Demographic Details

First Name	Gender	
Luis	Male	- 3
Middle Name	Date of Birth	
	1985	C
Last Name ≠	Name Suffix	
Espinosa		
Previous Name(s)	City of Birth	
Social Security Number	Place of Birth	
Tax Identification Number	Weight (in lbs)	
Height	Eye Color	
Hair Color	Comments (non-public inform	mation)
	Public Information	
Is this person deceased?		
○ Yes ○ No		
Date Deceased		
Do you have a Nevada Business License in your individual name?		
○ Yes ○ No		
Nevada BIN		
Historical File Number		

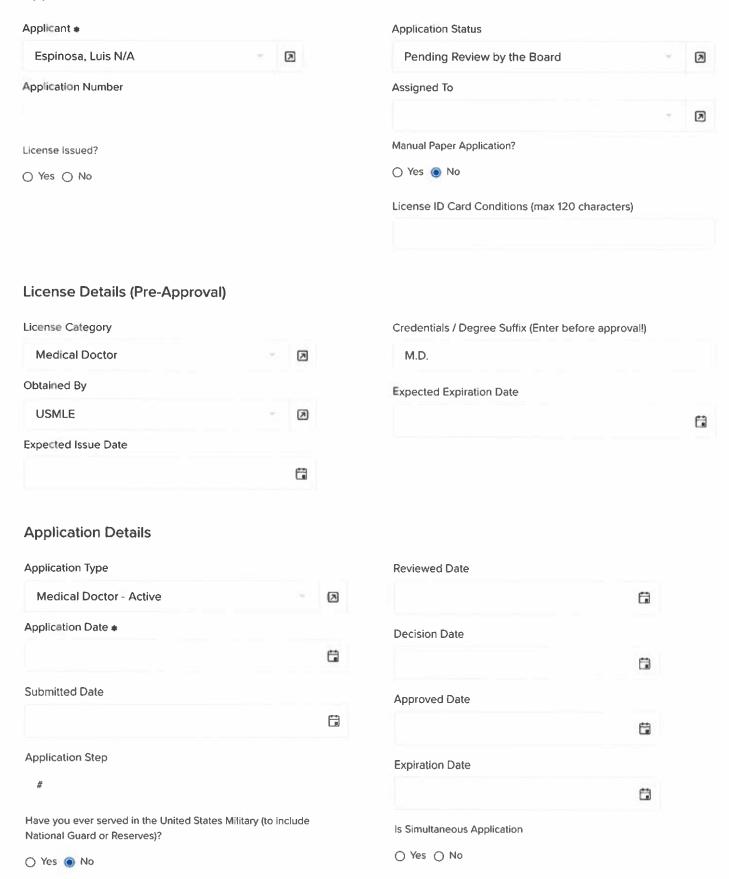
Military Detail

Have you ever served in the United States Military (to include National	Guard or Reserves)?
○ Yes ● No	
Discipline / SPL	
Disciplinary Action?	SPL?
○ Yes ○ No	○ Yes ○ No
	Date of SPL Issuance
Contact Information	
Primary Phone	Secondary Phone
#	#
Primary Phone Extension	Secondary Phone Extension
Primary E-mail Address	Mail should be directed to
	7
Cell Phone	Fax
#	#
Public Address	
Street Address	ZIP / Postal Code
9550 S Eastern Ave Ste 253	89123
Address Line 2	State / Province
Address Line 2	Nevada
City	Country
Las Vegas	United States
County	Is your physical address different from your mailing address?
Clark	
	Public Phone
	# (352) 359-2389

Mailing Address

Street Address	City (Mailing)
Address Line 2	State / Province (Mailing)
ZIP / Postal Code (Mailing)	County (Mailing)
	County (Mailing)

Application Status



Are you the spouse of an active duty member or surviving spouse of a veteran?	
○ Yes ○ No	
Invoices	
Application Invoice	Application Payment Date
· 2	
Licensure Invoice	Licensure Payment Date
· 2	ä
Attestations	
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.	l 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. (a) Yes (b) No I 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. (c) Yes (c) No
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.	Child Support Attestation Type Not subject to a court order I have read this responsibility statement and understand that I alone am accountable for completing my application for medical licensure in Nevada. Yes No
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	In consideration for processing my application I, the undersigned, whose name and signature voluntarily appears below; do hereby and irrevocably agree to the Civil Applicant Waiver. Yes No

