

Demographic Details

First Name

Michael

Middle Name

Jack

Last Name *

Feinberg

Previous Name(s)

Social Security Number

Tax Identification Number


Height

Hair Color

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

Gender

Male  

Date of Birth

-1961 

Name Suffix

City of Birth

Place of Birth

Weight (in lbs)

Eye Color

Comments (non-public information)

Public Information

Military Detail

Have you ever served in the United States Military (to include National Guard or Reserves)?

Yes No

Discipline / SPL

Disciplinary Action?

Yes No

SPL?

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

Cell Phone

#

Fax

#

Public Address

Street Address

781 Mill Street

ZIP / Postal Code

89502

Address Line 2

State / Province

Nevada

City

Reno

Country

United States

County

Washoe

Is your physical address different from your mailing address?

Yes No

Public Phone

#

(805) 969-4117

Mailing Address

Street Address

Address Line 2

ZIP / Postal Code (Mailing)

City (Mailing)

State / Province (Mailing)


County (Mailing)



County (Mailing)

Application Status

Applicant *


 

Application Number

License Issued?

Yes No

Application Status

Assigned To


Manual Paper Application?

Yes No


License ID Card Conditions (max 120 characters)

License Details (Pre-Approval)

License Category

Obtained By

Expected Issue Date


Credentials / Degree Suffix (Enter before approval!)

Expected Expiration Date


 

Application Details

Application Type

Application Date *

Submitted Date

Application Step


Have you ever served in the United States Military (to include National Guard or Reserves)?

Yes No

Reviewed Date

Decision Date

Approved Date

Expiration Date

Is Simultaneous Application

Yes No

Are you the spouse of an active duty member or surviving spouse of a veteran?

Yes No

Invoices

Application Invoice

- Paid in Full

Licensure Invoice

Application Payment Date

Licensure Payment Date

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.

Yes 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.

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 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 No

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

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.

Yes No

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

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

Activities

| Licensee / Applicant ▼ | Name of Organization / Institution ▼ | Start Date ↑ | End Date ▼ | Percent Clinical |
|------------------------|--|--------------|-------------|------------------|
| Michael Feinberg | Cedars Sinai Medical Center | Jul-01-1988 | Jun-30-1989 | 50 |
| Michael Feinberg | Monmouth Medical Center | Jul-01-1989 | Jun-30-1990 | 50 |
| Michael Feinberg | Centinela Airport Medical Clinic | May-15-1991 | May-01-1993 | 100 |
| Michael Feinberg | United Airlines Medical Department | Jul-01-1991 | Mar-01-1993 | 100 |
| Michael Feinberg | Texaco International Headquarters | Aug-01-1991 | May-15-1993 | 100 |
| Michael Feinberg | GM Automotive Plant | May-15-1993 | May-15-1996 | 100 |
| Michael Feinberg | Federal Aviation Administration | Feb-15-1997 | Feb-15-2000 | 20 |
| Michael Feinberg | Goleta Valley Occupational Health Center | Jun-01-2001 | Jun-01-2005 | 100 |
| Michael Feinberg | Advanced Medical Reviews | Jul-01-2005 | Jul-15-2014 | 100 |
| Michael Feinberg | Med XM | Feb-15-2015 | Feb-15-2022 | 100 |
| Michael Feinberg | Accuity Delivery Systems | Mar-07-2018 | Feb-15-2022 | 0 |
| Michael Feinberg | Compliance Navigation Specialists | May-01-2021 | Oct-03-2023 | 50 |

Application Activity Details

Licensee / Applicant

Name of Organization / Institution

Start Date

End Date



 

Percent Clinical *

#

Position


Application

Location Details

Street Address 1

Country


City

State / Province

Zip / Postal Code

Application Activity Details

Licensee / Applicant

Name of Organization / Institution

Start Date

End Date



 

Percent Clinical *


#

Position

Application



Activity Type

Location Details

Street Address 1

Country


City

State / Province

Zip / Postal Code


Application Activity Details

Licensee / Applicant

Name of Organization / Institution

Start Date

End Date



 

Percent Clinical *



#

Position

Application



Activity Type

Location Details

Street Address 1

Country

City

State / Province

Zip / Postal Code

Application Activity Details

Licensee / Applicant


  

Name of Organization / Institution

Start Date

End Date



 

