# AGENDA ITEM 19(b)

# Uniform Application for Licensure

**Application ID:** 281039
**FID:** 201425873

**License Requested:** MD
**License Type:** Permanent Medical License
**Submitted to:** Nevada State Board of Medical Examiners
**Submission Date:** 06/24/2019

## Practitioner Name

**St.Martin, Dacelin**

**Alternate Name(s):** St. Martin Hicher, Dacelin

## Contact Information

Address

| Public Access | Board Contact | Type | Address |
|---|---|---|---|
| Yes | No | Business | 1990 N Prospect Ave<br>Lecanto, FL 34461<br>UNITED STATES |
| No | Yes | Business | |
| No | No | Home | |

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Phone

| Public Access | Board Contact | Type | Phone Number | Phone Extension |
|---|---|---|---|---|
| Yes | No | Business | (352) 527-6888 | |
| No | No | Business | | |
| No | Yes | Business | | |
| No | No | Mobile | | |

Email

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

## Identification

| USMLE Number | SSN | Birth Date | Birth Place | Gender | NRI | Practitioner Type | US Citizen |
|---|---|---|---|---|---|---|---|
| | | 1966 | HAITI | M | | MD | Yes |

## Medical School

| Medical School Name | Address | Start Date | End Date | Graduation Date | Degree Code |
|---|---|---|---|---|---|
| Universidad De Montemorelos | Escuela De medicina<br>Avenida Libertad Poniente 1300<br>APDO 16-10<br>Montemorelos, NLE 67530<br>MEXICO | 01/06/1989 | 06/30/1995 | 04/17/1996 | PS |

## Fifth Pathway

None Reported

## ECFMG

| Certificate Number | Issue Date |
|---|---|
| 04883062 | 01/26/1996 |

## Postgraduate Training

**Hospital Name:** **New York Medical College (Metropolitan) Program**
New York, NY UNITED STATES

**Program Code:** ACGME 1403531290

**Attendance Dates:**

**Institution:** New York Medical College

**Start Date:** 07/01/1996

**Training Specialty:** Internal Medicine

**End Date:** 06/30/1997

**Program Type:** Residency

**Training Status:** Completed

**Clinical %:** 100

**Administrative %:** 0

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**Hospital Name:** **Yale University (Bridgeport) Program**
Bridgeport, CT UNITED STATES

**Program Code:** ACGME 7000844008

**Attendance Dates:**

**Institution:** Bridgeport Hospital

**Start Date:** 07/01/1997

**Training Specialty:** Internal Medicine/Pediatrics

**End Date:** 06/30/2001

**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 | | 06/08/1993 | Pass | 2 |
| USMLE Step 2 CK Examination | | 03/30/1994 | Pass | 1 |
| USMLE Step 3 Examination | | 12/02/1997 | Pass | 1 |

## State Licensure History

MD, DO, PA License History

| License Entity | Licensing State | License Number | Issue Date | Expiration Date | License Type | License Status |
|---|---|---|---|---|---|---|
| Colorado Medical Board | CO | | | | Full | |
| Tennessee Board of Medical Examiners | TN | | | | | Applicant |
| Connecticut Medical Examining Board | CT | 038355 | 12/30/1999 | 08/31/2004 | Full | Inactive |
| Massachusetts Board of Registration in Medicine | MA | 205680 | 10/11/2000 | 08/07/2005 | | Inactive |
| Rhode Island Board of Medical Licensure and Discipline | RI | MD10520 | 03/14/2001 | 06/30/2004 | Full | |
| Georgia Composite Medical Board | GA | 53720 | 09/12/2003 | 08/31/2007 | Full | Lapsed |
| Florida Board of Medicine | FL | ME90844 | 06/24/2004 | 01/31/2020 | Full | Active |
| State Medical Board of Ohio | OH | APP-000255773 | | | Full | Pending |
| Washington Medical Quality Assurance Commission | WA | MD60966553 | | | Full | Pending |

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:** **Universidad De Montemorelos** **Chronology Type:** Medical Education

**Address:** Montemorelos, NLE
MX



**Position/Dept:**

**Clinical %:**

**Admin %:**

**Attendance Dates:**
**Start Date:** 01/06/1989
**End Date:** 06/30/1995

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

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**Practice/Emp/ Desc:** **St. Anne's Bay Hospital** **Chronology Type:** Work