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

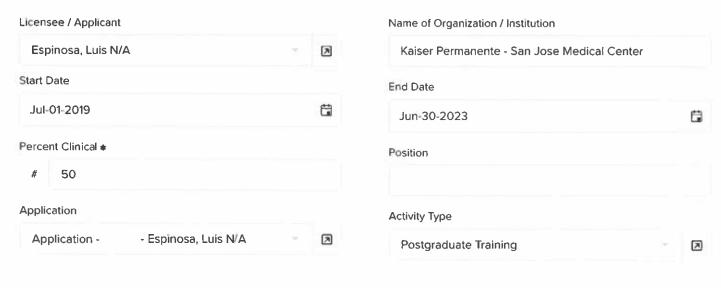
medicine in the state of Nevada.

Yes O No

Activities

									_
Licensee / Applicant	Ŧ	Name of Organization / Institution	T	Start Date †	•	End Date	*	Percent Cilnical	
Luis Espinosa		Kalser Permanente - San Jose Medical Center		Jul-01-2019		Jun-30-2023		50	
Espinosa, Luis N/A		Gap - Job Search		Jul-01-2023		Oct-02-2023		0	
Espinosa, Luis N/A		Telkiatry		Oct-02-2023		Nov-16-2023		50	

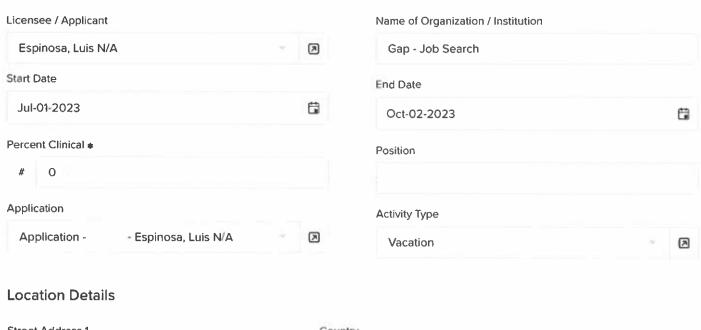
Application Activity Details



Location Details

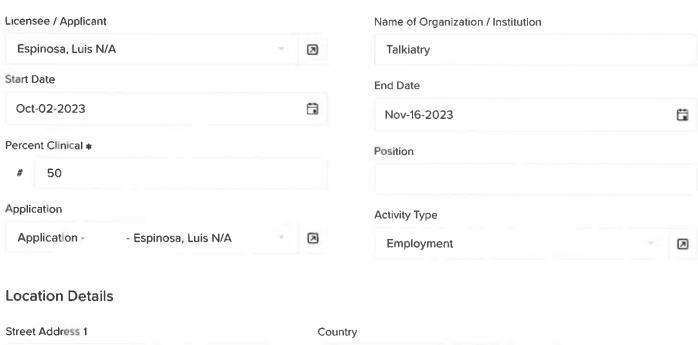


Application Activity Details



Street Address 1	Country	
		- 3
City	State / Province	
	Zip / Postal Code	

Application Activity Details



Street Address 1	Country	
	United States	7
City	State / Province	
New York	New York	
	Zip / Postal Code	

