# **Demographic Details**

First Name	Gender	
Bradford	Male	7
Middle Name	Date of Birth	
Alan	-1964	ä
Last Name *	Name Suffix	
KOLB		
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 information	ation)
Is this person deceased?	r dane intermedien	
○ Yes ○ No		
Date Deceased		
Do you have a Nevada Business License in your individual name?		
○ Yes ○ No		
Nevada BIN		
Historical File Number		

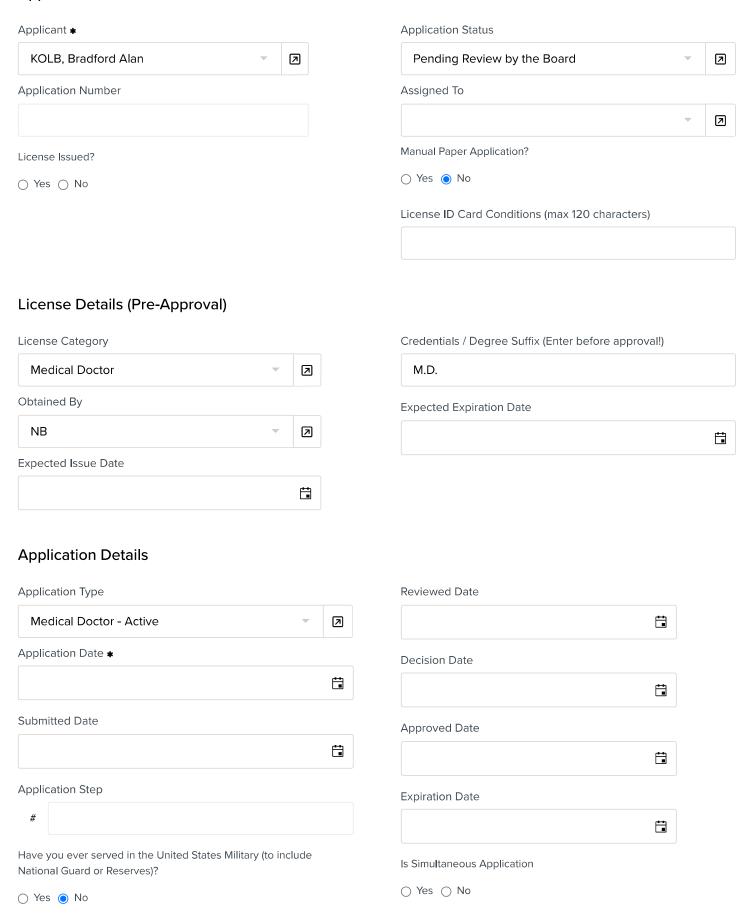
# Military Detail

Have you ever served in the United States Military (to include National G	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
Cell Phone	Fax
#	#
Public Address	
Street Address	ZIP / Postal Code
HRC Fertility, 55 S. Lake Avenue	91101
Address Line 2	State / Province
Address Line 2	California
City	Country
Pasadena	United States
County	Is your physical address different from your mailing address?
Los Angeles	
	Public Phone
	# (626) 440-9161

# 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 s a veteran?	urviving spouse of		
○ Yes <b>○</b> No			
Invoices			
Application Invoice		Application Payment Date	
- Paid in Full	7	Ē	•
Licensure Invoice		Licensure Payment Date	
∀	7	Ė	•
Attestations  I hereby attest to knowledge of and compliance w	ith the guidelines	I attest and affirm that I am aware of and understand the reportin	ng
of the Centers for Disease Control and Prevention prevention of transmission of infectious agents thr	ough safe and	requirements found in Nevada Revised Statute 432B.220 regards the abuse or neglect of a child.	ling
appropriate injection practices. I also attest that an currently, or will be under my control as their supe the future, and who is not licensed pursuant to Ch.	rvising physician in	Yes     No	
Nevada Revised Statutes and whose duties involved practices, has knowledge of and is in compliance of the Centers for Disease Control and Prevention prevention of transmission of infectious agents threappropriate injection practices.	e injection with the guidelines concerning the	I consent to accept communications and service of process from Nevada State Board of Medical Examiners (Board) by electronic r for physicians and physician assistants who practice medicine in state of Nevada or via telemedicine and whose physical presence exists outside the state of Nevada or the United States.	mail, the
Yes     No		○ Yes ○ No	
I am willing to accept Board communications to me service of process as defined under Nevada Revis		Child Support Attestation Type	
630.344, via electronic mail (more commonly know	, ,	Not subject to a court order	7

in Nevada.

