# **Demographic Details**

First Name	Gender	
Joseph	Male	7
Middle Name	Date of Birth	
S	-1952	Ħ
Last Name *	Name Suffix	
Guarisco		
Previous Name(s)	City of Birth	
Joseph Guarisco		
Social Security Number	Place of Birth	
Tax Identification Number	Weight (in lbs)	
Height	Eye Color	
Hair Color	Comments (non-public informa	tion)
Is this person deceased?		
○ Yes ○ No		
Date Deceased		
ä		
Do you have a Nevada Business License in your individual name?		
○ Yes ○ No		
Nevada BIN		
Historical File Number		

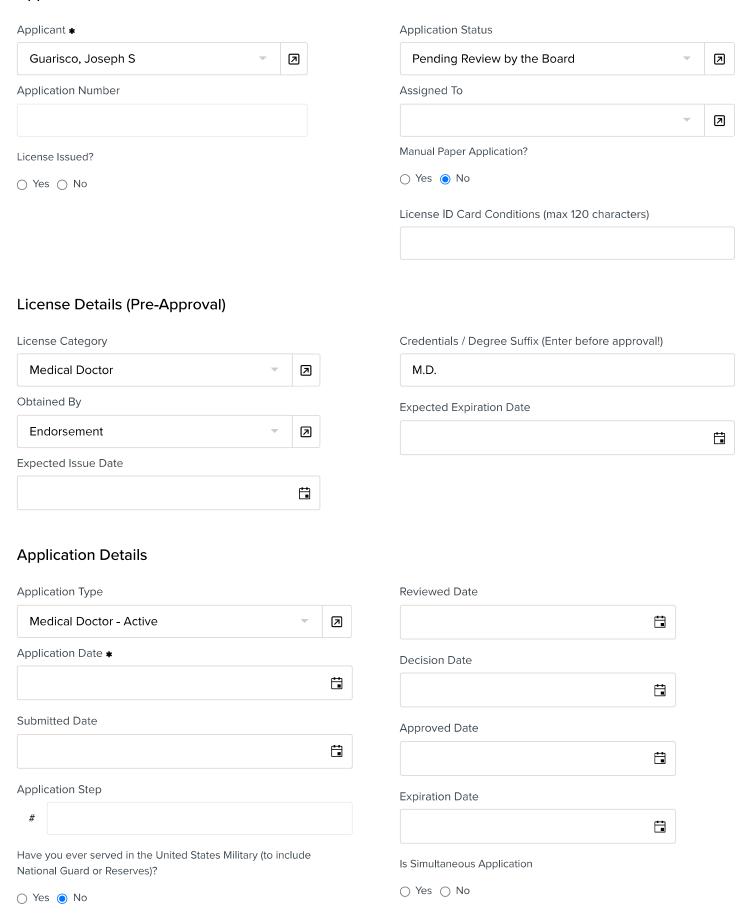
# Military Detail

Have you ever served in the United States Militar	y (to include 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>-</b> 2
Cell Phone	Fax
#	#
Public Address	
Street Address	ZIP / Postal Code
299 Walnut St.	70118
Address Line 2	State / Province
	Louisiana
City	Country
New Orleans	United States
County	Is your physical address different from your mailing address?
Orleans	○ Yes   No
	Public Phone
	# (504) 239-2766

# Mailing Address

Street Address	City (Mailing)	
Address Line 2	State / Province (Mailing)	
ZIP / Postal Code (Mailing)	County (Mailing)	
		<u>a</u>
	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]	
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.	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	○ 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.	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	

O Yes ○ No

O Yes ○ No

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

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

The answers to the foregoing questions and statements made in the

contained on any separate attached pages, are true and correct, that

above application, as well as any and all further explanations

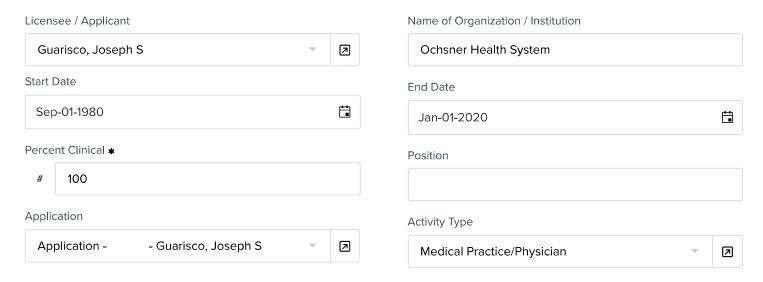
O Yes O No

medicine in the state of Nevada.

