AGENDA ITEM 21(b)

PHYSICIAN (M.D.)
APPLICATION FOR LICENSURE
NEVADA STATE BOARD OF
MEDICAL EXAMINERS
9600 Gateway Drive, Reno, Nevada 89521
Phone (775) 688-2559

Date Received by Board
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NEVADA STATE BOARD OF
MEDICAL EXAMINERS
For Board Use Only

License No.____________

File No.____________

Identity:

1. Present Legal Name Stephen (Last) Holmes (First) E. (Middle) ______ (Maiden)

List any other name(s) ever used ____________

Address:
The **Public Access Address** will be available to the public on the Board's website, and will also be your contact address once licensed. It can be changed if the Licensee completes the Notification of Address Change form available on the Board's website: www.medboard.nv.gov.
The **Mailing Address** that you choose will be used for communication only during the application process. It can be one and the same.

2. Public Address ______ Street ______ City ______ County ______ State ______ Zip

☒ Please check if you choose to have your Mailing Address the same as the Public Address you have entered above.

3. Mailing Address 418 10th St. NW (Street) Rochester (City) ______ (County) MN (State) 55902 (Zip)

4. Telephone Numbers ( ) ______ Office ( ) ______ Fax ( ) ______ Home ( ) ______ Cellular (Optional)

Email address ______

5. Date of Birth ______ (Month / Day / Year) Place of Birth ______ (City, State, Country) Gender ___F ___M

6. Citizenship: U.S. Citizen ___ Alien Registration # ______ Employment Authorization # ______ Visa ______

Submit a Certified Birth Certificate or original Certificate of Naturalization or current U.S. Passport or copy of the front and back of your Alien Registration card, Employment Authorization card or Visa. Please note: Copy of the document authorizing your name change (marriage license, divorce decree, etc.) must be included.

7. Social Security Number ______ Color of Eyes ______ Color of Hair ______ Height ______ Weight ______

NRS 630.197(1)(a) An applicant for the issuance of a license to practice medicine shall include the social security number of the applicant in the application submitted to the Board.
NRS 630.165(5) The applicant bears the burden of proving and documenting his qualifications for licensure.

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 legitmate medical purposes and in accordance with the prescriber's direction.

FOR ALL "YES" RESPONSES TO THE FOLLOWING QUESTIONS, YOU MUST SUBMIT YOUR SIGNED WRITTEN EXPLANATION(S) ON A SEPARATE SHEET ATTACHED TO YOUR COMPLETED *APPLICATION FOR LICENSURE* FORM.

8. 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 explanation on separate sheet.) ___Yes ✓ No

9. 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 explanation on separate sheet.) ___Yes ___No ✓ N/A

10. 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 explanation on separate sheet.) ___Yes ___No ✓ N/A

11. 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 explanation on separate sheet.) ___Yes ✓ No

Malpractice Questions:

12. 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?

_____Yes X No

12a. 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?

_____Yes X 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 you have not answered "yes" to questions #12 and/or #12a 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:

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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/or 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:

Arrest Question:

13. 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 misdemea nor, 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 be ing in control of a motor vehicle while under the influence of a chemical substance, including alcohol, is not considered a minor t raffic 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 di smissal, or expungement. ____Yes __X__No

(If "Yes," attach explanation on separate sheet.)

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Nevada License History:

14. Have you previously applied for medical licensure in Nevada (including in a Residency program)? ____Yes __x__No

(If "Yes," attach explanation on separate sheet.)

Medical School and Postgraduate Training History:

15. List names and addresses of all medical schools attended. **HAVE EACH MEDICAL SCHOOL SUBMIT AN OFFICIAL TRANSCRIPT DIRECTLY TO THE BOARD.**

Medical School Name	City/State/Country	Place Where Instruction Received	Dates of Attendance From (Mo./Yr.) To (Mo./Yr.)
Spartan Health Sciences University	Vieux Fort, FC, St. Lucia		09/1996 - 04/2000

(All information must begin on the application. If more space is needed, please attach separate sheet.)