O Yes ○ No

O Yes O No

I have read this responsibility statement and understand that I alone

am accountable for completing my application for medical licensure

In consideration for processing my application I, the undersigned,

irrevocably agree to the Civil Applicant Waiver.

whose name and signature voluntarily appears below; do hereby and

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.

O Yes O No

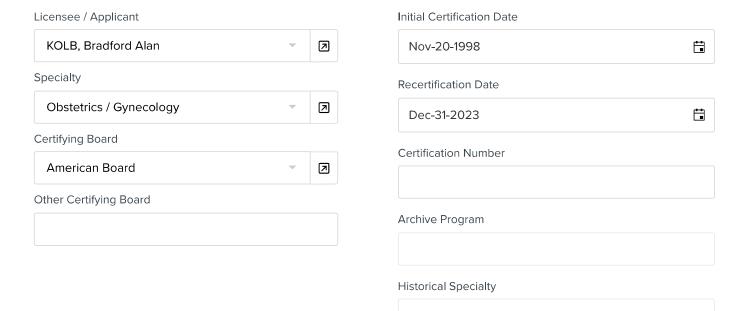
The answers to the foregoing questions and statements made in the above application, as well as any and all further explanations contained on any separate attached pages, are true and correct, that I am the person named in the credentials to be submitted, and that the same were procured in the regular 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.

O Yes O No

# **Board Certifications**

Licensee / Applicant	Certifying Board	Other Certifying Board	•	Specialty <b>Y</b>	Initial Certification Date	Recertification Date †
KOLB, Bradford Alan	American Board	N/A		Obstetrics / Gynecology	Nov-20-1998	Dec-31-2023
KOLB, Bradford Alan	American Board Subboard	N/A		Endocrinology,Reproductive	Apr-18-2001	Dec-31-2023