## Activities

Licensee / Applicant	Name of Organization / Institution	Start Date †	End Date	Percent Clinical
Joseph Guarisco	Ochsner Health System	Sep-01-1980	Jan-01-2020	100
Joseph Guarisco	Prime Occupational Medicine	Jan-01-2020	Nov-01-2023	100

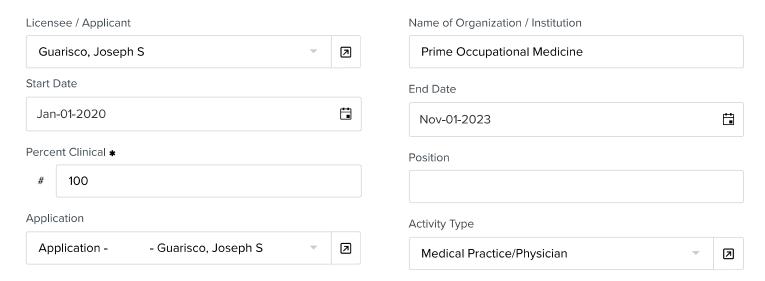
## **Application Activity Details**



#### **Location Details**



## **Application Activity Details**



#### **Location Details**



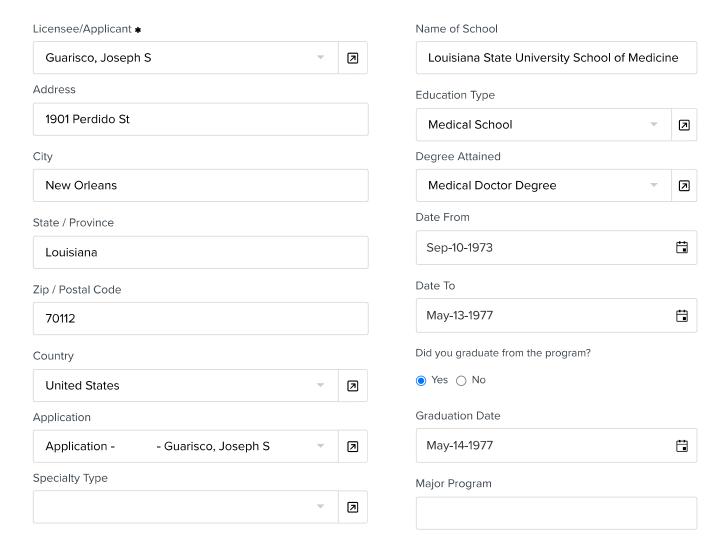
#### Declarations

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

## Education

Licensee/Applicant	Education Type	Name of School	Degree Attained	<b>T</b>	Date From 🔻	Date To ↑ ▼	Graduation Date
Guarisco, Joseph S	Medical School	Louisiana State University School of Medicine	Medical Doctor Degree		Sep-10-1973	May-13-1977	May-14-1977

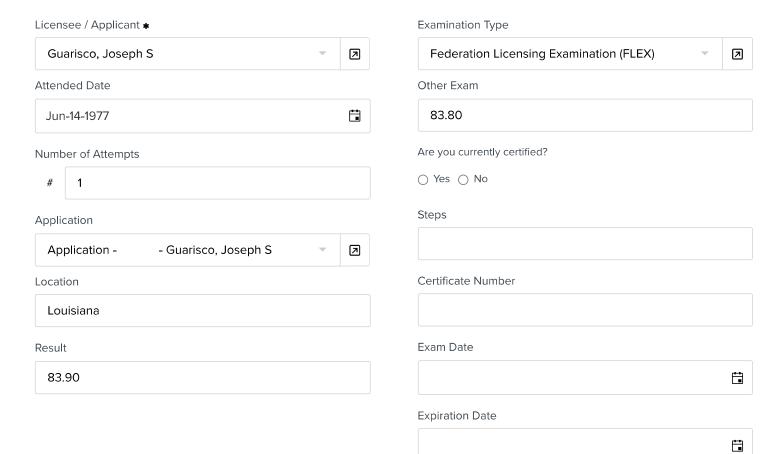
#### **Education Details**



## Examinations

Licensee / Applicant	Examination Type	•	Attended Date
Guarisco, Joseph S	Federation Licensing Examination (FLEX)		Jun-14-1977

