# **Demographic Details**

First Name	Gender	
Paul	Male	<b>—</b> [7]
Middle Name	Date of Birth	
Peter	1980	ä
Last Name *	Name Suffix	
Harkey		
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 informat	tion)
Is this person deceased?	r dolle illiorination	
○ Yes ○ No		
Date Deceased		
ä		
Do you have a Nevada Business License in your individual name?		
○ Yes ○ No		
Nevada BIN		
Historical File Number		

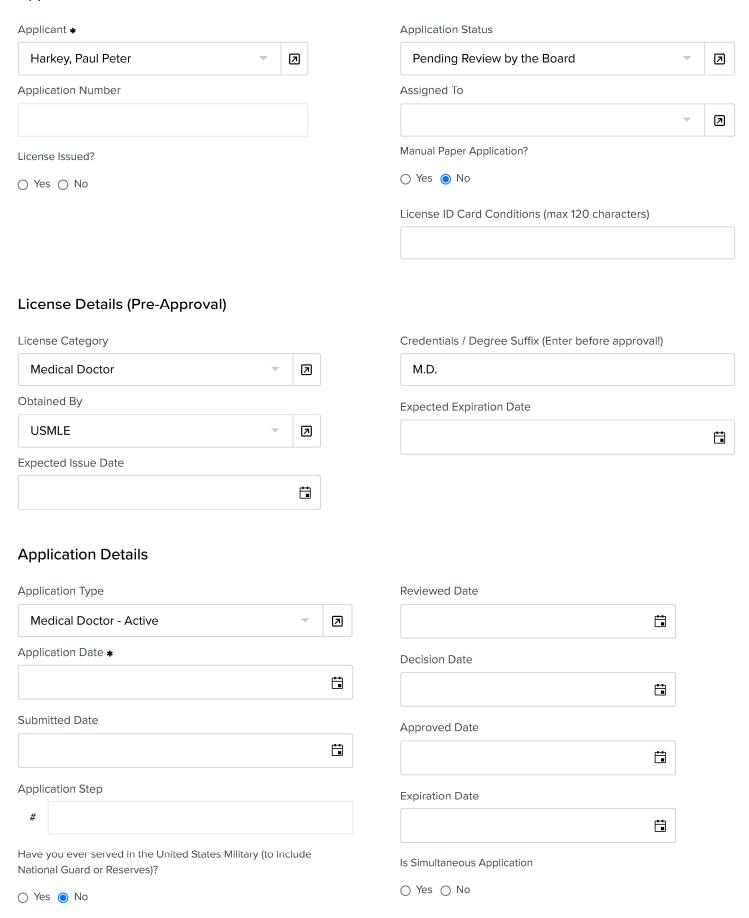
# Military Detail

Have you ever served in the United States Military (to includ	e National Guard or Reserves)?
○ Yes <b>③</b> 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
	<b>Z</b>
Cell Phone	Fax
#	#
Public Address	
Street Address	ZIP / Postal Code
9500 Euclid Ave	44195
Address Line 2	State / Province
	Ohio
City	Country
Cleveland	United States
County	Is your physical address different from your mailing address?
Cuyahoga	Yes ○ No
	Public Phone
	# (216) 986-4665

# Mailing Address

Street Address	City (Mailing)
Address Line 2	State / Province (Mailing)
ZIP / Postal Code (Mailing)	County (Mailing)
	7
	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
- Paid in Full	
Licensure Invoice	Licensure Payment Date
<b>—</b> [2]	
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.	requirements found in Nevada Revised Statute 432B.220 regarding the abuse or neglect of a child.  Tes 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
I am willing to accept Board communications to me, to include service of process as defined under Nevada Revised Statute (NRS)	Child Support Attestation Type
630.344, via electronic mail (more commonly known as e-mail).  Further, should the electronic mail address provided below change	Not subject to a court order
for any reason, I agree to apprise the Board in writing of my new electronic mail address within 30 days after the change.	I have read this responsibility statement and understand that I alone am accountable for completing my application for medical licensure in Nevada.
● Yes ○ No	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	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.

O Yes O No

medicine in the state of Nevada.

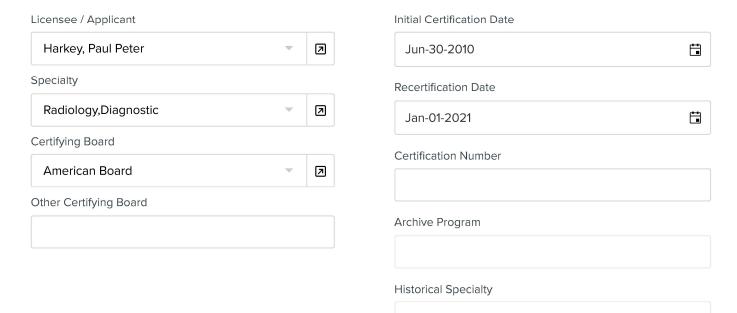
the same were procured in the regular course of instruction and

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

# **Board Certifications**

Licensee / Applicant	Certifying Board	Other Certifying Board	Specialty <b>T</b>	Initial Certification Date	Recertification Date
Harkey, Paul Peter	American Board	N/A	Radiology,Diagnostic	Jun-30-2010	Jan-01-2021