#### **Board Certification Details**

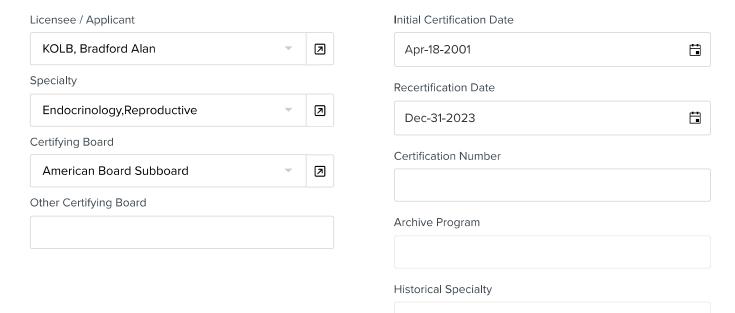


#### **Connected Record**

Application



#### **Board Certification Details**



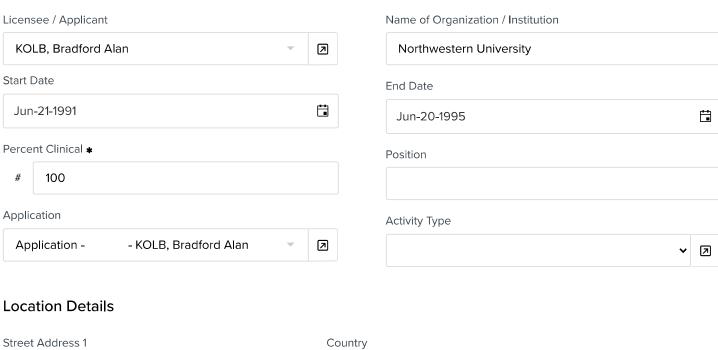
#### **Connected Record**

Application

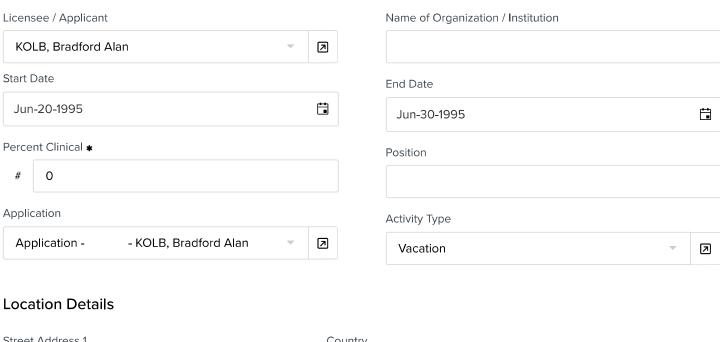


# Activities

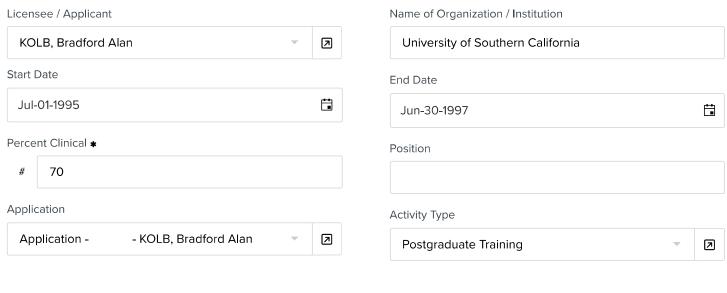
Licensee / Applicant	Name of Organization / Institution	Start Date ↑ ▼	End Date	Percent Clinical
Bradford Kolb	Northwestern University	Jun-21-1991	Jun-20-1995	100
Bradford Ko <b>l</b> b	N/A	Jun-20-1995	Jun-30-1995	0
Bradford Kolb University of Southern California		Jul-01-1995	Jun-30-1997	70
Bradford Ko <b>l</b> b	N/A	Jul-01-1997	Jul-31-1997	0
Bradford Ko <b>l</b> b	University of Southern California-Associate Professor	Aug-01-1997	Mar-31-2012	0
Bradford Kolb	Kaiser Permanente Medical Center	Aug-01-1997	Mar-31-2003	100
Bradford Ko <b>l</b> b	HRC Fertility	Mar-01-2001	May-31-2024	80
Bradford Ko <b>l</b> b	Keck School of Medicine of USC	Aug-01-2023	Aug-31-2024	0





