# Uniform Application for Licensure

**Application ID:** 304180
**FID:** 217316496

**License Requested:** MD
**License Type:** Permanent Medical License
**Submitted to:** Nevada State Board of Medical Examiners
**Submission Date:** 7/7/2020 1:55 PM



## Practitioner Name

Lin, Bingtao

## Contact Information

### Address

| Public Access | Board Contact | Type | Address |
|---|---|---|---|
| Yes | No | Home | [redacted]<br>UNITED STATES |
| No | Yes | Business | 1600 CREEKSIDE DR.<br>STE: 2400<br>FOLSOM<br>Folsom, CA 95630<br>UNITED STATES |

### Phone

| Public Access | Board Contact | Type | Phone Number | Phone Extension |
|---|---|---|---|---|
| No | Yes | Business | (916) 673-9414 | |
| Yes | No | | | |

### Email

| Public Access | Board Contact | Email |
|---|---|---|
| Yes | No | |
| No | Yes | |

## Identification

| USMLE Number | SSN | Birth Date | Birth Place | Gender | NPI | Practitioner Type | US Citizen |
|---|---|---|---|---|---|---|---|
| | | '1976 | CHINA | M | | MD | No |

## Medical School

| Medical School Name | Address | Start Date | End Date | Graduation Date | Degree Code |
|---|---|---|---|---|---|
| Sun Yat-Sen University Of Medical Sciences | Zhongshan Road II<br>Guangzhou, 44<br>CHINA | 09/07/1994 | 07/02/1999 | 07/05/1999 | BM |

## Fifth Pathway

None Reported

## ECFMG

| Certificate Number | Issue Date |
|---|---|
| 08756652 | 06/22/2012 |

## Postgraduate Training

| | | | |
|---|---|---|---|
| **Hospital Name:** | **Brookdale University Hospital and Medical Center Program**<br>Brooklyn, NY UNITED STATES | **Program Code:** | ACGME 1403511264 |
| | | **Attendance Dates:** | |
| **Institution:** | Brookdale University Hospital and Medical Center | **Start Date:** | 07/01/2013 |
| **Training Specialty:** | Internal Medicine | **End Date:** | 06/30/2014 |
| | | **Program Type:** | Residency |
| **Training Status:** | Completed | | |
| **Clinical %:** | 25 | **Administrative %:** | 75 |



| | | | |
|---|---|---|---|
| **Hospital Name:** | **Rutgers Robert Wood Johnson Medical School Program**<br>New Brunswick, NJ UNITED STATES | **Program Code:** | ACGME 1803321157 |
| | | **Attendance Dates:** | |
| **Institution:** | Rutgers Robert Wood Johnson Medical School | **Start Date:** | 07/01/2014 |
| **Training Specialty:** | Neurology | **End Date:** | 07/01/2015 |
| | | **Program Type:** | Residency |
| **Training Status:** | Completed | | |
| **Clinical %:** | 100 | **Administrative %:** | 0 |

## Examination History

| Exam | State | Last Attempt | Pass/Fail | Number Of Attempts |
|---|---|---|---|---|
| USMLE Step 2 CS Examination | | 02/01/2012 | Pass | 1 |
| USMLE Step 2 CK Examination | | 07/02/2012 | Pass | 1 |
| USMLE Step 1 Examination | | 07/23/2012 | Pass | 1 |
| USMLE Step 3 Examination | | 07/29/2015 | Pass | 3 |

## 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-141761 | 04/05/2016 | 07/31/2021 | Full | Active |
| Washington Medical Commission | WA | MD61019680 | 03/24/2020 | 07/22/2022 | 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:** | **Sun Yat-Sen University Of Medical Sciences** | **Chronology Type:** | Medical Education |

Address: Guangzhou, 44
CN

Attendance Dates:

Position/Dept:

From: 09/07/1994 to 07/02/1999

Clinical %:

Admin %:



Employment: Staff Privileges: Affiliation:

Practice/Emp/ Desc: **Orthopedic Resident**

Chronology Type: PGT/Education

Address: 106 Zhongshan 2nd Road
Guangzhou, 44
CN

Attendance Dates:

Position/Dept: Orthopedic Surgery Resident - Orthopedics

From: 07/01/1999 to 07/01/2004

Clinical %: 100

Admin %: 0

Employment: Staff Privileges: Affiliation:

Practice/Emp/ Desc: **Guangdong General Hospital**

Chronology Type: PGT/Education

Address: 106 Zhongshan, 2nd Road
Guangzhou, 44
CN

Attendance Dates:

Position/Dept: Chief Orthopedic Surgeon Resident - Orthopedics

From: 07/01/2004 to 07/01/2010

Clinical %: 100

Admin %: 0

Employment: Staff Privileges: Affiliation:

Practice/Emp/ Desc: **Orthopedic Fellowship**

Chronology Type: PGT/Education

Address: Odense, Denmark
Odense, 83
DK

Attendance Dates:

Position/Dept: Orthopedic Fellowship - Orthopedics

From: 09/01/2006 to 12/30/2006

Clinical %: 80

Admin %: 20

Employment: Staff Privileges: Affiliation:

Practice/Emp/ Desc: **Hong Kong Medic-Express**

Chronology Type: Work

Address: Closed
Hong Kong, * 95631
HK

Attendance Dates:

Position/Dept: Consultant Sports Doctor, Director of Sports Medicine Department - Sports Medicine