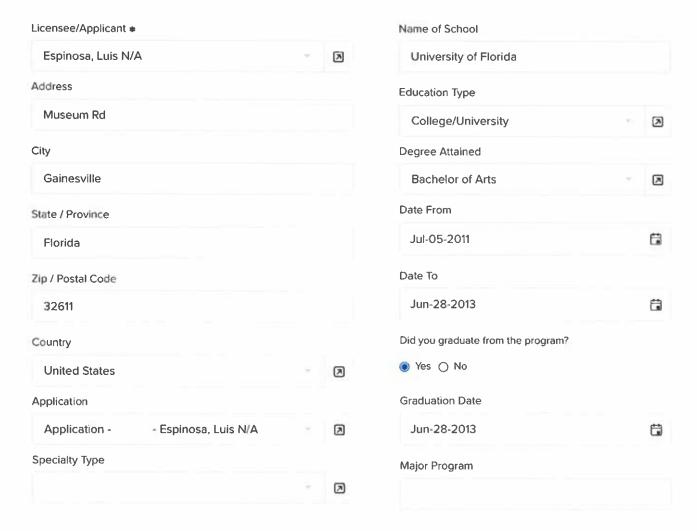
Declarations

Ordinal †	•	Licensee/Applicant	•	Declaration Question	•	Answer	•	Answer Details
1		Luis Espinosa		MD, PA – Q1 – Medical Condition Impair Safe Practice		No		
2		Luis Espinosa		MD, PA – Q2 – Medical Condition Field of Practice		No		
3		Luis Espinosa		MD, PA – Q3 – Chemical Substances Impair Safe Practice		No		
4		Luis Espinosa		MD. PA, LL - Q4 = Performance of Public Service Requirement		No		
5		Luis Espinosa		ALL – Q5 – Named Defendant Respond to Legal Action		No		
6		Luis Espinosa		ALL - Q6 - Matpractice Claim Paid		No		
7		Luis Espinosa		ALL – Q7 – Arrest Question		No		
8		Luis Espinosa		MD. Previously applied for licensure in Nevada.		No.		
9		Luis Espinosa		MD – Investigation Disciplinary during Training Program		No		
10		Luis Espinosa		MD – Q8 ~ Denied License / Permission to Practice Medicine		No		
11		Luis Espinosa		MD – Q9 – Medical License Revoked		No		
12		Luis Espinosa		MD ~ Q11 – Voluntarily Surrendered a License		No		
13		Luis Espìnosa		MD = Q12 - Denied Membership		No		
14		Luis Espinosa		MD – Q13 – Investigation – Respond To/Notify Of		No		
15		Luis Espinosa		MD, PA – QIO – Controlled Substance Registration		No		
16		Luis Espinosa		MD, PA, CCP, Hospital Privileges Denied, Suspended.		No		

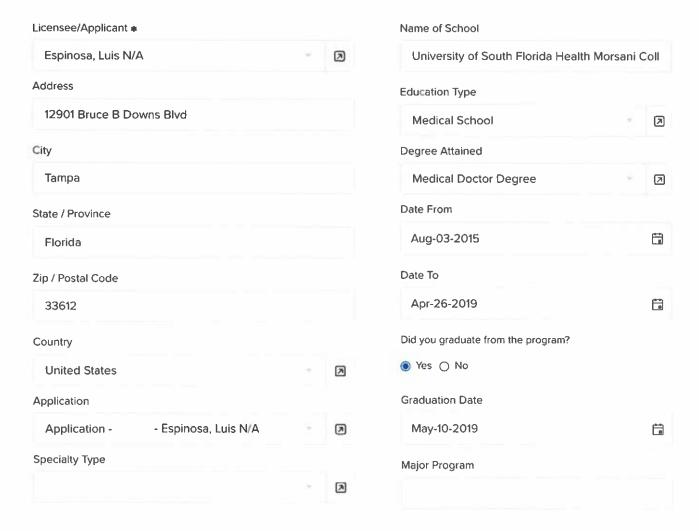
Education

Licensee/Applicant	Education Type 🔻	Name of School	Degree Attained Y	Date From ▼	Date To ↑ ▼	Graduation Date
Luis Espinosa	College/University	University of Florida	Bachelor of Arts	Jul-05-2011	Jun-28-2013	Jun-28-2013
Espinosa, Luis N/A	Medical School	University of South Fiorida Health Morsani College of Medicine	Medical Doctor Degree	Aug-03-2015	Apr-26-2019	May-10-2019