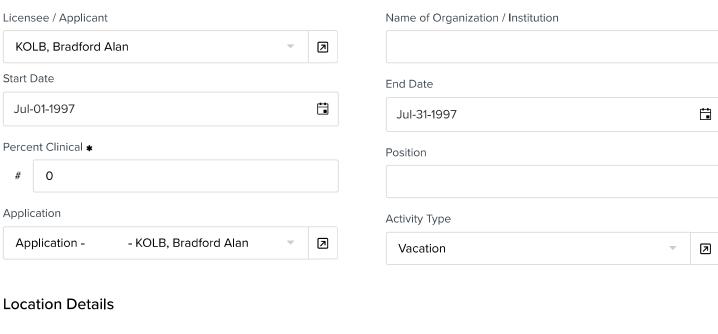


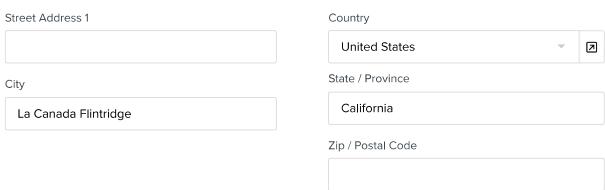


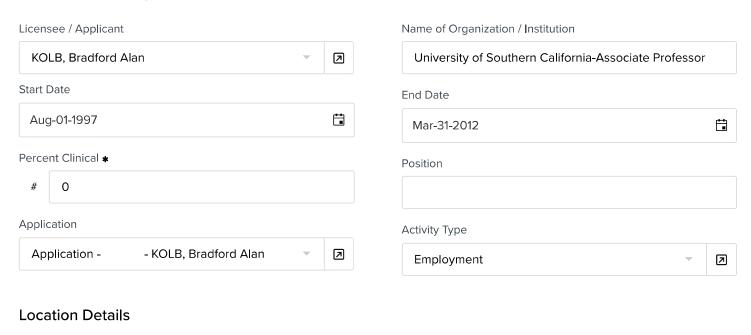


#### **Location Details**

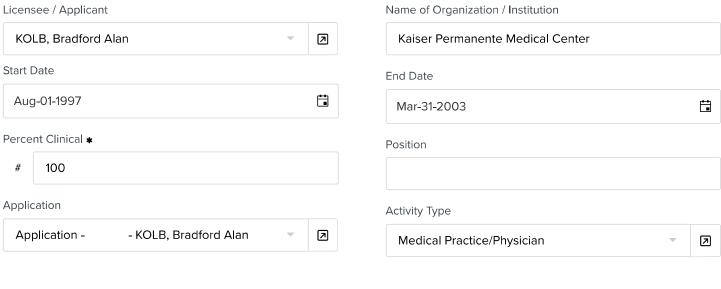




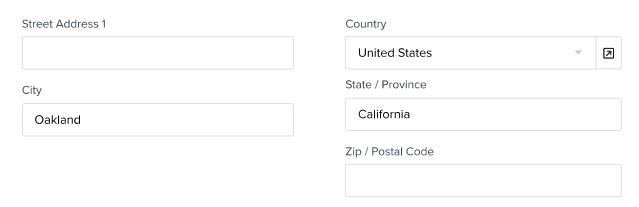


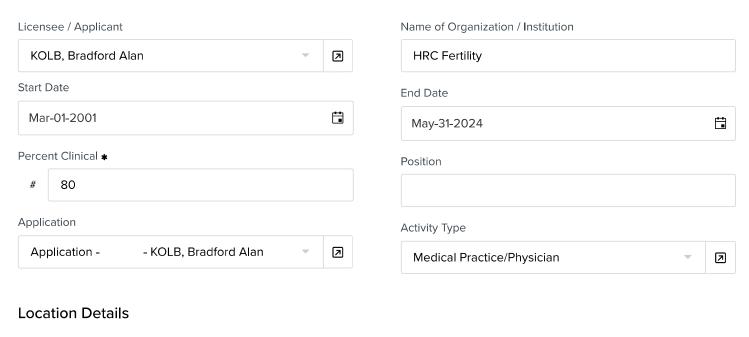




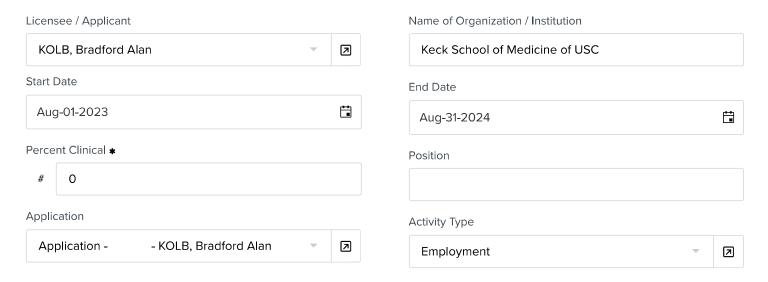


#### **Location Details**

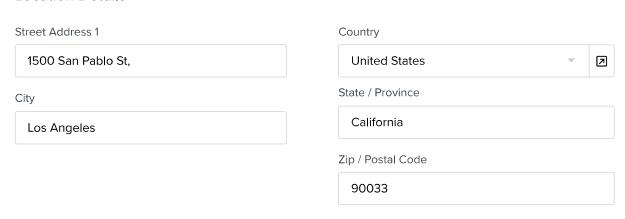








#### **Location Details**

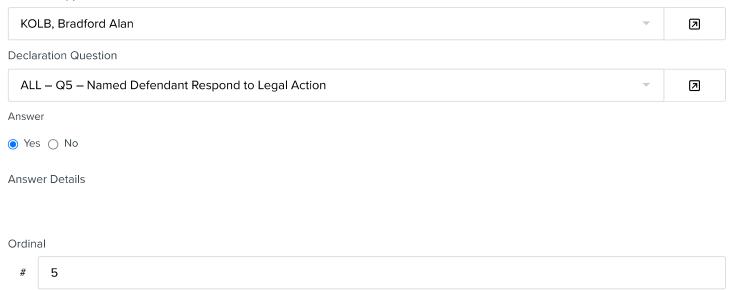


# Declarations

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

#### **Declaration**

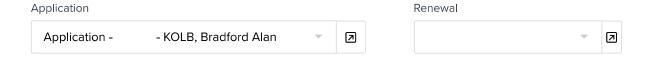
Licensee/Applicant



Declaration Text

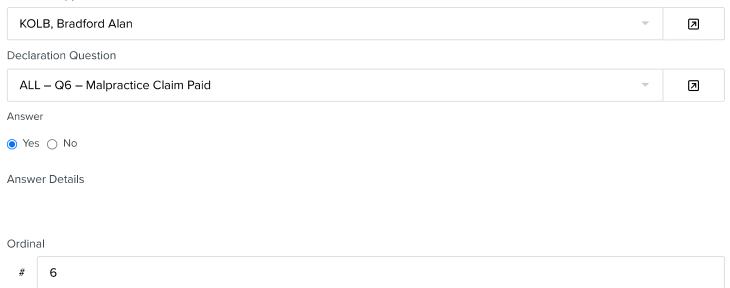
Have you EVER been named as a defendant, or been requested to respond as a defendant, to a legal action involving professional liability, or malpractice, including any military tort claims if applicable?