16. Doctor of Medicine Degree granted by:

Medical School Name	City/State/Country	Exact Date of Issuance (Month/Day/Year)
Spartan Health Sciences University	Vieux Fort, FC, St. Lucia	04/21/2000

17. List all ACGME* approved postgraduate medical education you have received as an Intern, Resident or Fellowship in the United States or Canada.
*Accreditation Council for Graduate Medical Education

Postgraduate Year (e.g. PGY1, PGY2, etc.)	Hospital/ Institution	City/State	Specify (I =Internship or R = Residency) (F = Fellowship)	Type of Specialty	Dates of Attendance From (Mo./Yr.) To (Mo./Yr.)
1-3	Guthrie Robert Packer Hospital	Sayre, PA	R	Family Medicine	07/2003 - 6/2006
4	Community Health Center	Salt Lake City, UT	F	Family Medicine	07/2006 - 12/2006

(All information must begin on the application. If more space is needed, please attach separate sheet.)

18. List non-ACGME Fellowship training or non-ACGME combined postgraduate medical education attended in the United States or Canada.

If combined program list Postgraduate Year (e.g. PGY1, PGY2, etc.)	Hospital/ Institution	City/State	Specify (I =Internship or R = Residency) (F = Fellowship)	Type of Specialty	Dates of Attendance From (Mo./Yr.) To (Mo./Yr.)

(All information must begin on the application. If more space is needed, please attach separate sheet.)

19. 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 explanation on separate sheet.) ____Yes __✓__No

20. If you graduated from a medical school located outside the United States of America or Canada, list your ECFMG#: 0-597-537-0

Examinations:

21. For each of the following licensing examinations, list the location, parts and dates taken, and scores obtained. (Also include failed examinations.) FOR EACH EXAM TAKEN, HAVE CERTIFICATE OF SCORES SUBMITTED FROM THE TESTING ENTITY DIRECTLY TO THE BOARD OFFICE.

21a. STATE Written Examination:

Location	Date (Mo./Yr.)	Results (Scores)

21b. NATIONAL BOARD (not ABMS Board certification): (ALSO INCLUDE ALL INFORMATION PERTAINING TO ANY AND ALL FAILED EXAMS)

Part Taken	Date (Mo./Yr.)	Results (Scores)

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

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21c. FLEX (Federation Licensing Examination): (ALSO INCLUDE ALL INFORMATION PERTAINING TO ANY AND ALL FAILED EXAMS)

Date (Mo./Yr.)	Results (FLEX weighted average)

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

21d. USMLE (United States Medical Licensing Examination): (ALSO INCLUDE ALL INFORMATION PERTAINING TO ANY AND ALL FAILED EXAMS)

Step Taken	Number of Attempts	Date (Mo./Yr.)	Results (Three Digit Scores)
USMLE Step 1	5	6/98, 8/99, 6/00, 2/01, 12/01	167, 167, 159, 174, 185
USMLE Step 2 CK	4	12/99, 8/00, 7/01, 7/02	167, 170, 173, 201
USMLE Step 3	1	12/8/2004	188

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

21e. LMCC (Licentiate of the Medical Counsel of Canada): (ALSO INCLUDE ALL INFORMATION PERTAINING TO ANY AND ALL FAILED EXAMS)

Part Taken	Date (Mo./Yr.)	Results (Scores)

21f. SPEX (Special Purpose Examination):

Date (Mo./Yr.)	Results (Score)

Specialty:

22. State your scope of practice / specialty (ies) Family Medicine

23. List any and all certifications and re-certifications by a board or sub-board recognized by the **AMERICAN BOARD OF MEDICAL SPECIALTIES (ABMS).** INCLUDE ALL INFORMATION PERTAINING TO ANY AND ALL FAILED ATTEMPTS.

ABMS Primary Board	Specialty Board	If you are Lifetime Board Certified, indicate "Lifetime"	Certification #	Dates of Certification and Recertification (Mo./Yr.)
ABFM	Family Medicine	N/A		12/06 - 12/16

Activities:

24. Account for, **in chronological order**, all activities since graduation from medical school. **ALL PERIODS OF TIME MUST BE ACCOUNTED FOR.** Activities include Postgraduate Training, Medical Practice/Physician, Non-Medical (such as seeking employment or vacation), Military Assignment, and Working at a Federal Facility. **Curriculum Vitae cannot be submitted in lieu of your answer to this question.**

Activities	Location (City/State/Country)	From (Mo./Yr.) To (Mo./Yr.)	Percent Clinical (%)
Please see attached	Rochester, MN, USA	05/2000 - 06/2003	N/A
Guthrie Robert Packer Hospital Family Medicine Residency	Sayre, PA, USA	07/2003 - 06/2006	N/A
Community Health Center Family Medicine Fellowship	Salt Lake City, UT, USA	07/2006 - 12/2006	N/A
Moved from UT to MT looking for a job after Fellowship		01/2007 - 04/2007	N/A
Frances Mahon Deaconess Hospital	Glasgow, MT, USA	04/2007 - 03/2011	80%
Moved to Rochester, MN interviewing for numerous jobs		03/2011 - 07/2011	N/A

(All information must begin on the application. If more space is needed, please attach separate sheet.)