Education Details

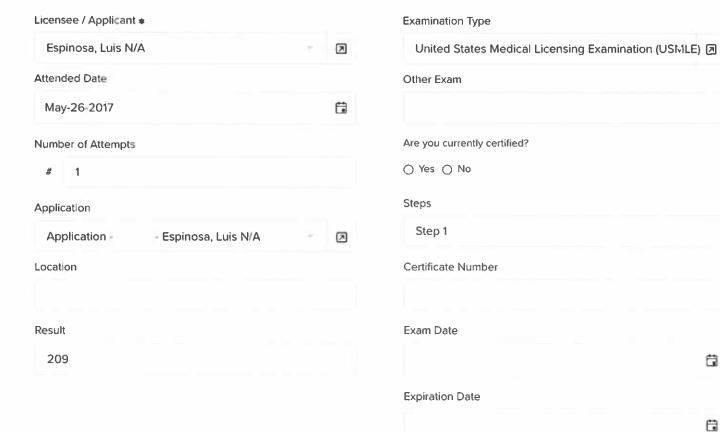


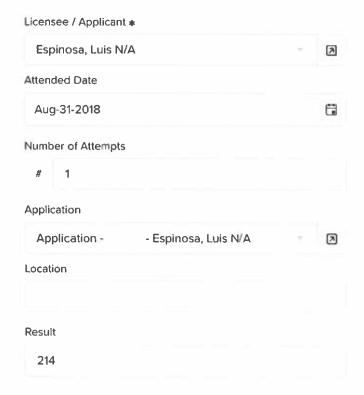
Education Details



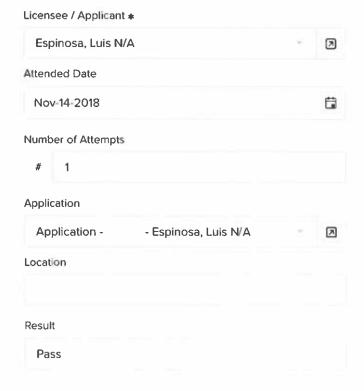
Examinations

Licensee / Applicant	۳	Examination Type	•	Attended Date †
Espinosa, Luii N/A		United States Medical Licensing Examination (USMLE)		May-26-2017
Espinosa, Luis N/A		United States Medical Licensing Examination (USMLE)		Aug-31-2018
Luis Espínosa		United States Medical Licensing Examination (USMLE)		Nov-14-2018
Espinosa, Luis N/A		United States Medical Licensing Examination (USMLE)		Dec-06-2021

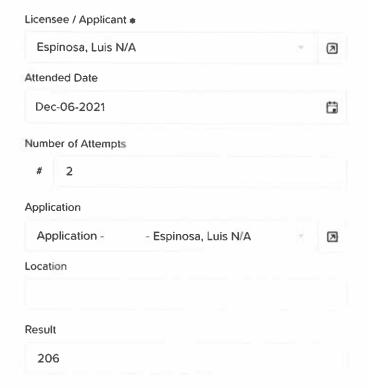




Examination Type	
United States Medical Licensing Examination (USML	.E) 🗷
Other Exam	
Are you currently certified?	
○ Yes ○ No	
Steps	
Step 2 CK	
Certificate Number	
Exam Date	
Expiration Date	



Examination Type	
United States Medical Licensing Examination (USMLE) [2	9
Other Exam	
Are you currently certified?	
○ Yes ○ No	
Steps	
Step 2 CS	
Certificate Number	
Exam Date	
Ė	1
Expiration Date	
5	3

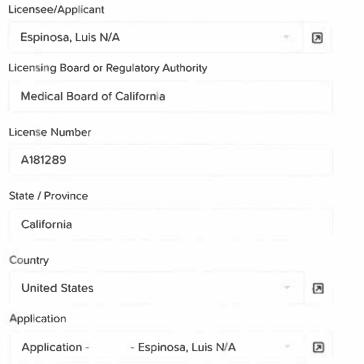


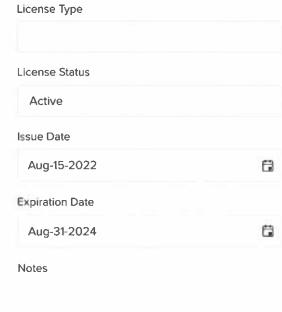
Examination Type	
United States Medical Licensing Examinati	on (USMLE) 🗷
Other Exam	
Are you currently certified?	
○ Yes ○ No	
Steps	
Step 3	
Certificate Number	
Exam Date	
Expiration Date	
	G

