

Demographic Details

First Name

Middle Name

Last Name *

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

Military Detail

Gender



Date of Birth



Name Suffix

City of Birth

Place of Birth

Weight (in lbs)

Eye Color

Comments (non-public information)

Public Information

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

#

Primary Phone Extension

Primary E-mail Address



Cell Phone

#

Secondary Phone

#

Secondary Phone Extension

Mail should be directed to



Fax

#

Public Address

Street Address

9500 Euclid Ave

Address Line 2

City

Cleveland

County

Cuyahoga

ZIP / Postal Code

44195

State / Province

Ohio

Country

United States



Is your physical address different from your mailing address?

Yes No

Public Phone

#

(216) 986-4665

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

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

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

Board Certifications

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

Board Certification Details

Licensee / Applicant

Specialty


  

Certifying Board

Other Certifying Board

Initial Certification Date

Recertification Date



Certification Number

Archive Program

Historical Specialty

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

Application Activity Details

Licensee / Applicant



Start Date

Percent Clinical *


#

Application

Name of Organization / Institution

End Date

Position

Activity Type

Location Details

Street Address 1

Country


City

State / Province

Zip / Postal Code

Application Activity Details

Licensee / Applicant



Start Date

Percent Clinical *

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Application

Name of Organization / Institution

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Activity Type

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Zip / Postal Code

Application Activity Details

Licensee / Applicant



Start Date

Percent Clinical *


#

Application

Name of Organization / Institution

End Date

Position

Activity Type


  

Location Details

Street Address 1

City

Country


  

State / Province


Zip / Postal Code

Application Activity Details

Licensee / Applicant



Start Date

Percent Clinical *

#

Application

Name of Organization / Institution

End Date

Position


Activity Type

Location Details

Street Address 1

Country

City

State / Province


Zip / Postal Code

Application Activity Details

Licensee / Applicant



Start Date

Percent Clinical *

#

Application

Name of Organization / Institution

End Date

Position



Activity Type

Location Details

Street Address 1

Country

City

State / Province


Zip / Postal Code

Application Activity Details

Licensee / Applicant



Start Date

Percent Clinical *

#

Application

Name of Organization / Institution

End Date

Position


Activity Type

Location Details

Street Address 1

Country


City

State / Province


Zip / Postal Code

Application Activity Details

Licensee / Applicant



Start Date

Percent Clinical *


#

Application

Name of Organization / Institution

End Date

Position



Activity Type

Location Details

Street Address 1

Country

City

State / Province


Zip / Postal Code

Application Activity Details

Licensee / Applicant



Start Date

Percent Clinical *


#

Application

Name of Organization / Institution

End Date

Position


Activity Type

Location Details

Street Address 1

Country


City

State / Province


Zip / Postal Code

Application Activity Details

Licensee / Applicant



Start Date

Percent Clinical *


#

Application

Name of Organization / Institution

End Date

Position

Activity Type

Location Details

Street Address 1

Country

City

State / Province


Zip / Postal Code

Declarations

Ordinal ↑	Licensee/Applicant	Declaration Question	Answer	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

Harkey, Paul Peter	▼	
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Declaration Question

ALL – Q5 – Named Defendant Respond to Legal Action	▼	
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Answer

Yes No

Answer Details

Ordinal


#	5
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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 -	- Harkey, Paul Peter	▼	
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Renewal

	▼	
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Declaration

Licensee/Applicant

Harkey, Paul Peter	▼	
--------------------	---	---

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 -	- Harkey, Paul Peter	▼	
---------------	----------------------	---	---

Renewal

	▼	
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Education

Licensee/Applicant ▼	Education Type ▼	Name of School ▼	Degree Attained ▼	Date From ▼	Date To ↑ ▼	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

Licensee/Applicant *


Address

City



State / Province

Zip / Postal Code

Country

Application


  

Specialty Type

Name of School

Date From


Date To

Did you graduate from the program?

Yes No

Graduation Date

Major Program

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

Examination Details

Licensee / Applicant *

Harkey, Paul Peter  



Attended Date

Jun-23-2003 

Number of Attempts

1

Application


Application - Harkey, Paul Peter  

Location

Result

219

Examination Type

United States Medical Licensing Examination (USMLE) 

Other Exam

Are you currently certified?


Yes No

Steps

Step 1

Certificate Number

Exam Date




Expiration Date




Examination Details

Licensee / Applicant *

Harkey, Paul Peter  



Attended Date

Aug-05-2004 

Number of Attempts

1

Application


Application - Harkey, Paul Peter  

Location

Result

211

Examination Type

United States Medical Licensing Examination (USMLE) 

Other Exam

Are you currently certified?


Yes No

Steps


Step 2 CK

Certificate Number

Exam Date



Expiration Date




Examination Details

Licensee / Applicant *

Harkey, Paul Peter 


Attended Date

Sep-25-2004 

Number of Attempts

1

Application


Application - Harkey, Paul Peter 

Location

Result

PASS

Examination Type

United States Medical Licensing Examination (USMLE) 

Other Exam

Are you currently certified?


Yes No

Steps

Step 2 CS

Certificate Number

Exam Date



Expiration Date



Examination Details

Licensee / Applicant *

Harkey, Paul Peter  



Attended Date

Jun-19-2006 

Number of Attempts

1

Application


Application - Harkey, Paul Peter  

Location

Result

209

Examination Type

United States Medical Licensing Examination (USMLE) 

Other Exam

Are you currently certified?


Yes No

Steps

Step 3

Certificate Number

Exam Date



Expiration 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

Licensee / Applicant


  

Name of Organization


Application

Start Date

End Date

Address Details

Street Address Line 1

State / Province

Street Address Line 2

ZIP / Postal Code

City

Country



Hospital Details

Licensee / Applicant

Name of Organization

Application

Start Date

End Date

Address Details

Street Address Line 1

State / Province

Street Address Line 2

ZIP / Postal Code


City

Country



Hospital Details

Licensee / Applicant


  

Name of Organization

Application

Start Date

End Date

Address Details

Street Address Line 1

State / Province

Street Address Line 2

ZIP / Postal Code

City

Country

Other Licenses

Licensee/Applicant ▼	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

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

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

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

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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 ▼
Harkey, Paul N/A	MetroHealth Medical Center/Case Western Reserve	Radiology, Diagnostic	Jul-01-2005	Jun-30-2010	Internship/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

Street Address 1



State / Province

Zip / Postal Code

County

Country


  

Specialties

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

Sign your name _____

Date 6/26/24

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