### **Board Certification Details**



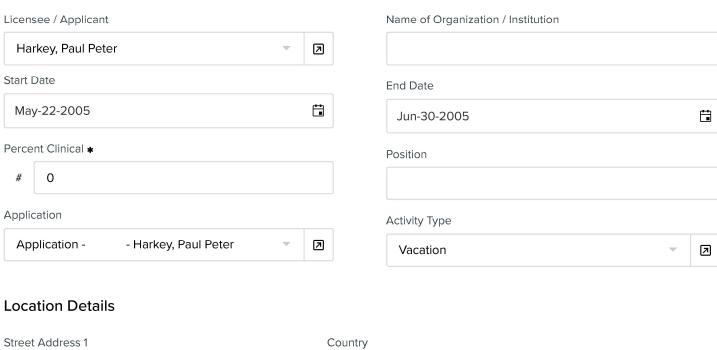
#### **Connected Record**

Application

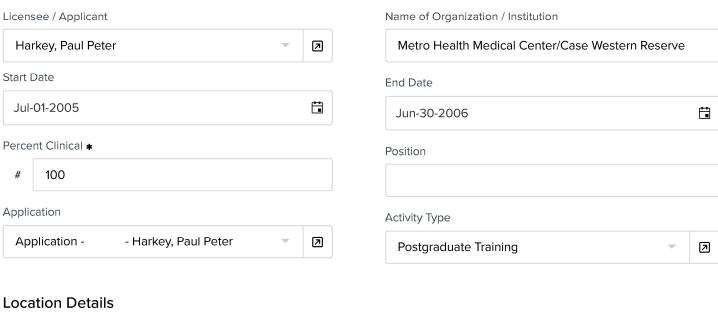


# Activities

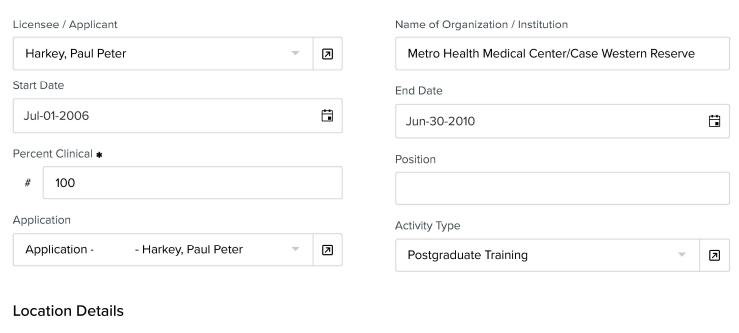
Licensee / Applicant	Name of Organization / Institution	Start Date †	End Date	Percent Clinical
Paul Harkey	N/A	May-22-2005	Jun-30-2005	0
Paul Harkey	Metro Health Medical Center/Case Western Reserve	Jul-01-2005	Jun-30-2006	100
Paul Harkey	Metro Health Medical Center/Case Western Reserve	Jul-01-2006	Jun-30-2010	100
Paul Harkey	Emory University	Jul-01-2010	Jun-30-2011	100
Harkey, Paul Peter	Emory University	Jul-01-2011	Jan-27-2023	100
Paul Harkey	N/A	Jan-27-2023	Mar-26-2023	0
Paul Harkey	AdventHealth	Mar-27-2023	Dec-01-2023	100
Paul Harkey	N/A	Dec-02-2023	Dec-31-2023	0
Paul Harkey	Cleveland Clinic	Jan-01-2024	Jun-24-2024	100