**Address:** St. Anne's Bay
Saint Ann, 06
JM

**Position/Dept:** Licensed Medical Practitioner - General Medicine

**Clinical %:** 100

**Admin %:** 0

**Attendance Dates:**
**Start Date:** 07/01/1995
**End Date:** 06/01/1996

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

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**Practice/Emp/ Desc:** **New York Medical College (Metropolitan) Program** **Chronology Type:** Accredited Training

| | | | |
|---|---|---|---|
| | **Address:** | New York, NY<br>US | **Attendance Dates:** |
| | **Position/Dept:** | | **Start Date:** 07/01/1996 |
| | | | **End Date:** 06/30/1997 |
| | **Clinical %:** | 100 | |
| | **Admin %:** | 0 | |

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

| | | | |
|---|---|---|---|
| **Practice/Emp/ Desc:** | **Yale University (Bridgeport) Program** | | **Chronology Type:** Accredited Training |
| | **Address:** | Bridgeport, CT<br>US | **Attendance Dates:** |
| | **Position/Dept:** | | **Start Date:** 07/01/1997 |
| | | | **End Date:** 06/30/2001 |
| | **Clinical %:** | 100 | |
| | **Admin %:** | 0 | |

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

| | | | |
|---|---|---|---|
| **Practice/Emp/ Desc:** | **Healthfirst Family Care Center** | | **Chronology Type:** Work |
| | **Address:** | 102 County Street<br>Fall River<br>Fall River, MA 02723<br>US | **Attendance Dates:** |
| | **Position/Dept:** | Primary Care Physician - Pediatrics and Internal Medicine | **Start Date:** 07/01/2001 |
| | | | **End Date:** 06/01/2004 |
| | **Clinical %:** | 100 | |
| | **Admin %:** | 0 | |

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

| | | | |
|---|---|---|---|
| **Practice/Emp/ Desc:** | **Horizon Primary Care Center** | | **Chronology Type:** Work |
| | **Address:** | 5262 Golden Gate Parkway<br>Naples<br>Naples, FL 34116<br>US | **Attendance Dates:** |
| | **Position/Dept:** | Primary Care Physician - Pediatrics and Internal Medicine | **Start Date:** 07/01/2004 |
| | | | **End Date:** 10/01/2005 |
| | **Clinical %:** | 100 | |
| | **Admin %:** | 0 | |



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

| | | | |
|---|---|---|---|
| **Practice/Emp/ Desc:** | **PedIM Healthcare** | | **Chronology Type:** Work |
| | **Address:** | 1990 N Prospect Ave<br>Lecanto<br>Lecanto, FL 344619792<br>US | **Attendance Dates:** |
| | **Position/Dept:** | Primary Care Physician - Pediatrics, Internal Medicine, Sleep Medicine | **Start Date:** 11/01/2005 |
| | | | **End Date:** 01/31/2020 |

Clinical 100

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 – ADDITIONAL PHYSICIAN INFORMATION



## CITIZENSHIP AND IDENTIFICATION

U.S. Citizen Yes ☑ No ☐ Alien Registration #_____

Employment Authorization #_____ Visa #_____

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 | Score Received | Examination Name | Score Received |
|---|---|---|---|
| USMLE Step 1 | 177 | | |
| USMLE Step 2 CK | 172 | | |
| USMLE Step 3 | 192 | | |

## SPECIALTY CERTIFICATION

Scope of Practice/Specialty(ies): Internal Medicine, Pediatrics and Sleep 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) |
|---|---|---|---|
| ABIM - Sleep Medicine | | | 11/19/2009 |
| ABIM - Internal Medicine | | | 12/31/2011 |
| ABP - Pediatrics | | | 12/01/2011 |

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 ☑ |
| 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 ☑ |
| 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<br><br>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 department or staff meetings, or maintain required malpractice insurance.)

| Hospital | Mailing Address | Type of Action | Dates of Action (From MM/YY to MM/YY) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

## 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: Daeetin St. Martin

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)? *If your answer is "No", you do not have to complete the remaining questions for the Military Service Attestation.*

_____Yes ✓ No



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

- ☐ Air Force
- ☐ Army
- ☐ Navy
- ☐ Marine Corp
- ☐ 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? _____Yes _____No

## APPLICATION AFFIRMATION

I, Daclin St-Martin
**(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.**

_____ 10/01/19
**Signature of applicant** **Date**

State of Florida County of Citrus

Subscribed and sworn to before me this 1 day of October, 2019.

(NOTARY SEAL)

Notary Public State of Florida
Rafael Hernandez
My Commission GG 034704
Expires 09/29/2020

Notary Public for the State of Florida

My Commission Expires: 9/29/2020

Residing at: Hernando (City) FL (State)

_____
Signature of Notary