#### Related To



#### **Declaration**

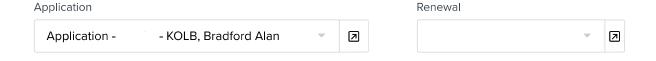
Licensee/Applicant



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?

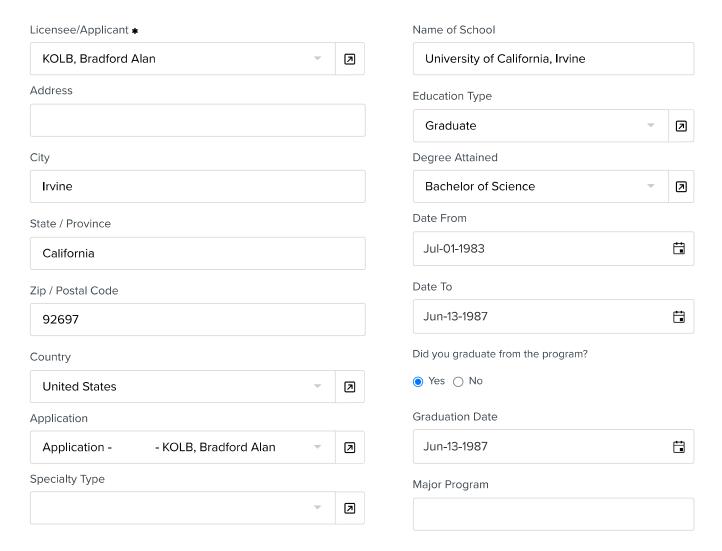
#### Related To



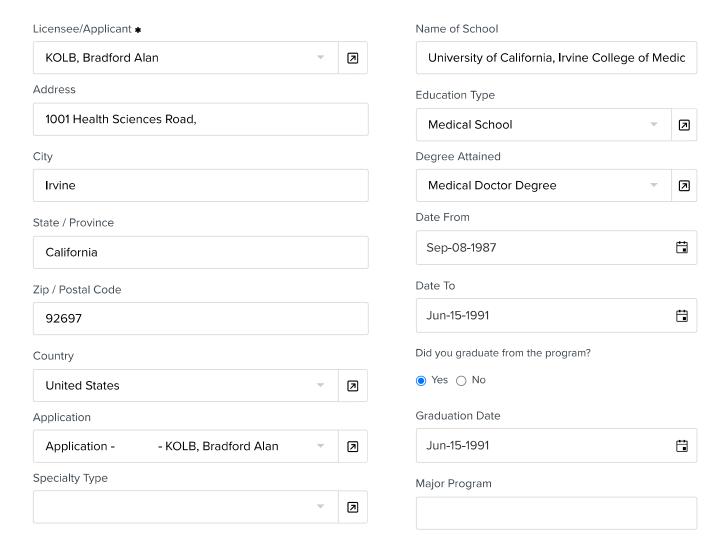
# Education

Licensee/Applicant	Education Type	Name of School	Degree Attained	Date From ▼	Date To ↑ ▼	Graduation Date
KOLB, Bradford Alan	Graduate	University of California, Irvine	Bachelor of Science	Jul-01 <b>-</b> 1983	Jun-13-1987	Jun-13-1987
KOLB, Bradford Alan	Medical School	University of California, Irvine College of Medicine	Medical Doctor Degree	Sep-08-1987	Jun-15-1991	Jun-15-1991

