

Demographic Details

First Name

Bryan

Middle Name

Kay

Last Name *

Monson

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

1974 

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

810 south 100 west Suite A

ZIP / Postal Code

84321

Address Line 2

State / Province

Utah

City

Logan

Country

United States



County

Cache

Is your physical address different from your mailing address?

Yes No

Public Phone

(435) 787-7200

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
Bryan Monson	Beth Israel Deaconess Medical Center	Jun-23-2007	Jun-23-2008	100
Bryan Monson	University of Utah Health Science Center	Jun-01-2008	Jun-01-2009	100
Bryan Monson	Tufts Medical Center	Jul-01-2009	Jun-30-2010	100
Bryan Monson	Tufts Medical Center	Jul-01-2010	Jun-30-2011	100
Bryan Monson	Tufts Medical Center	Jul-01-2011	Jun-30-2012	100
Bryan Monson	Southwestern Eye Center	Sep-01-2012	Sep-01-2016	100
Monson, Bryan Kay	Eye Association of New Mexico	Sep-01-2016	Jul-01-2020	100
Monson, Bryan Kay	Monson Vision	Jul-01-2017	Feb-29-2024	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 *

#

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

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

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

Education

Licensee/Applicant ▼	Education Type ▼	Name of School ▼	Degree Attained ▼	Date From ▼	Date To ↑ ▼	Graduation Date
Monson, Bryan Kay	Medical School	Tufts University School Of Medicine	Medical Doctor Degree	May-28-2002	May-18-2007	May-20-2007

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 ↑
Monson, Bryan Kay	United States Medical Licensing Examination (USMLE)	Aug-11-2004
Monson, Bryan Kay	United States Medical Licensing Examination (USMLE)	Mar-31-2007
Monson, Bryan Kay	United States Medical Licensing Examination (USMLE)	Feb-20-2008
Monson, Bryan Kay	United States Medical Licensing Examination (USMLE)	Sep-04-2008

Examination Details

Licensee / Applicant *

Monson, Bryan Kay 

Attended Date

Aug-11-2004 

Number of Attempts

1

Application


Application - - Monson, Bryan Kay 

Location

Result

189

Examination Type

United States Medical Licensing Examination (USMLE) 

Other Exam

Are you currently certified?


Yes No

Steps

USMLE Step 1 Examination

Certificate Number

Exam Date



Expiration Date



Examination Details

Licensee / Applicant *

Monson, Bryan Kay 

Attended Date

Mar-31-2007 

Number of Attempts

2

Application


Application - - Monson, Bryan Kay 

Location

Result

195

Examination Type

United States Medical Licensing Examination (USMLE) 

Other Exam

Are you currently certified?

Yes No

Steps

USMLE Step 2 CK Examination

Certificate Number

Exam Date



Expiration Date



Examination Details

Licensee / Applicant *

Monson, Bryan Kay 

Attended Date

Feb-20-2008 

Number of Attempts

2

Application


Application - - Monson, Bryan Kay 

Location

Result

Pass

Examination Type

United States Medical Licensing Examination (USMLE) 

Other Exam

Are you currently certified?


Yes No

Steps

USMLE Step 2 CS Examination

Certificate Number

Exam Date




Expiration Date



Examination Details

Licensee / Applicant *

Monson, Bryan Kay 

Attended Date

Sep-04-2008 

Number of Attempts

1

Application


Application - - Monson, Bryan Kay 

Location

Result

198

Examination Type

United States Medical Licensing Examination (USMLE) 

Other Exam

Are you currently certified?

Yes No

Steps

USMLE Step 3 Examination

Certificate Number

Exam Date



Expiration Date



Other Licenses

Licensee/Applicant ▼	License Number ▼	License Type ▼	Issue Date ↑	Expiration Date ▼	State / Province ↑
Monson, Bryan Kay	46712	N/A	Aug-15-2012	Apr-05-2017	Arizona
Monson, Bryan Kay	M-17047	N/A	Jan-25-2023	Jun-30-2024	Idaho
Monson, Bryan Kay	233042	N/A	Jun-06-2007	Jul-01-2012	Massachusetts
Monson, Bryan Kay	RS2011-0459	N/A	Sep-19-2011	Dec-18-2011	New Mexico
Monson, Bryan Kay	MD2013-0312	N/A	Jun-03-2013	Jul-01-2020	New Mexico
Monson, Bryan Kay	356947-1205	N/A	Oct-19-2015	Jan-31-2026	Utah

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

Postgraduate Training

Licensee / Applicant ▼	Name of School or Institution ▼	Specialty Type ▼	Date From ▼	Date To ↑ ▼	Program Type
Monson, Bryan Kay	Beth Israel Deaconess Medical Center	Transitional	Jun-23-2007	Jun-23-2008	Internship
Monson, Bryan Kay	University of Utah Health Sciences Center	Ophthalmology	Jun-01-2008	Jun-01-2009	Fellowship
Monson, Bryan Kay	Tufts Medical Center Program	Ophthalmology	Jul-01-2009	Jun-30-2012	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

Street Address 1



State / Province

Zip / Postal Code

County

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
Monson, Bryan Kay	Ophthalmology	Yes	Jun-01-2008	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 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 your 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 Bryan Kay Monson

Sign your name _____

Date Jul 10, 2024

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 15 2024
NEVADA STATE BOARD OF
MEDICAL EXAMINERS

