Unifor Application for Lic sure

Application ID: 295483
FID: 215816356

License Requested: MD
License Type: Permanent Medical License
Submitted to: Nevada State Board of Medical Examiners
Submission Date: 3/26/2020 3:09 PM

Practitioner Name

Curtis, William

Alternate Name(s): Curtis, William James
Curtis, William J

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Contact Information

Address

Public Access	Board Contact	Type	Address
Yes	Yes	Home	Wilmington, NC 28409 UNITED STATES

Phone

Public Access	Board Contact	Type	Phone Number	Phone Extension
Yes	Yes			

Email

Public Access	Board Contact	Email
Yes	Yes	

Identification

USMLE Number	SSN	Birth Date	Birth Place	Gender	NPI	Practitioner Type	US Citizen
		/1978	PA UNITED STATES	M		MD	Yes

Medical School

Medical School Name	Address	Start Date	End Date	Graduation Date	Degree Code
University of Texas-Houston Medical School	7000 Fannin Houston, TX 77030 UNITED STATES	08/20/2007	05/28/2010	05/29/2010	MD

Fifth Pathway

None Reported

ECFMG

Certificate Number	Issue Date
None Reported	

Postgraduate Training

Hospital Name: **Charleston Area Medical Center**
Charleston, WV UNITED STATES

Program Code:

Attendance Dates:

Training Specialty:	Craniomaxi ..cial Surgery	**End Date:**	06/30/201_
		Program Type:	Fellowship
Training Status:	Completed		
Clinical %:	100	**Administrative %:**	0

Hospital Name:	**University of Michigan**	**Program Code:**	
	Ann Arbor, MI UNITED STATES		
		Attendance Dates:	
Institution:		**Start Date:**	07/01/2013
Training Specialty:	Head and Neck Oncology and Microvascular Reconstruction	**End Date:**	06/30/2014
		Program Type:	Fellowship
Training Status:	Completed		
Clinical %:	100	**Administrative %:**	0

Hospital Name:	**University of Texas Health Science Center**	**Program Code:**	
	Houston, TX UNITED STATES		
		Attendance Dates:	
Institution:	University of Texas Health Science Center	**Start Date:**	07/01/2006
Training Specialty:	Surgery/Oral and Maxillofacial Surgery	**End Date:**	06/30/2007
		Program Type:	Internship
Training Status:	Completed		
Clinical %:	100	**Administrative %:**	0

Hospital Name:	**University of Texas Health Science Center**	**Program Code:**	
	Houston, TX UNITED STATES		
		Attendance Dates:	
Institution:	University of Texas Health Science Center	**Start Date:**	07/01/2007
Training Specialty:	Surgery/Oral and Maxillofacial Surgery	**End Date:**	06/30/2008
		Program Type:	Residency
Training Status:	Completed		
Clinical %:	100	**Administrative %:**	0

Hospital Name:	**University of Texas Health Science Center**	**Program Code:**	
	Houston, TX UNITED STATES		
		Attendance Dates:	
Institution:	University of Texas Health Science Center	**Start Date:**	07/01/2008
Training Specialty:	Surgery/Oral and Maxillofacial Surgery	**End Date:**	06/30/2009
		Program Type:	Residency
Training Status:	Completed		
Clinical %:	100	**Administrative %:**	0

Hospital Name:	**University of Texas Health Science Center**	**Program Code:**

Attendance Dates:

Institution:	University of Texas Health Science Center	**Start Date:**	07/01/2009
Training Specialty:	Surgery/Oral and Maxillofacial Surgery	**End Date:**	06/30/2010
		Program Type:	Residency
Training Status:	Completed		
Clinical %:	100	**Administrative %:**	0

Hospital Name:	**University of Texas Health Science Center at Houston Program** Houston, TX UNITED STATES	**Program Code:**	ACGME 4404821337

Attendance Dates:

Institution:	University of Texas Health Science Center at Houston	**Start Date:**	07/01/2010
Training Specialty:	Surgery	**End Date:**	06/30/2011
		Program Type:	Internship
Training Status:	Completed		
Clinical %:	100	**Administrative %:**	0

Hospital Name:	**University of Texas Health Science Center at Houston Program** Houston, TX UNITED STATES	**Program Code:**	ACGME 4404821337

Attendance Dates:

Institution:	University of Texas Health Science Center at Houston	**Start Date:**	07/01/2011
Training Specialty:	Surgery	**End Date:**	06/30/2012
		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		05/22/2008	Pass	1
USMLE Step 2 CK Examination		07/11/2009	Pass	1
USMLE Step 2 CS Examination		03/29/2010	Pass	1
USMLE Step 3 Examination		08/26/2010	Pass	1

State Licensure History

MD, DO, PA License History

License Entity	Licensing State	License Number	Issue Date	Expiration Date	License Type	License Status
North Carolina Medical Board	NC	2016-00508	03/30/2016	10/01/2020		Active
Michigan Board of Medicine	MI	4301103647	06/18/2013	01/31/2017	Full	Active
Kentucky Board of Medical Licensure	KY	47483	09/18/2014	02/28/2017		Expired
Texas Medical Board	TX	BP10041658	07/01/2011	06/30/2012	Training	Terminated