#### **Education Details**



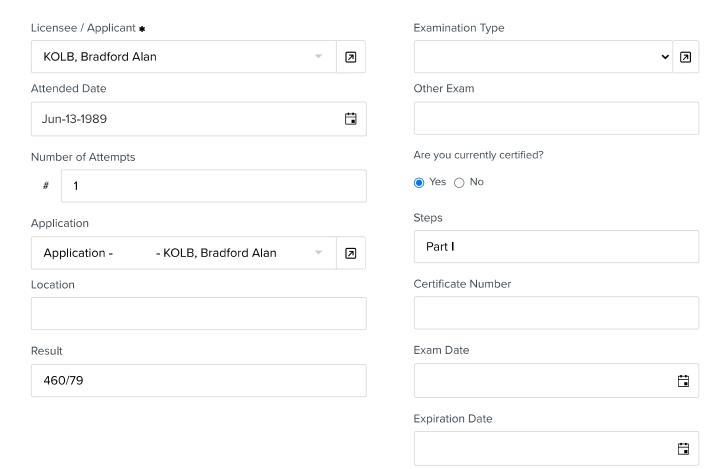
#### **Education Details**



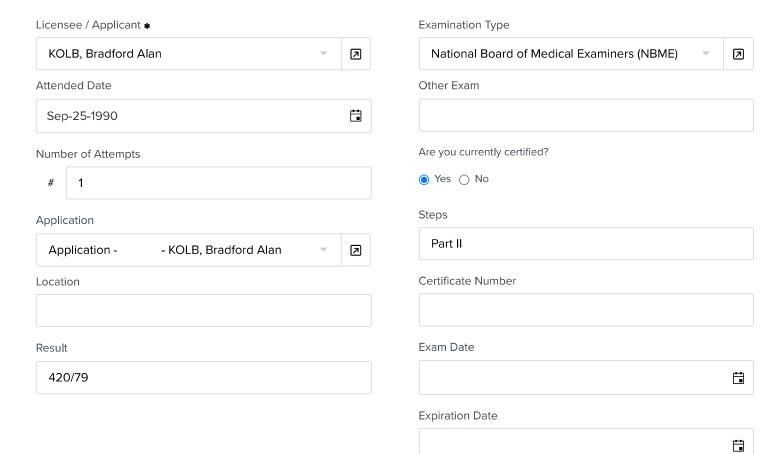
### Examinations

Licensee / Applicant	Examination Type	Attended Date †
KOLB, Bradford Alan	National Board of Medical Examiners (NBME)	Jun-13-1989
KOLB, Bradford Alan	National Board of Medical Examiners (NBME)	Sep-25-1990
KOLB, Bradford Alan	National Board of Medical Examiners (NBME)	Mar-04-1992

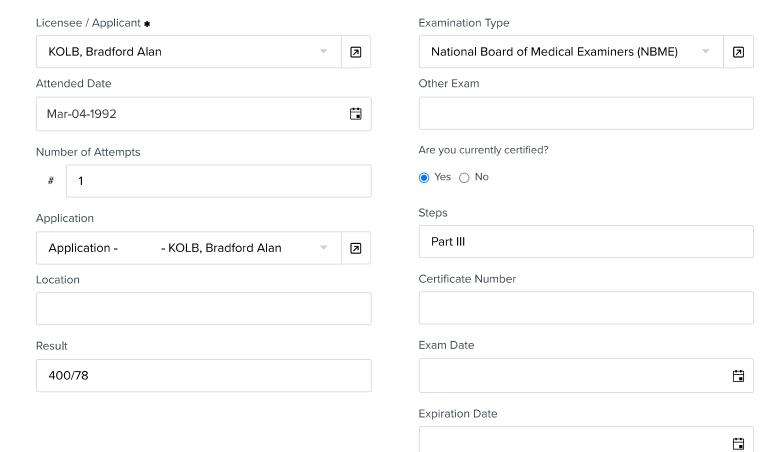
#### **Examination Details**



#### **Examination Details**



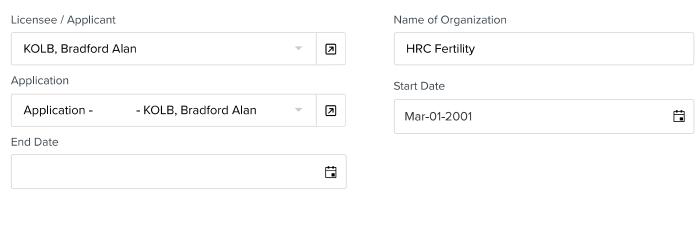
#### **Examination Details**



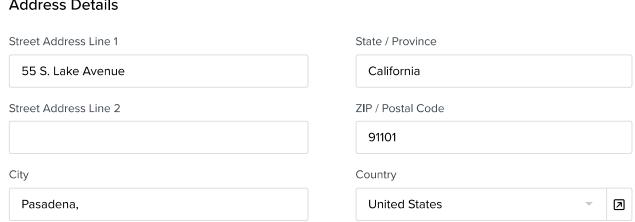
# Hospitals

Licensee / Applicant	Name of Organization	₹	Start Date	<b>T</b>	End Date
Bradford Kolb	HRC Fertility		Mar-01-2001		N/A