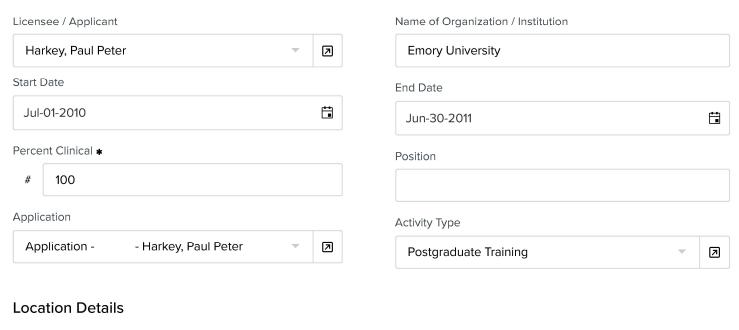




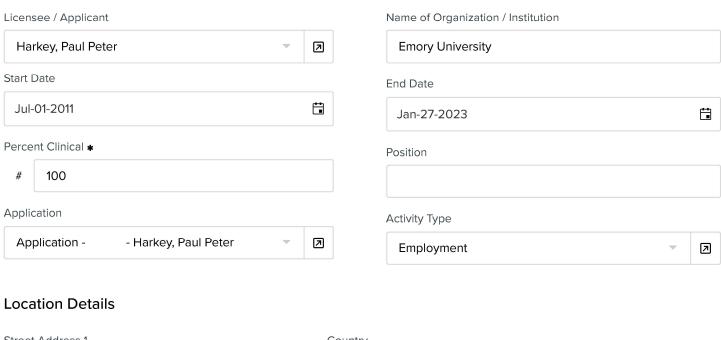




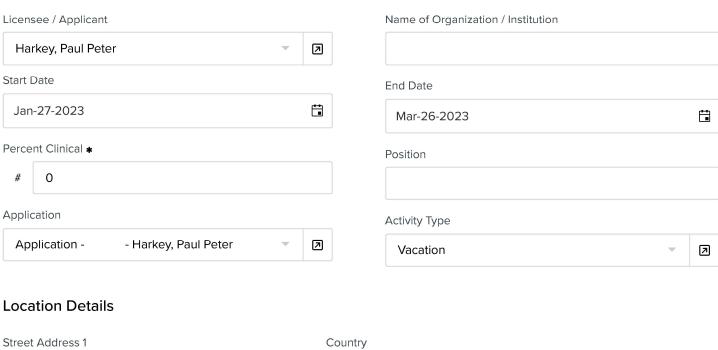


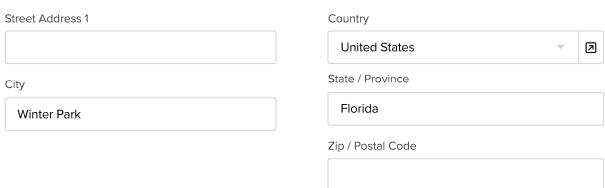


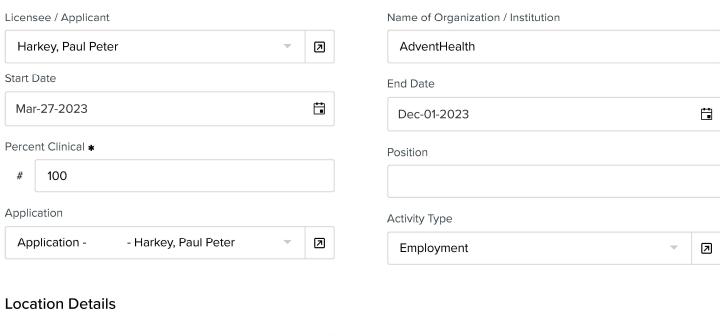


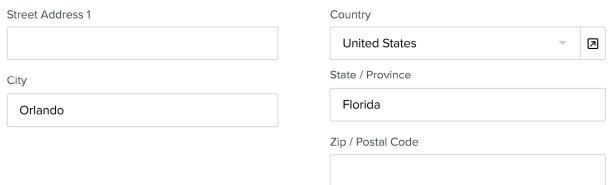


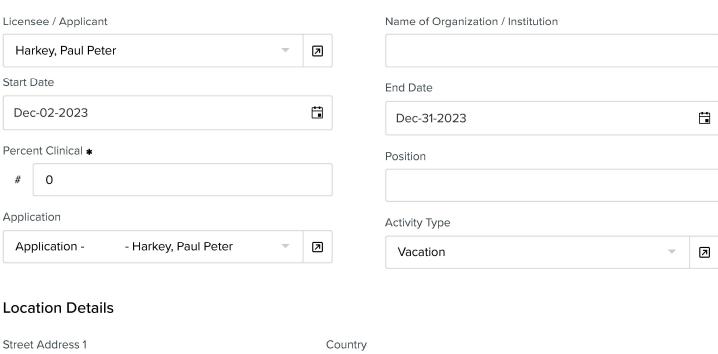




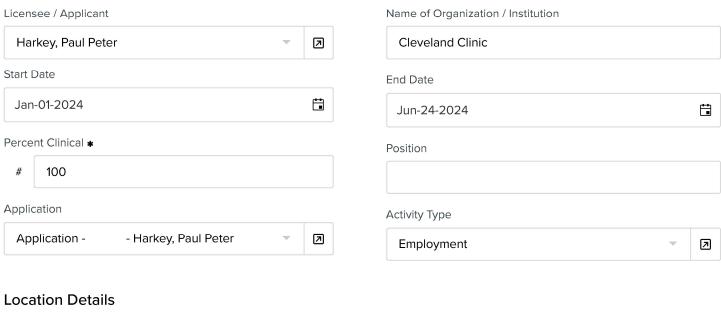












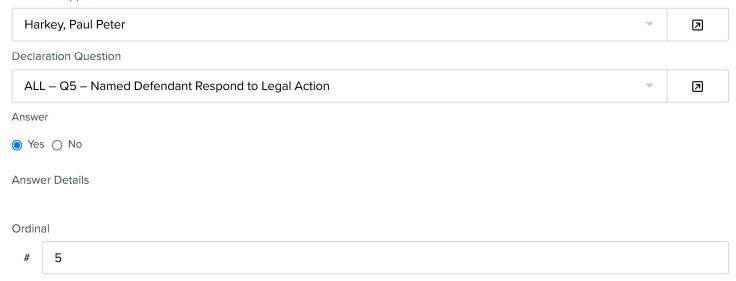


# Declarations

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

#### Declaration

Licensee/Applicant



**Declaration Text** 

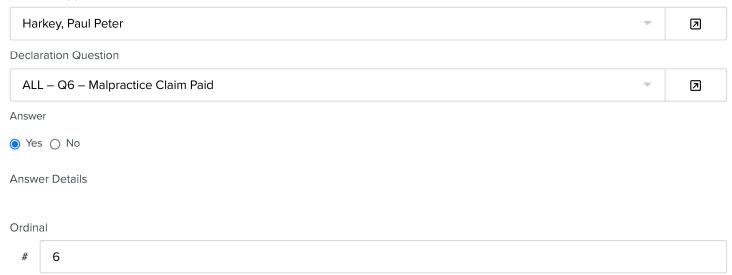
Have you EVER been named as a defendant, or been requested to respond as a defendant, to a legal action involving professional liability, or malpractice, including any military tort claims if applicable?