Other Licenses

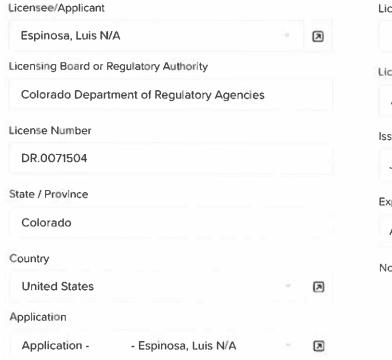
Licensee/Applicant	Ŧ	License Number	•	License Type	•	Issue Date	₹	Expiration Date	T	State / Province †	
Espinosa, Luis N/A		A181289		N/A		Aug-15-2022		Aug:31:2024		California	
Espinosa, Luis N/A		DR.0071504		N/A		Jun-28-2023		Apr-30-2025		Colorado	
Luis Espinosa		323943		N/A		Jun-13-2023		May-31-2025		New York	
					-						

Other License Details



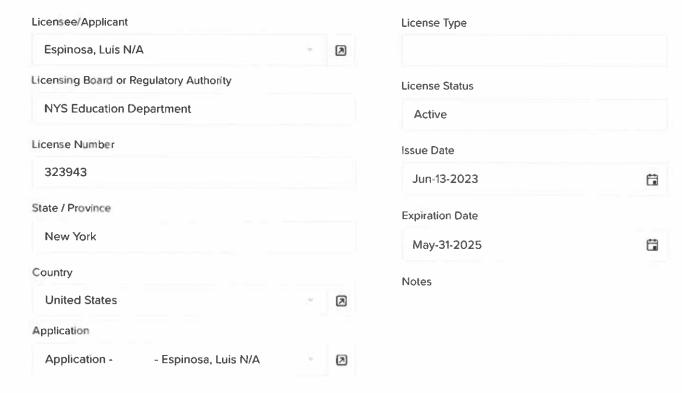


Other License Details



License Status	
Active	
Issue Date	
Jun-28-2023	C
Expiration Date	
Apr-30-2025	6
Notes	

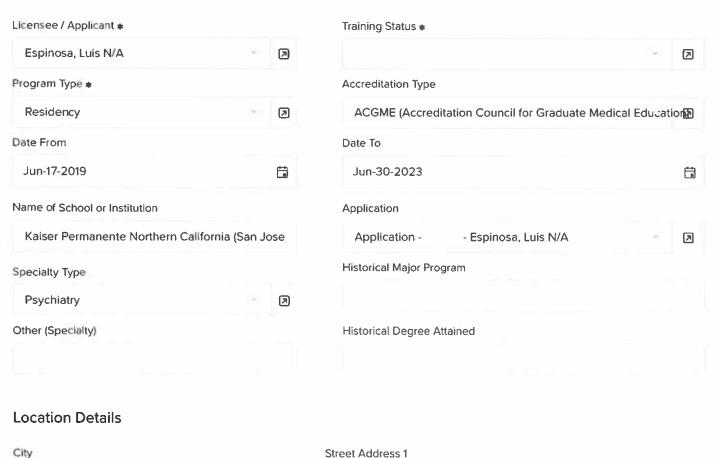
Other License Details



Postgraduate Training

Licensee / Applicant	Name of School or Institution	Specialty Type	т	Date From	т	Date To †	т	Program Type	
Espinosa, Luis N/A	Kaiser Permanente Northern California (San Jose) Program	Psychiatry		Jun-17-2019		Jun-30-2023		Residency	

Postgraduate Training Details

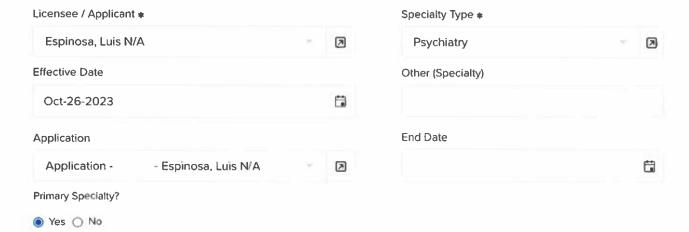




Specialties

Licensee / Applicant	7	Specialty Type	T	Primary Specialty?	T	Effective Date	T	End Date
Espinosa. Luis N/A		Psychiatry		Yes		Oct-26-2023		N/A

Specialty Details



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, perfusion or respiratory care 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 medical school or your postgraduate 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 y	your name Luis Espinosa	
Sign y	your name	
Date	10/27/2023	

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.



