

**PRACTITIONER OF RESPIRATORY CARE
APPLICATION FOR LICENSURE
NEVADA STATE BOARD OF
MEDICAL EXAMINERS**
9600 Gateway Drive, Reno, NV 89521
Phone (775) 688-2559

RECEIVED Date Received by Board
MAR 23 2020
NEVADA STATE BOARD OF
MEDICAL EXAMINERS (Use Only)

License No. _____
File No. _____

Identity:

1. Present Legal Name Acosta-Martinez Ignacio
Last First Middle Maiden
List any other name 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 10346 Park Meadows Dr. # Lone Tree, Douglas CO 80124
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 _____
Street City County State Zip

4. Telephone Numbers (218) 553 1264 _____
Office Fax Home Cellular (Optional)

Email address _____

5. Date of Birth 1954 Place of Birth CUBA Gender F M
Month / Day / Year (City / State / Country)

6. Citizenship: U.S. Citizen No Alien Registration # A Employment Authorization # _____ Visa _____

Non U.S. Citizen (without the foregoing): Individual Taxpayer Identification Number (ITIN) _____

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. Non Citizens (without the foregoing) submit an Original ITIN assignment letter from the IRS. 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; however, AB275 (2019) provides that an applicant who does not have a social security number must provide an Individual Taxpayer Identification Number (ITIN) when completing an application for licensure.
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:

"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.

"Currently" does not mean on the day of, or even in the weeks or months preceding the completing of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee.

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 that in any way impairs or limits your ability to provide respiratory care services 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 as a respiratory therapist, 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 provide respiratory care services with reasonable skill and safety? (If "Yes," attach explanation on separate sheet.) _____ Yes No _____ N/A

Malpractice Questions:

11. 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," attach explanation on separate sheet.) Yes No
12. 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," attach explanation on separate sheet.) Yes No

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Arrest Question:

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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 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 explanation on separate sheet.) Yes No

Nevada License History:

14. Have you previously applied for an allied health license in Nevada? (This does not include Blood Gas Licenses). (If "Yes," attach explanation on separate sheet.) Yes No

Practitioner for Respiratory Care Education:

15. List all schools attended in **chronological order** including high school, college and/or university, and Practitioner of Respiratory care education. Please show dates of attendance in months and years:

School Name	City/State	Type of Degree / Major Received	Dates of Attendance (From (mo/yr) To (mo/yr))
Escuela Secundaria Basica Camilo Cienfuegos	Havana, CUBA	General Education	09/1970 - 09/1973
Southland College	Los Angeles, CA	Respiratory Therapy Technician	02/1982 - 03/1983
Mount San Antonio College	Walnut, CA	Respiratory Care Practitioner	09/1988 - 07/1992

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

16. Respiratory Degree granted by:

Respiratory School	City / State	Exact Date of Issuance
Southland College	Los Angeles, CA	03/15/1983

Activities:

17. List briefly all activities in **chronological order** since graduation from respiratory school. ALL PERIODS OF TIME MUST BE ACCOUNTED FOR. Activities include working as a Respiratory Therapist and also non-medical activities (seeking employment, moving, job search, applying for a license, vacation etc.)

Activities	City / State (and Country if other than U.S.)	From (Mo./Yr.) To (Mo./Yr.)
Reliable Health Care Services	Colton City, CA	03/1983 - 01/1988
General Electric Major Appliances Warehouse	La Puente, CA	01/1988 - 07/1990
From 07/1990 to 2/1993 doing odd jobs for Temporary Agencies and in jail.		
Starling Home Care Services	City of Industry, CA	02/1993 - 04/1994
Reliable Health Care Services	Las Vegas, NV	04/1994 - 12/2000
University Medical Center	Las Vegas, NV	12/2000 - 01/2007

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

State licenses:

18. List any and all licenses (including training licenses and permits) YOU HOLD OR HAVE HELD to practice as a respiratory therapist in any state or territory.

State/Territory	License #	Date of Issuance (Mo/Yr)	Status
1- Colorado	RTL-0006009	06-18-2019	Active
2- Minnesota	4607	07-01-2019	

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

Examination:

19. Are you currently certified by and/or registered with the National Board for Respiratory Care? Yes No

If "No", Date scheduled to sit for the exam: _____ Expiration Date: _____
(For those who are certified or registered after 7/1/2002)

If you are an RRT, provide Registration number: _____

Disciplinary Questions:

20. Have you ever been denied a license or certification/registration to provide respiratory care services or permission to practice as a respiratory care therapist or permission to take an examination to practice as a respiratory care therapist or permission to practice any other healing art in any state, country or U.S. territory? (If "Yes," attach explanation on separate sheet.) Yes No

21. Have you ever had a certificate or license to provide respiratory care services or 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 No