#### Related To



#### Declaration

Licensee/Applicant



**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?

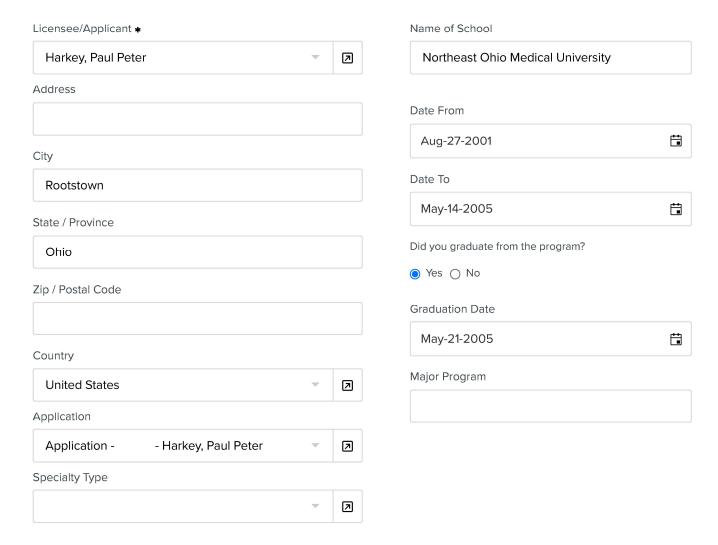
#### Related To



# Education

Licensee/Applicant	Education Type	Name of School	▼	Degree Attained	<b>T</b>	Date From	<b>T</b>	Date To ↑	<b>T</b>	Graduation Date
Harkey, Paul Peter	Medical School	Northeast Ohio Medical University		Medical Doctor Degree		Aug-27-2001		May-14-2005		May-21-2005

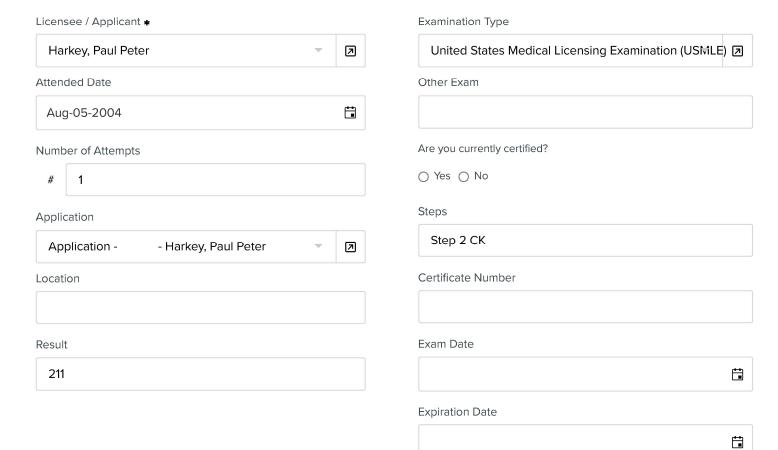
#### **Education Details**



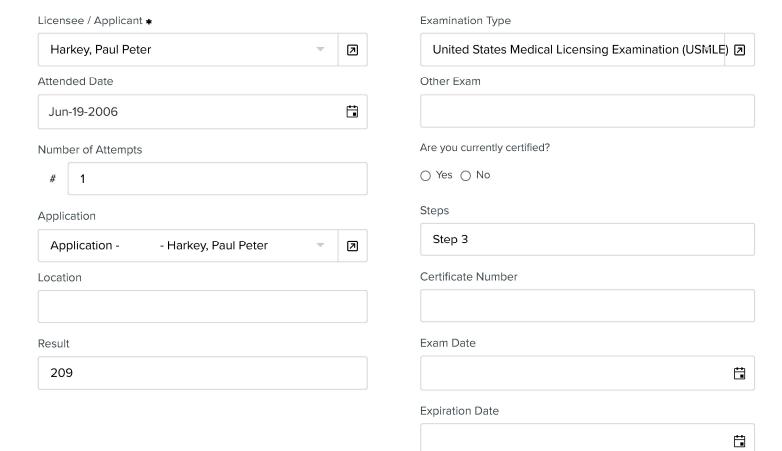
# Examinations

Licensee / Applicant	Examination Type	Attended Date †
Harkey, Paul N/A	United States Medical Licensing Examination (USMLE)	Jun-23-2003
Harkey, Paul N/A	United States Medical Licensing Examination (USMLE)	Aug-05-2004
Harkey, Paul N/A	United States Medical Licensing Examination (USMLE)	Sep-25-2004
Harkey, Paul N/A	United States Medical Licensing Examination (USMLE)	Jun-19-2006