Physician Reported License History

Practitioner License Type	Licensing State	License Number	Issue Date	Expiration Date	Type	License Status
Doctor of Dental Medicine	WV	3983	04/16/2012		Full	Expired
Doctor of Dental Medicine	TX	26275	01/28/2011		Full	Expired
Doctor of Dental Medicine	MI	2951000405	07/05/2013	08/31/2014	Training	Lapsed
Doctor of Dental Medicine	KY	9413	01/10/2014	12/31/2017	Full	Non-Renew

Chronology of Activity Type

Practice/Emp/ Desc: **University of Nevada Las Vegas** **Chronology Type:** PGT/Education

Address: 4505 S. Maryland Parkway
Box 451029
Las Vegas, NV 891541029
US

Attendance Dates:

Position/Dept: Dental Student - UNLV School of Dental Medicine

From: 08/01/2002 to 05/01/2006

Clinical %: 100

Admin %: 0

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

Practice/Emp/ Desc: **University of Texas Health Science Center** **Chronology Type:** Other Training

Address: Houston, TX
US

Attendance Dates:

Position/Dept:

From: 07/01/2006 to 06/30/2007

Clinical %: 100

Admin %: 0

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

Practice/Emp/ Desc: **University of Texas Health Science Center** **Chronology Type:** Other Training

Address: Houston, TX
US

Attendance Dates:

Position/Dept:

From: 07/01/2007 to 06/30/2008

Clinical %: 100

Admin %: 0

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

Practice/Emp/ Desc: **University of Texas-Houston Medical School** **Chronology Type:** Medical Education

Address: Houston, TX
US

Attendance Dates:

Position/Dept:

From: 08/20/2007 to 05/28/2010

Clinical %:

Admin %:

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

Practice/Emp/ Desc: **University of Texas Health Science Center** **Chronology Type:** Other Training

Address: Houston, TX
US

Attendance D.

Position/Dept:

From: 07/01/2008 to 06/30/2009

Clinical %: 100

Admin %: 0

Employment: Staff Privileges: Affiliation:

Practice/Emp/ Desc: **University of Texas Health Science Center**

Chronology Type: Other Training

Address: Houston, TX
US

Attendance Dates:

Position/Dept:

From: 07/01/2009 to 06/30/2010

Clinical %: 100

Admin %: 0

Employment: Staff Privileges: Affiliation:

Practice/Emp/ Desc: **University of Texas Health Science Center at Houston Program**

Chronology Type: Accredited Training

Address: Houston, TX
US

Attendance Dates:

Position/Dept:

From: 07/01/2010 to 06/30/2011

Clinical %: 100

Admin %: 0

Employment: Staff Privileges: Affiliation:

Practice/Emp/ Desc: **University of Texas Health Science Center at Houston Program**

Chronology Type: Accredited Training

Address: Houston, TX
US

Attendance Dates:

Position/Dept:

From: 07/01/2011 to 06/30/2012

Clinical %: 100

Admin %: 0

Employment: Staff Privileges: Affiliation:

Practice/Emp/ Desc: **Charleston Area Medical Center**

Chronology Type: Other Training

Address: Charleston, WV
US

Attendance Dates:

Position/Dept:

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

Clinical %: 100

Admin %: 0

Employment: Staff Privileges: Affiliation:

Practice/Emp/ Desc: **University of Michigan**

Chronology Type: Other Training

	Address: ANN ARBOR, MI US	Attendance D		
	Position/Dept:	From:	07/01/2013	to 06/30/2014
	Clinical %: 100			
	Admin %: 0			

Employment:	Staff Privileges:	Affiliation:

Practice/Emp/ Desc:	University of Kentucky	Chronology Type:	Work	
	Address: 2195 Harrodsburg Rd Lexington, KY US	Attendance Dates:		
	Position/Dept: Assistant Professor - Oral & Maxillofacial Surgery	From:	07/01/2014	to 06/30/2016
	Clinical %: 95			
	Admin %: 5			

Employment:	Staff Privileges:	Affiliation:

Practice/Emp/ Desc:	New Hanover Regional Medical Center	Chronology Type:	Work	
	Address: 1725 New Hanover Medical Park Dr Wilmington, NC US	Attendance Dates:		
	Position/Dept: Maxillofacial Surgeon - Maxillofacial Surgery	From:	07/01/2016	to In Progress
	Clinical %: 95			
	Admin %: 5			

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 1	5/22/08	204			
USMLE Step 2 CK	7/11/09	204			
USMLE Step 2 CS	3/29/10	PASS			
USMLE Step 3	8/26/10	207			

SPECIALTY CERTIFICATION

Scope of Practice/Specialty(ies): ORAL & MAXILLOFACIAL SURGERY

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)

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
N/A			

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: WILLIAM JAMES CURTIS

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?

- ☐ 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, WILLIAM JAMES CURTIS,
(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.

_____ 4/24/20
Signature of applicant **Date**

KIRSTIN FOWLER NOTARY PUBLIC NEW HANOVER COUNTY, NC My Commission Expires 06-15-2024
(NOTARY SEAL)

State of NC County of New Hanover

Subscribed and sworn to before me this 24 day of April, 2020.

Notary Public for the State of NC

My Commission Expires: 06/15/2024

Residing at: Wilmington NC
City State

Kirstin Fowler
Signature of Notary

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

Curtis, William, J

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

04/23/20 20

Date of signature (must correspond to date of notarization)