Percent Clinical *



#

Position

Application



Activity Type

Location Details

Street Address 1

Country

City

State / Province

Zip / Postal Code

Application Activity Details

Licensee / Applicant


  

Name of Organization / Institution

Start Date

End Date



 

Percent Clinical *



#

Position

Application

Activity Type

Location Details

Street Address 1

Country

City

State / Province

Zip / Postal Code

Application Activity Details

Licensee / Applicant

Name of Organization / Institution

Start Date

End Date



 

Percent Clinical *



#

Position

Application


Activity Type

Location Details

Street Address 1

Country

City

State / Province

Zip / Postal Code

Application Activity Details

Licensee / Applicant


  

Name of Organization / Institution

Start Date

End Date



 

Percent Clinical *

#

Position

Application

Activity Type

Location Details

Street Address 1

Country

City

State / Province

Zip / Postal Code

Application Activity Details

Licensee / Applicant


  

Name of Organization / Institution

Start Date

End Date



 

Percent Clinical *

#

Position

Application


Activity Type

Location Details

Street Address 1

Country


City

State / Province

Zip / Postal Code

Application Activity Details

Licensee / Applicant


  

Name of Organization / Institution

Start Date

End Date



 

Percent Clinical *

#

Position

Application



Activity Type

Location Details

Street Address 1

Country


City

State / Province

Zip / Postal Code

Application Activity Details

Licensee / Applicant

Name of Organization / Institution

Start Date

End Date



 

Percent Clinical *


#

Position

Application


Activity Type

Location Details

Street Address 1

Country


City

State / Province

Zip / Postal Code


Application Activity Details

Licensee / Applicant

Name of Organization / Institution

Start Date

End Date



 

Percent Clinical *



#

Position

Application



Activity Type

Location Details

Street Address 1

Country

City

State / Province

Zip / Postal Code

Application Activity Details

Licensee / Applicant

Name of Organization / Institution

Start Date

End Date



 

Percent Clinical *



#

Position

Application



Activity Type

Location Details

Street Address 1

Country

City

State / Province


Zip / Postal Code

Declarations

| Ordinal ↑ | Licensee/Applicant | Declaration Question | Answer | Answer Details |
|-----------|--------------------|---|--------|----------------|
| 1 | Michael Feinberg | MD, PA – Q1 – Medical Condition Impair Safe Practice | No | |
| 2 | Michael Feinberg | MD, PA – Q2 – Medical Condition Field of Practice | No | |
| 3 | Michael Feinberg | MD, PA – Q3 – Chemical Substances Impair Safe Practice | No | |
| 4 | Michael Feinberg | MD, PA, LL – Q4 – Performance of Public Service Requirement | No | |
| 5 | Michael Feinberg | ALL – Q5 – Named Defendant Respond to Legal Action | Yes | |
| 6 | Michael Feinberg | ALL – Q6 – Malpractice Claim Paid | Yes | |
| 7 | Michael Feinberg | ALL – Q7 – Arrest Question | No | |
| 8 | Michael Feinberg | MD, Previously applied for licensure in Nevada. | No | |
| 9 | Michael Feinberg | MD – Investigation Disciplinary during Training Program | No | |
| 10 | Michael Feinberg | MD – Q8 – Denied License / Permission to Practice Medicine | No | |
| 11 | Michael Feinberg | MD – Q9 – Medical License Revoked | No | |
| 12 | Michael Feinberg | MD – Q11 – Voluntarily Surrendered a License | No | |
| 13 | Michael Feinberg | MD – Q12 – Denied Membership | No | |
| 14 | Michael Feinberg | MD – Q13 – Investigation – Respond To/Notify Of | Yes | |
| 15 | Michael Feinberg | MD, PA – Q10 – Controlled Substance Registration | No | |
| 16 | Michael Feinberg | MD, PA, CCP, Hospital Privileges Denied, Suspended. | No | |

Declaration

Licensee/Applicant

| | | |
|------------------------|---|---|
| Feinberg, Michael Jack | ▼ |  |
|------------------------|---|---|

Declaration Question

| | | |
|--|---|---|
| ALL – Q5 – Named Defendant Respond to Legal Action | ▼ |  |
|--|---|---|

Answer

Yes No

Answer Details

Ordinal


| | |
|---|---|
| # | 5 |
|---|---|

Declaration Text


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?