22. Have you ever voluntarily surrendered a license or certificate to provide respiratory care services or any other healing art in any state, country or U.S. territory? (If "Yes," attach explanation on separate sheet.) Yes No

23. Have you ever failed the National Board for Respiratory Care examination, or any state or other jurisdiction examination for certification, licensure or registration? If your answer is "yes", give details regarding how many times you failed, including dates and the reason(s) you believe you failed the examination(s). Sign your explanation. (If "Yes," attach explanation on separate sheet.) Yes No

24. Have you ever had your registration/certification revoked, suspended and/or limited by the National Board for Respiratory Care? (If "Yes," attach explanation on separate sheet.) Yes No

25. 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 provider of respiratory care by any licensing board, hospital, medical society, governmental entity or other agency other than the Nevada State Board of Medical Examiners? (If "Yes," attach explanation on separate sheet.) Yes No

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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.

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;
- (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.

Yes No

www.leg.state.nv.us/NRS/NRS-432B.html#NRS432BSec220

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.

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 Logistics or Supply
 Aviation Maintenance
 Civil Engineering Medical Services
 Communications Security Forces or Military Police
 Infantry or Armor Other
 Legal or Chaplin Corps

4&5-Dates of service in the Military: 4-From: ___/___/___ 5-To: ___/___/___
DD MM YYYY 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 N/A

COMMUNICATIONS AFFIRMATION

Consent to accept communications and service of process from the Nevada State Board of Medical Examiners (Board) by electronic mail, for licensees who practice medicine, and those licensees who practice respiratory care and perfusion, 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: Ignacio Agosto Martinez

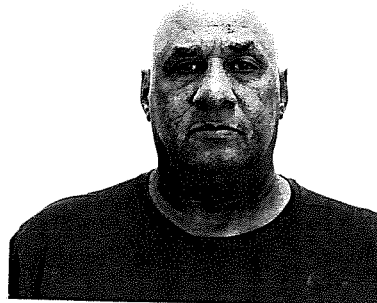
Signature of Applicant: [Signature]

Electronic Mail Address: _____

APPLICANT PHOTOGRAPH

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

PHOTOGRAPH MUST HAVE BEEN TAKEN WITHIN THE LAST SIX (6) MONTHS AND BE AT LEAST 2" x 2" IN SIZE.



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months.

**NEVADA STATE BOARD OF
MEDICAL EXAMINERS**

I hereby certify that the attached photograph is a true likeness of me taken within the last six (6)

[Handwritten Signature]

Signature of applicant

03/16/20
Date

APPLICATION AFFIRMATION

I, Ignacio Acosta Martinez
(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

03/16/20
Date

(NOTARY SEAL)

**VICTORIA MONDRAGON
NOTARY PUBLIC
STATE OF COLORADO**
NOTARY ID 20184007740
My Commission Expires February 15, 2022

State of Colorado County of Arapahoe
Subscribed and sworn to before me this 16th day of
March, 2020

Notary Public for the State of Colorado

My Commission Expires: 02/15/2022

Residing at: Centennial CO
City State

Victoria M Mondragon
Signature of Notary

END OF APPLICATION

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NEVADA STATE BOARD OF
MEDICAL EXAMINERS

**ATTENTION APPLICANT!
RESPONSIBILITY STATEMENT**

**Please sign and return this statement with your application for licensure to:
The Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521**

Because you are applying for the privilege of practicing medicine in Nevada, you should know that our state has some of the most stringent licensing requirements and comprehensive investigation programs in the United States.

Via FBI fingerprinting and other investigative modalities, our licensing specialists are likely to discover if data you have submitted on your application is erroneous or incomplete; therefore, you must answer all questions truthfully and completely. Specifically, this includes any sanctions or disciplinary actions you may have experienced during your training, or any involvement you may have had with the legal system, either civil or criminal — criminal to include charges that may have ultimately been expunged, lessened, or dismissed, and no matter how long ago the event(s) occurred.

Explaining and documenting a problem to your licensing specialist will be much less painful than discussing your veracity before the entire Board of Medical Examiners due to inconsistencies between your application and incongruent input from outside sources.

ONLY YOU — NOT A LAWYER, DOCTOR, SPOUSE, OR CREDENTIALING COMPANY — ARE RESPONSIBLE FOR READING AND ANSWERING EVERY QUESTION ACCURATELY AND COMPLETELY.

If you have *any* questions about your application, **ASK YOUR LICENSING SPECIALIST**. Our licensing specialists are here to help you.

○ ○ ○ ○ ○

I have read this responsibility statement and understand that I alone am accountable for completing my application for medical licensure in Nevada.

Print your name Ignacio Acosta-Martinez

Sign your name _____

Date 03/16/2020

Note: It is your responsibility to keep the Board informed of any circumstance or event that would require a change to your initial responses provided to the Board in your application for licensure, and which occurs prior to you being granted licensure to practice medicine in the state of Nevada.