# **Hospital Details**



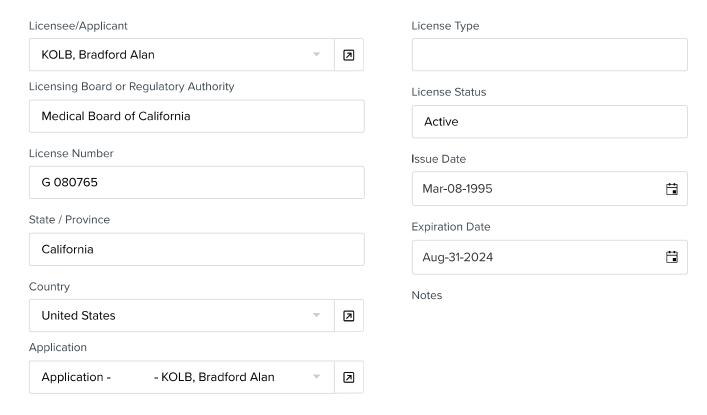
#### **Address Details**



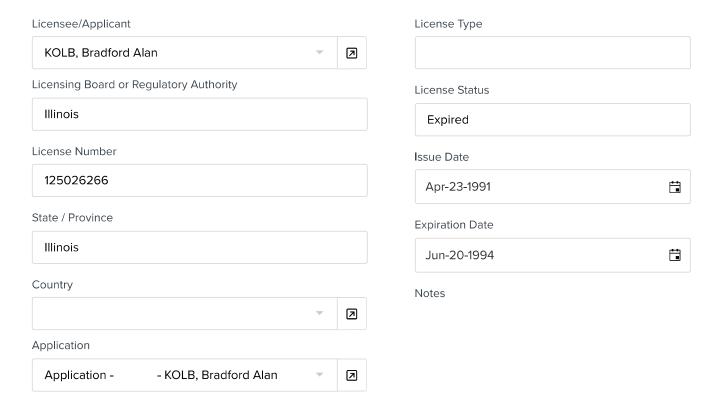
# Other Licenses

Licensee/Applicant	License Number	License Type	Issue Date	Expiration Date	State / Province †
Bradford Kolb	G 080765	N/A	Mar-08-1995	Aug-31-2024	California
KOLB, Bradford Alan	125026266	N/A	Apr-23-1991	Jun-20-1994	Illinois
KOLB, Bradford Alan	036086903	N/A	Jul-21-1993	Jul-31-1996	Illinois