Licensee / Applicant *	Examination Type		
Harkey, Paul Peter	United States Medical Licensing Examination (USMLE) 🗷		
Attended Date	Other Exam		
Jun-23-2003			
Number of Attempts	Are you currently certified?		
# 1	○ Yes ○ No		
Application	Steps		
Application Harkey, Paul Peter 🔻 🗵	Step 1		
Location	Certificate Number		
Result	Exam Date		
219			
	Expiration Date		



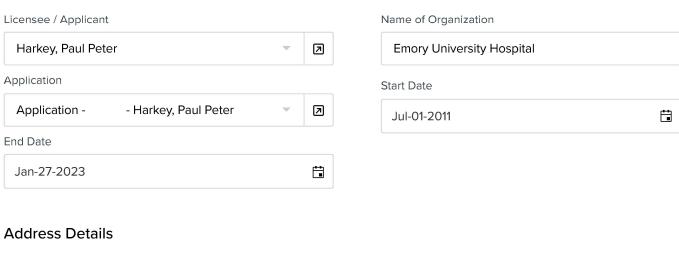
Licensee / Applicant *	Exami	nation Type
Harkey, Paul Peter	• Unit	ted States Medical Licensing Examination (USMLE)
Attended Date	Other	Exam
Sep-25-2004		
Number of Attempts	Are yo	u currently certified?
# 1	○ Yes	○ No
Application	Steps	
Application Harkey, Paul Peter •	Ste	2 CS
Location	Certific	cate Number
Result	Exam	Date
PASS		ä
	Expira	tion Date



# Hospitals

Licensee / Applicant	Name of Organization	Start Date †	End Date
Paul Harkey	Emory University Hospital	Jul-01-2011	Jan-27-2023
Paul Harkey	AdventHealth - Orlando	Mar-27-2023	Dec-01-2023
Paul Harkey	Cleveland Clinic	Jan-01-2024	Jun-24-2024

# **Hospital Details**



# Street Address Line 1 State / Province



Atlanta United States 

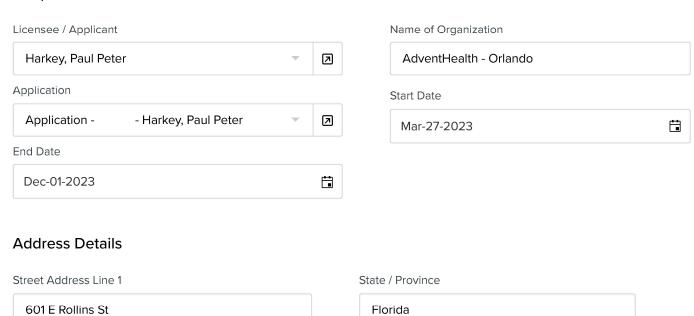
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# **Hospital Details**