Related To

Application


| | | | |
|---------------|--------------------------|---|---|
| Application - | - Feinberg, Michael Jack | ▼ |  |
|---------------|--------------------------|---|---|

Renewal

| | | |
|--|---|---|
| | ▼ |  |
|--|---|---|

Declaration

Licensee/Applicant

| | | |
|------------------------|---|---|
| Feinberg, Michael Jack | ▼ |  |
|------------------------|---|---|

Declaration Question

| | | |
|-----------------------------------|---|---|
| ALL – Q6 – Malpractice Claim Paid | ▼ |  |
|-----------------------------------|---|---|

Answer

Yes No

Answer Details

Ordinal


| | |
|---|---|
| # | 6 |
|---|---|

Declaration Text


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?

Related To

Application


| | | | |
|---------------|--------------------------|---|---|
| Application - | - Feinberg, Michael Jack | ▼ |  |
|---------------|--------------------------|---|---|

Renewal

| | | |
|--|---|---|
| | ▼ |  |
|--|---|---|

Declaration

Licensee/Applicant

| | | |
|------------------------|---|---|
| Feinberg, Michael Jack | ▼ |  |
|------------------------|---|---|

Declaration Question

| | | |
|---|---|---|
| MD – Q13 – Investigation – Respond To/Notify Of | ▼ |  |
|---|---|---|

Answer

Yes No

Answer Details

Ordinal


| | |
|---|----|
| # | 14 |
|---|----|

Declaration Text


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?

Related To

Application

| | | | |
|---------------|--------------------------|---|---|
| Application - | - Feinberg, Michael Jack | ▼ |  |
|---------------|--------------------------|---|---|

Renewal

| | | |
|--|---|---|
| | ▼ |  |
|--|---|---|

Education

| Licensee/Applicant ▼ | Education Type ▼ | Name of School ▼ | Degree Attained ▼ | Date From ▼ | Date To ↑ ▼ | Graduation Date |
|------------------------|--------------------|---------------------------------------|-----------------------|-------------|-------------|-----------------|
| Michael Feinberg | College/University | University of Pennsylvania | Bachelor of Arts | May-15-1979 | May-15-1983 | May-15-1983 |
| Feinberg, Michael Jack | Medical School | Albert Einstein College of Medicine | Medical Doctor Degree | Aug-29-1984 | May-27-1988 | Jun-01-1988 |
| Michael Feinberg | Graduate | UCLA Fielding School of Public Health | Master of Science | May-01-1991 | May-01-1993 | May-01-1993 |

Education Details

Licensee/Applicant *

Address

City


State / Province

Zip / Postal Code


Country

Application

Specialty Type

Name of School


Education Type

Degree Attained

Date From


Date To

Did you graduate from the program?

Yes No


Graduation Date

Major Program

Education Details

Licensee/Applicant *

Address

City


State / Province

Zip / Postal Code


Country

Application

Specialty Type

Name of School


Education Type


Degree Attained

Date From


Date To

Did you graduate from the program?

Yes No


Graduation Date

Major Program

Education Details

Licensee/Applicant *

Address

City



State / Province

Zip / Postal Code



Country

Application

Specialty Type


  

Name of School


Education Type


Degree Attained

Date From


Date To

Did you graduate from the program?

Yes No

Graduation Date

Major Program

Examinations

| Licensee / Applicant ▼ | Examination Type ▼ | Attended Date ↑ |
|------------------------|--|-----------------|
| Feinberg, Michael Jack | National Board of Medical Examiners (NBME) | Jun-10-1986 |
| Feinberg, Michael Jack | National Board of Medical Examiners (NBME) | Sep-23-1986 |
| Feinberg, Michael Jack | National Board of Medical Examiners (NBME) | May-17-1989 |

Examination Details

Licensee / Applicant *



Attended Date

Number of Attempts

#



Application

Location

Result

Examination Type

Other Exam

Are you currently certified?

Yes No

Steps

Certificate Number

Exam Date

Expiration Date

Examination Details

Licensee / Applicant *

Feinberg, Michael Jack 


Attended Date

Sep-23-1986 

Number of Attempts

2

Application


Application - - Feinberg, Michael Jack 

Location

Result

300/75

Examination Type

National Board of Medical Examiners (NBME) 

Other Exam

Are you currently certified?