25. List below the requested information for all hospitals or surgery centers in which you **ARE, OR HAVE EVER BEEN** a staff member at any level during the last ten years. If none, please indicate. Do not list internship, residency or fellowship affiliation.

Hospital	Complete Mailing Address	Dates of Appointment From (Mo./Yr.) To (Mo./Yr.)
Frances Mahon Deaconess Hospital	221 5th Ave S, Glasgow, MT 59230	04/2007 - 03/2011

(All information must begin on the application, if more space is needed, please attach separate sheet.)

26. List any and all licenses **YOU HOLD OR HAVE HELD** (including postgraduate training/resident licenses) to practice medicine in any state, territory or country. Note: You will not be required to verify your training licenses by direct source.

State/Territory Country	License #	Date of Issuance (Mo./Yr.)	Status
✓ IA	MD-39478	04/22/2011	Active
✓ MT	58839	07/28/2017	Active
✓ PA	MT181176	06/4/2003	Inactive
✓ OR	MD186627	07/10/2018	Active
✓ UT	618894-8905	06/16/2006	Expired

(All information must begin on the application, if more space is needed, please attach separate sheet.)

Disciplinary Questions:

27. 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 explanation on separate sheet.) ____Yes X No

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28. 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 explanation on separate sheet.) ____Yes X No

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29. Have you EVER voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory in lieu of disciplinary action? (If "Yes," attach explanation on separate sheet.) ____Yes X No

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30. Have you EVER been denied membership, asked to resign, or expelled from a medical society or other professional medical organization? (If "Yes," attach explanation on separate sheet.) ____Yes X No

31. 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 explanation on separate sheet.) ____Yes X No

32. Have you EVER surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? (If "Yes," attach explanation on separate sheet.) ____Yes X No

33. 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.)

(All information must begin on the application, if more space is needed, please attach separate sheet.)

Attestations/Affirmations:

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.

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

X (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. X Yes ______No

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

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. X Yes ______No

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 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.

Printed Name of Applicant/Licensee: Stephen Holmes MD

Signature of Applicant/Licensee: ______

Electronic Mail Address: ______

MILITARY SERVICE ATTESTATION

1-Have you ever served in the United States Military (to include National Guard or Reserves)? __X__ 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?

- ☐ 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 1969 YYYY 5-To: ____ DD ____ MM 197? YYYY

6-Are you still serving? ______ Yes __X__ No

7-Have you ever served on active duty in the Armed Forces of the United States? __X__ 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 __X__ 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 __X__ 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? * Honorable Discharge __X__ Yes ______ No ______ N/A

APPLICANT PHOTOGRAPH

ATTACH A FINISHED PHOTOGRAPH OF PASSPORT QUALITY OF YOUR HEAD AND SHOULDERS ONLY.

PHOTOGRAPH MUST HAVE BEEN TAKEN WITHIN THE LAST SIX MONTHS AND BE AT LEAST 2" x 2" IN SIZE.

I hereby certify that the attached photograph is a true likeness of me taken within the last six months.

________________ Signature of applicant   2/17/2020 Date

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APPLICATION AFFIRMATION

I, Stephen Holmes, MD
(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.

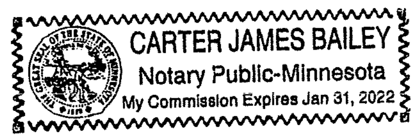
I am responsible to keep the Board informed of any circumstance or event that would require a change to my initial responses provided to the Board in my application for licensure, and which occurs prior to my being granted licensure to practice medicine in the state of Nevada.

MD 2/17/2020
Signature of applicant Date

State of MN County of Olmsted
Subscribed and sworn to before me this 17th day of
February, 2020
Notary Public for the State of MN
My Commission Expires: 1/31/2022
Residing at: Rochester MN
City State

Signature of Notary

(NOTARY SEAL)



END OF APPLICATION