Street Address Line 2

City

Orlando



ZIP / Postal Code

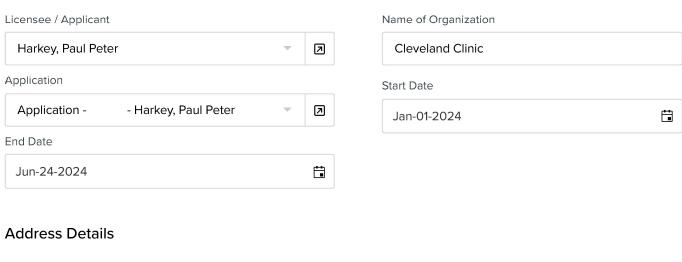
**United States** 

7

32803

Country

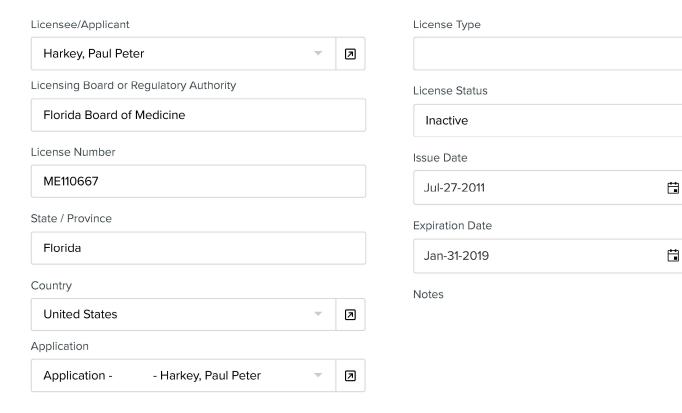
# **Hospital Details**

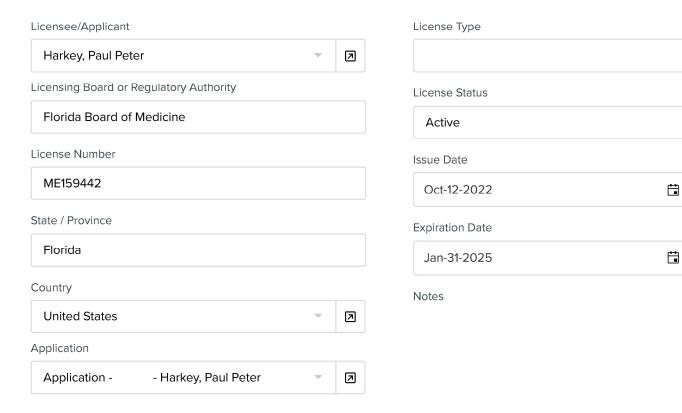


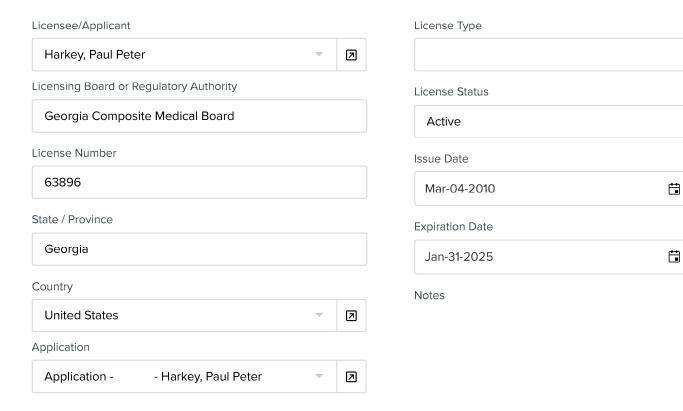


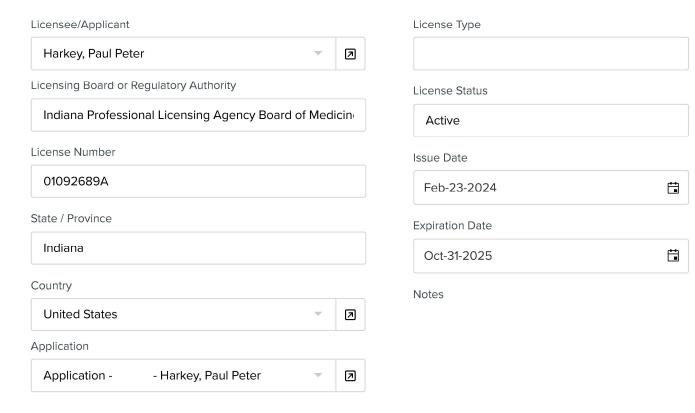
# Other Licenses

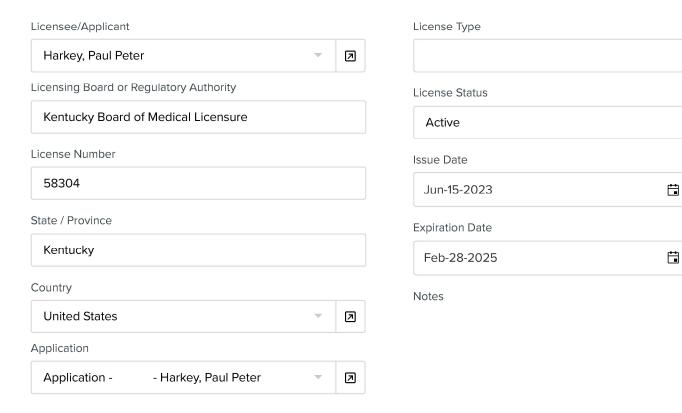
Licensee/Applicant <b>Y</b>	License Number	License Type	Issue Date	Expiration Date	State / Province †
Paul Harkey	ME110667	N/A	Jul-27-2011	Jan-31-2019	Florida
Paul Harkey	ME159442	N/A	Oct-12-2022	Jan-31-2025	Florida
Paul Harkey	63896	N/A	Mar-04-2010	Jan-31-2025	Georgia
Paul Harkey	01092689A	N/A	Feb-23-2024	Oct-31-2025	Indiana
Harkey, Paul Peter	58304	N/A	Jun-15-2023	Feb-28-2025	Kentucky
Paul Harkey	TP907	N/A	Mar-24-2023	Sep-24-2023	Kentucky
Paul Harkey	4301510743	N/A	Jan-04-2024	Jan-04-2027	Michigan
Harkey, Paul N/A	35-090834	N/A	Nov-28-2007	Oct-01-2024	Ohio
Harkey, Paul Peter	57-010313	N/A	Sep-23-2005	Jun-30-2008	Ohio
Paul Harkey	MD483543	N/A	Dec-15-2023	Dec-31-2024	Pennsylvania
Paul Harkey	13647967-1205	N/A	Oct-23-2023	Jan-31-2026	Utah
Paul Harkey	16650A	N/A	Jan-26-2024	Jun-30-2025	Wyoming
Paul Harkey	TL8038	N/A	Dec-05-2023	Jan-26-2024	Wyoming