Yes No

Steps


Part II

Certificate Number

Exam Date



Expiration Date



Examination Details

Licensee / Applicant *

Feinberg, Michael Jack  



Attended Date

May-17-1989 

Number of Attempts

2

Application

Application - - Feinberg, Michael Jack  



Location

New York

Result

325/76

Examination Type

National Board of Medical Examiners (NBME)  

Other Exam

Are you currently certified?

Yes No

Steps

Part III

Certificate Number

Exam Date



Expiration Date



Other Licenses

| Licensee/Applicant ▼ | License Number ▼ | License Type ▼ | Issue Date ▼ | Expiration Date ▼ | State / Province ↑ |
|------------------------|------------------|----------------|--------------|-------------------|--------------------|
| Feinberg, Michael Jack | G-68023 | N/A | Nov-30-2000 | Jun-30-2024 | California |
| Feinberg, Michael Jack | 37801 | Physician | Dec-02-1993 | Dec-31-2001 | Georgia |
| Feinberg, Michael Jack | 234505 | N/A | Nov-19-2004 | May-31-2024 | New York |
| Feinberg, Michael Jack | 016616 | MD | Aug-04-1993 | Dec-31-1994 | South Carolina |

Other License Details

Licensee/Applicant

Licensing Board or Regulatory Authority



License Number

State / Province

Country


Application


License Type

License Status

Issue Date

Expiration Date

Notes

Other License Details

Licensee/Applicant

Licensing Board or Regulatory Authority



License Number

State / Province

Country


Application


License Type

License Status

Issue Date


Expiration Date

Notes

Other License Details

Licensee/Applicant



  

Licensing Board or Regulatory Authority



License Number

State / Province

Country

Application


License Type

License Status

Issue Date

Expiration Date

Notes

Other License Details

Licensee/Applicant

Licensing Board or Regulatory Authority



License Number

State / Province

Country


Application


License Type

License Status

Issue Date

Expiration Date



Notes

Postgraduate Training

| Licensee / Applicant ▼ | Name of School or Institution ▼ | Specialty Type ▼ | Date From ▼ | Date To ↑ ▼ | Program Type |
|------------------------|------------------------------------|------------------------------|-------------|-------------|--------------|
| Feinberg, Michael Jack | Cedars-Sinai Medical Center | Pathology, Anatomic/Clinical | Jul-01-1988 | Jun-30-1989 | Internship |
| Feinberg, Michael Jack | Monmouth Medical Center | Radiology,Diagnostic | Jul-01-1989 | Jun-30-1990 | Residency |
| Feinberg, Michael Jack | University of Texas Medical Branch | Aerospace Medicine | Aug-01-1999 | Jul-31-2000 | Residency |

Postgraduate Training Details

Licensee / Applicant *

Program Type *



  

Date From

Name of School or Institution

Specialty Type

Other (Specialty)

Training Status *

Accreditation Type

Date To

Application

Historical Major Program



Historical Degree Attained

Location Details

City

State / Province


County

Street Address 1



Zip / Postal Code

Country

Postgraduate Training Details


Licensee / Applicant *

Program Type *

Date From

Name of School or Institution

Specialty Type

Other (Specialty)

Training Status *



Accreditation Type

Date To

Application

Historical Major Program



Historical Degree Attained

Location Details

City

State / Province



County

Street Address 1



Zip / Postal Code

Country

Postgraduate Training Details


Licensee / Applicant *

Program Type *

Date From


Name of School or Institution

Specialty Type

Other (Specialty)


Training Status *


Accreditation Type

Date To

Application

Historical Major Program



Historical Degree Attained

Location Details

City

State / Province



County

Street Address 1

Zip / Postal Code

Country

Specialties

| Licensee / Applicant | Specialty Type | Primary Specialty? | Effective Date | End Date |
|----------------------|--------------------|--------------------|----------------|----------|
| Michael Feinberg | Aerospace Medicine | Yes | May-10-1999 | N/A |

Specialty Details



Licensee / Applicant *

Effective Date



Application

Primary Specialty?

Yes No

Specialty Type *

Other (Specialty)

End Date

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 your name MICHAEL J. FEINBERG

Sign your name _____

Date 11/16/2023

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.

RECEIVED
NOV 16 2023
NEVADA STATE BOARD OF
MEDICAL EXAMINERS