From: 07/01/2010 to 07/01/2013

Clinical %: 100

Admin %: 0

Employment: Staff Privileges: Affiliation:

Practice/Emp/ Desc: Brookdale University Hospital and Medical Center Program

Address: Brooklyn, NY US

Position/Dept:

Clinical %: 25

Admin %: 75

Chronology Type: Accredited Training

Attendance Dates:

From: 07/01/2013 to 06/30/2014



Employment: Staff Privileges: Affiliation:

Practice/Emp/ Desc: Rutgers Robert Wood Johnson Medical School Program

Address: New Brunswick, NJ US

Position/Dept:

Clinical %: 100

Admin %: 0

Chronology Type: Accredited Training

Attendance Dates:

From: 07/01/2014 to 07/01/2015

Employment: Staff Privileges: Affiliation:

Practice/Emp/ Desc: Robert Wood Johnson University Hospital

Address: 1 Robert Wood Johnson Pl. New Brunswick, NJ 08901 US

Position/Dept: PGY2 Adult Neurology Residency - Neurology

Clinical %: 100

Admin %: 0

Chronology Type: PGT/Education

Attendance Dates:

From: 07/01/2014 to 07/01/2015

Employment: Staff Privileges: Affiliation:

Practice/Emp/ Desc: Seeking Employment

Address:

Position/Dept:

Clinical %: 0

Admin %: 0

Chronology Type: Seeking Employment

Attendance Dates:

From: 08/01/2015 to 12/01/2015

Employment: Staff Privileges: Affiliation:

Practice/Emp/ Desc: Central Valley Pain Management

Address: 6401 Truxtun Ave. Suite B Bakersfield, CA 93309 US

Position/Dept: Pain Management Clinical /Staff Physician - Pain Management

Clinical %: 100

Admin %: 0

Chronology Type: Work

Attendance Dates:

From: 12/01/2015 to 08/01/2017

Employment: Staff Privileges: Affiliation:

| | | | | | |
|---|---|---|---|---|---|
| Practice/Emp/ Desc: | Advanced Pain Diagnostic and Solutions | | Chronology Type: | Work | |
| | Address: | 729 Sunrise Ave suite 602<br>Roseville, CA 95661<br>US | Attendance Dates: | | |
| | Position/Dept: | Associate Medical Director - Pain Managment | From: | 09/01/2017 | to 09/01/2018 |
| | Clinical %: | 100 | | | |
| | Admin %: | 0 | | | |
| | Employment: | Staff Privileges: | Affiliation: | | |



| | | | | | |
|---|---|---|---|---|---|
| Practice/Emp/ Desc: | Ortho-Gen | | Chronology Type: | Work | |
| | Address: | 1600 CREEKSIDE DR.<br>STE: 2400<br>FOLSOM<br>Folsom, CA 95630<br>US | Attendance Dates: | | |
| | Position/Dept: | CEO/Medical Director - Pain Management | From: | 10/01/2018 | to In Progress |
| | Clinical %: | 100 | | | |
| | Admin %: | 0 | | | |
| | 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 | Examination Name | Date Taken | Score Received |
|---|---|---|---|---|---|
| USMLE Step 2 CS | 2/01/2012 | Pass | | | |
| USMLE Step 2 CK | 7/02/2012 | Pass | | | |
| USMLE Step 1 | 7/23/2012 | Pass | | | |
| USMLE Step 3 | 7/29/2015 | Pass | | | |
| | | | | | |
| | | | | | |

## SPECIALTY CERTIFICATION

Scope of Practice/Specialty(ies): Pain Management / Sports Medicine

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) |
|---|---|---|---|
| | | | |
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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: Binqtao Lin

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 X 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, Bingtao Lin, **(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**

07/07/20 **Date**

State of CALIFORNIA County of EL DORADO

Subscribed and sworn to before me this 7TH day of JULY 2020.

(NOTARY SEAL)

KENNETH K. WONG
COMM. # 2193063
NOTARY PUBLIC - CALIFORNIA
EL DORADO COUNTY
MY COMM. EXP. APR. 22, 2021

Notary Public for the State of CALIFORNIA

My Commission Expires: 4/22/2021

Residing at: EL DORADO HILLS (City) CA (State)

_____
Signature of Notary

UA UNIFORM APPLICATION FOR LICENSURE

For State Board Use Only

**Applicant:** In the presence of a notary public, sign this form with attached photo. If you are using FCVS for credentials verification, consider having that form notarized at the same time. Send the separate notarized FCVS form to FCVS. **Do not send this form to FCVS** as doing so will delay your licensure.

**Send this form to the board you are applying to for licensure.** Include all other required materials. A directory of state medical and osteopathic boards is available at: http://www.fsmb.org/contact-a-state-medical-board/.

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NEVADA STATE BOARD OF MEDICAL EXAMINERS

Please send this form to: Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521

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

LIN, BINGTAO

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

07/07/2020

*Date of signature (must correspond to date of notarization)*

KENNETH K. WONG
COMM. # 2193063
NOTARY PUBLIC - CALIFORNIA
EL DORADO COUNTY
MY COMM. EXP. APR. 22, 2021

**NOTARY:**

KENNETH K. WONG
COMM. # 2193063
NOTARY PUBLIC - CALIFORNIA
EL DORADO COUNTY
MY COMM. EXP. APR. 22, 2021

[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 CALIFORNIA, County of EL DORADO.

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 7TH day of JULY, 2020.

Notary Public Signature _____ My Notary Commission Expires 4/22/2021