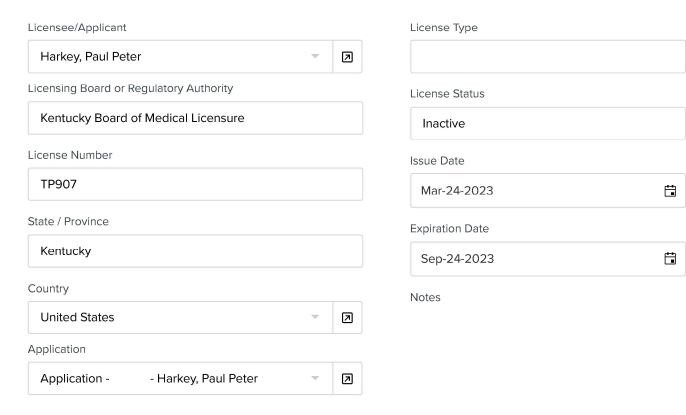


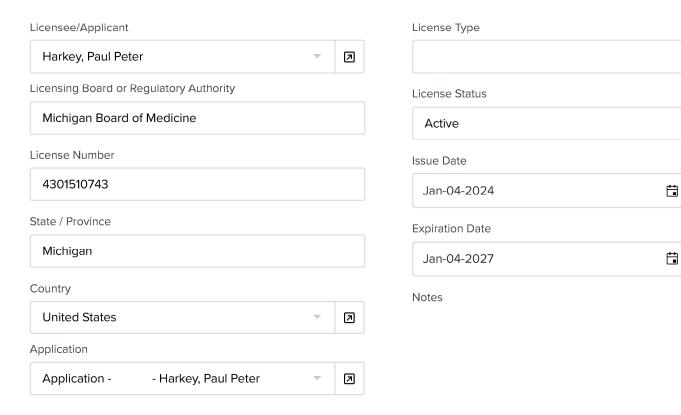


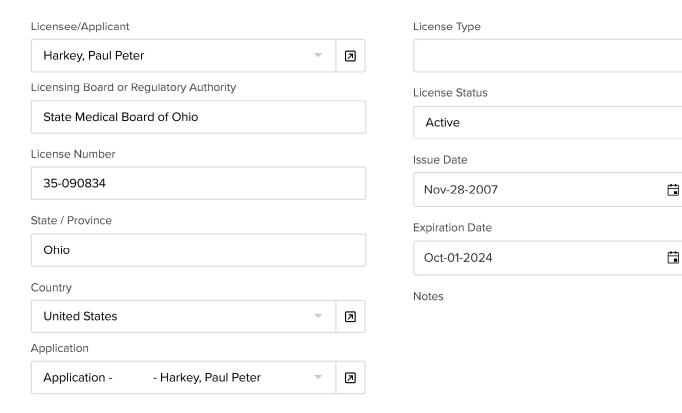


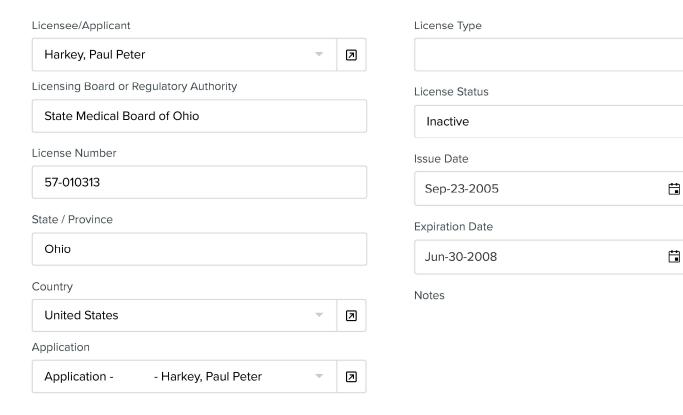


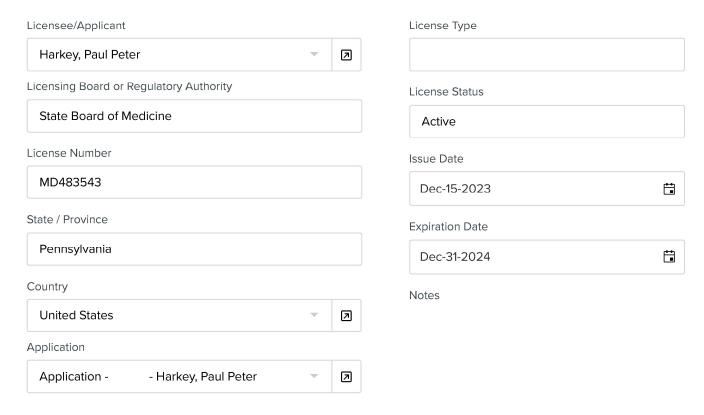


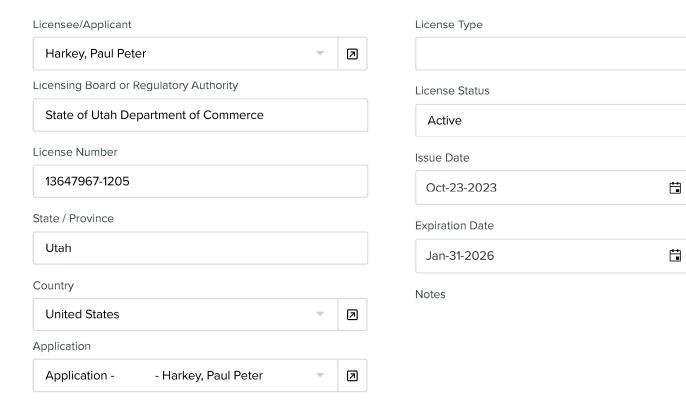


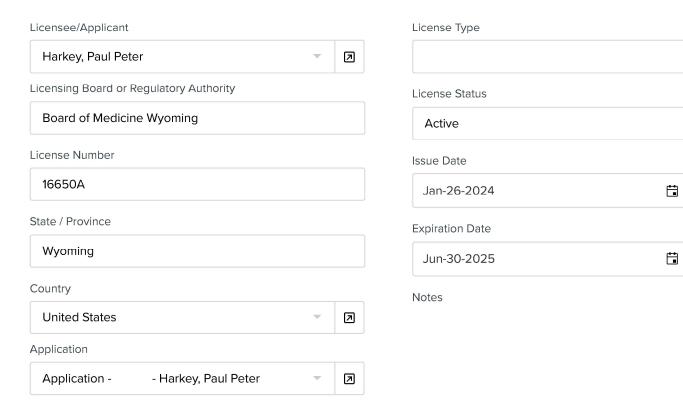


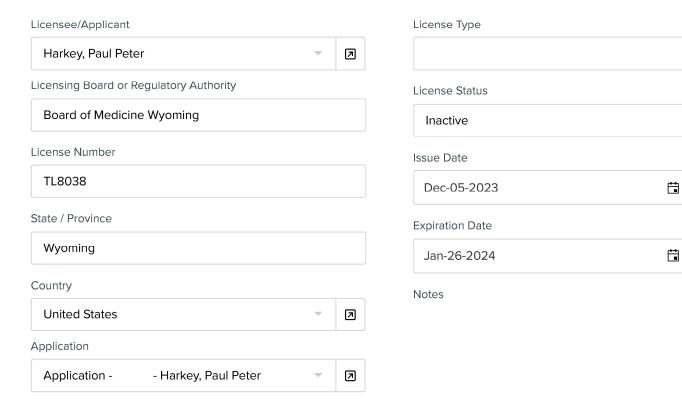








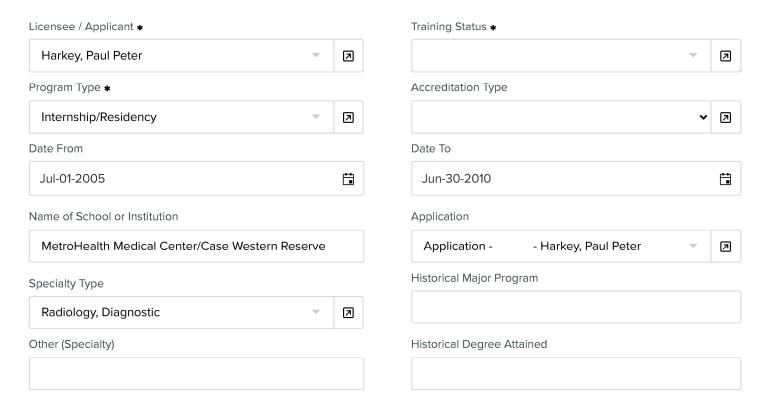




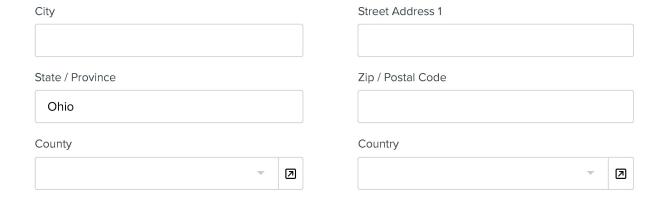
## Postgraduate Training

Licensee / Applicant	T	Name of School or Institution	<b>T</b>	Specialty Type	•	Date From ▼	Date To ↑	▼	Program Type