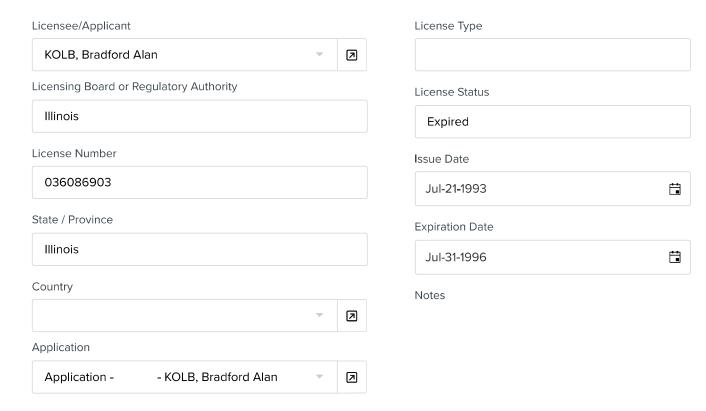
#### Other License Details



### Other License Details



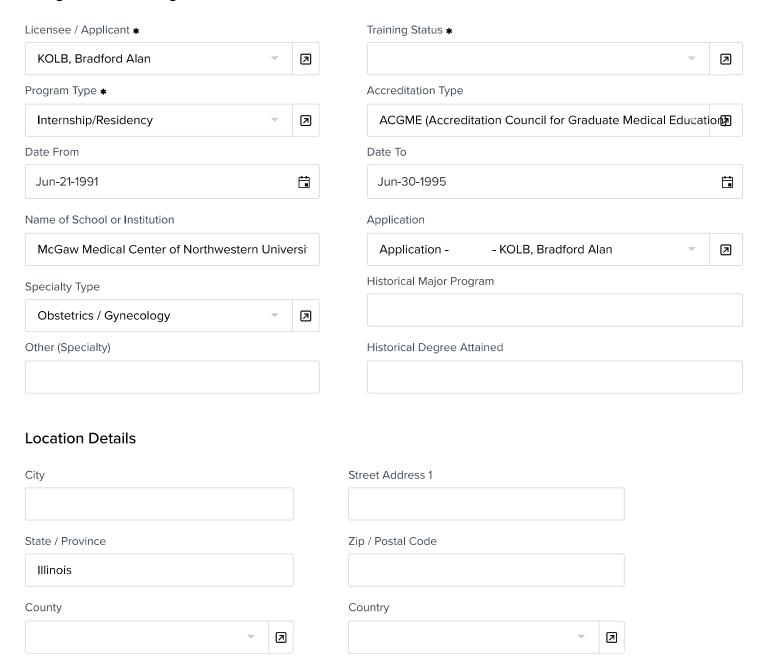
### Other License Details



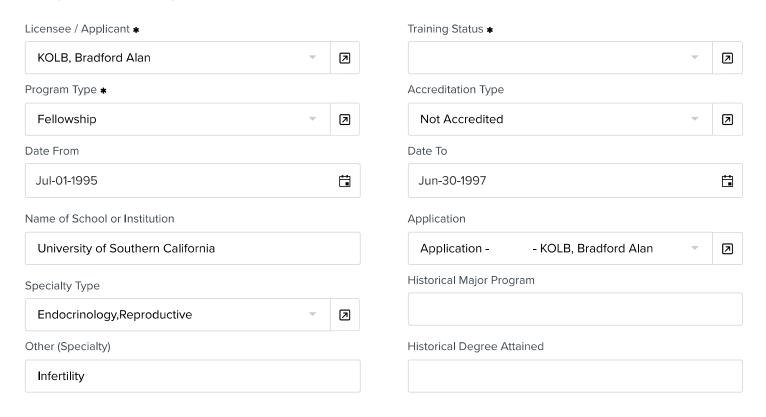
# Postgraduate Training

Licensee / Applicant	Name of School or Institution	Specialty Type	Date From ▼	Date To ↑ ▼	Program Type
KOLB, Bradford Alan	McGaw Medical Center of Northwestern University Program	Obstetrics / Gynecology	Jun-21-1991	Jun-30-1995	Internship/Residency
KOLB, Bradford Alan	University of Southern California	Endocrinology,Reproductive	Jul-01-1995	Jun-30-1997	Fellowship

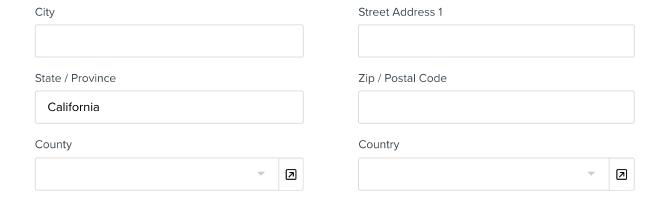
### Postgraduate Training Details



# Postgraduate Training Details



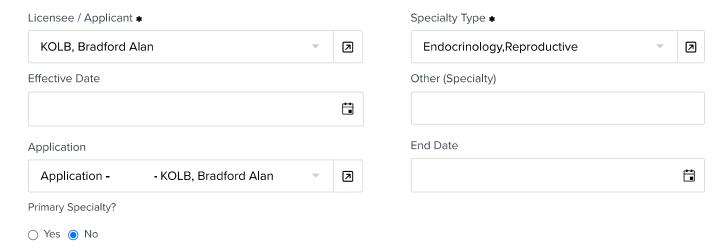
#### **Location Details**



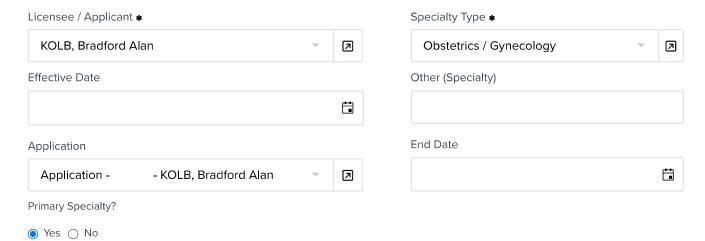
# Specialties

Licensee / Applicant	Specialty Type ▼	Primary Specialty?	Effective Date	End Date
Bradford Kolb	Endocrinology,Reproductive	No	N/A	N/A
Bradford Kolb	Obstetrics / Gynecology	Yes	N/A	N/A
Bradford Ko <b>l</b> b	Infertility	No	N/A	N/A

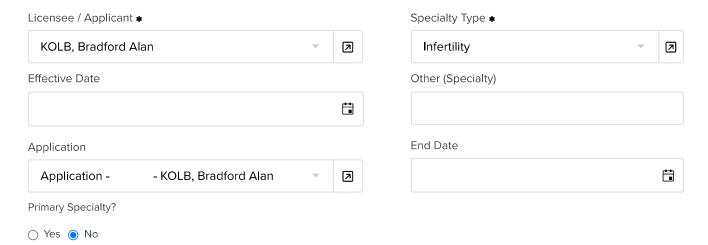
# **Specialty Details**



# **Specialty Details**



# **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.

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

MAR 1 3 2024

MEDICAL EXAMINERS

