Address:	Attendance Dates:	
	Position/Dept:	From:	06/01/2019 to In Progress
	Clinical %: 0		
	Admin %: 0		

Employment:	Staff Privileges:	Affiliation:

Malpractice

Patient Name:

State Incident Occurred: **Court:**

Case Number: **Insurance Carrier:**

Case Status: **Date of Event:**

Judgement/Settlement Amount: **Amount Paid:**

What is/was your status? **Date of Lawsuit:**

Provide specifics in reference to the event including the allegations and your role:

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 [X] 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 [X] 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 [X] 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 [X] 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 [X] 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 [X] 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.)

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Hospital	Mailing Address	Type of Action	Dates of Action
St. Rose Dominican Hospitals	3001 Saint Rose Parkway Henderson, Nevada 89052	Revocation	11/01/2007

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 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: Kent Alan Swaine, M.D.

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 __X__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?

- ☐ 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, Kent Alan Swaine, M.D.,
(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.

_____ _____ 2/13/20
Signature of applicant **Date**

(NOTARY SEAL)

NOTARY PUBLIC
STATE OF NEVADA
County of Clark
HANNA R. KORN
No. 14-15413-1 My Appointment Expires October 15, 2022

State of Nevada County of Clark

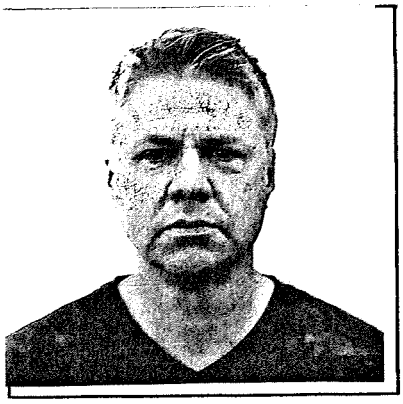
Subscribed and sworn to before me this 13th day of February, 2020.
by Kent A Swaine

Notary Public for the State of Nevada

My Commission Expires: 10/15/2022

Residing at: Las Vegas, NV
City State

_____
Signature of Notary



Applicant's signature (must be signed in the presence of a notary)

Swaine, Kent, A

Applicant's printed last name, first name, middle initial, and suffix (e.g., Jr.)

2/13/20

Date of signature (must correspond to date of notarization)

NOTARY:

[Please note: The Notary Public seal should overlap the bottom of the photo to the left. Do not cover the entire face with the seal.]

State of ∝, County of ∝,

I certify that on the date set forth below, the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document.

The statements on this document are subscribed and sworn to before me by the applicant on this _____ day of _____, 20____.

Notary Public Signature ∝ See Notary Attach ∝ My Notary Commission Expires ∝