Harkey, Paul N/A		MetroHealth Medical Center/Case Western Reserve		Radiology, Diagnostic		Jul-01-2005	Jun-30-2010		Internship/Residency

### Postgraduate Training Details



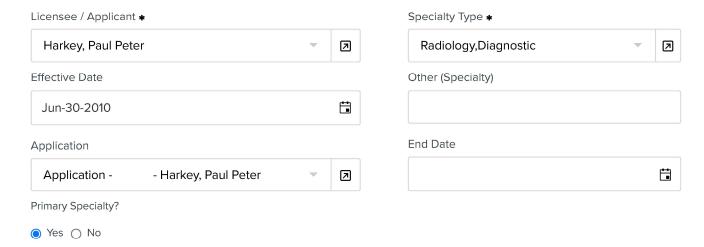
#### **Location Details**



## Specialties

Licensee / Applicant	Ŧ	Specialty Type	T	Primary Specialty?	▼	Effective Date	▼	End Date
Harkey, Paul N/A		Radiology,Diagnostic		Yes		Jun-30-2010		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.

0 0 0 0

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	Paul P. Harkey, MD	
Sign your name		
Date <u>6/</u> 2	26/24	

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

JUL 12 2024

NEVADA STATE BOARD OF MEDICAL EXAMINERS