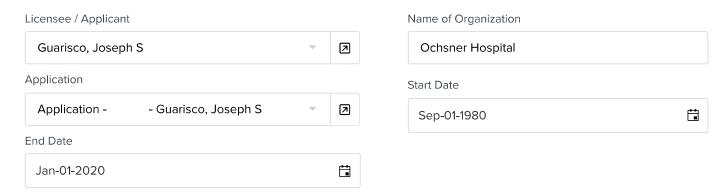
#### **Examination Details**



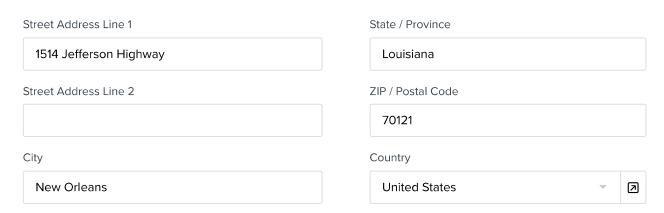
# Hospitals

Licensee / Applicant	Name of Organization	Start Date	<b>T</b>	End Date
Joseph Guarisco	Ochsner Hospital	Sep-01-1980		Jan-01-2020

## **Hospital Details**

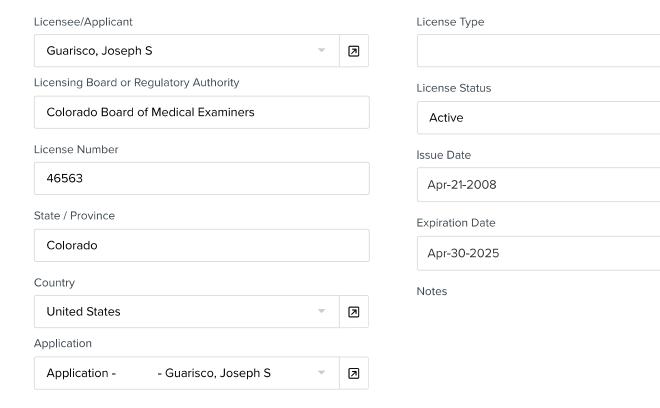


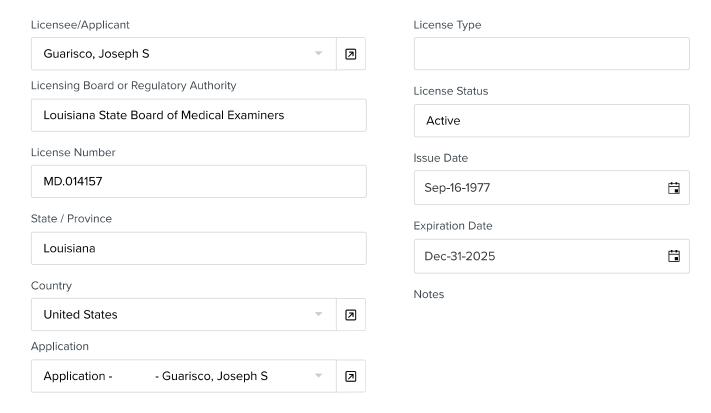
#### **Address Details**

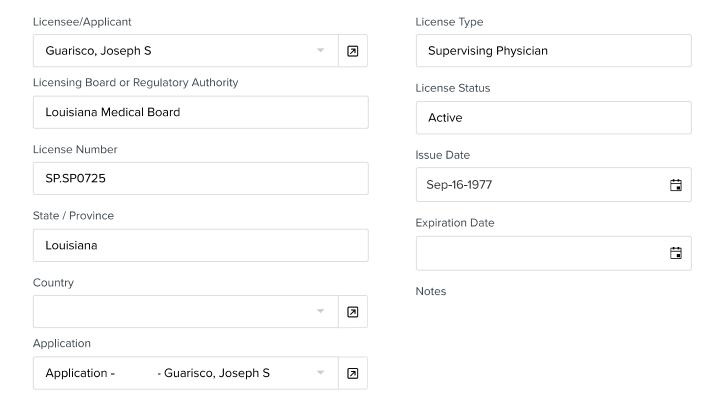


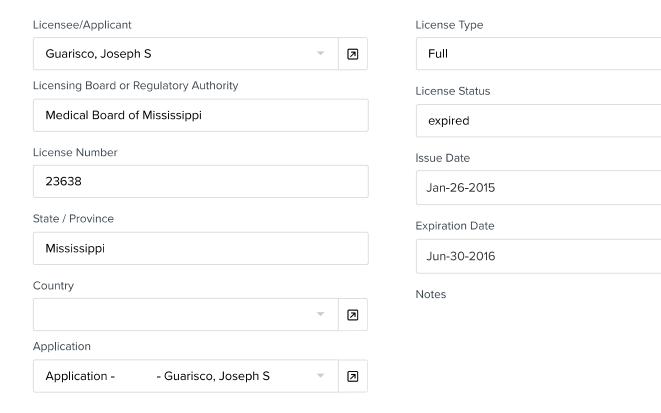
## Other Licenses

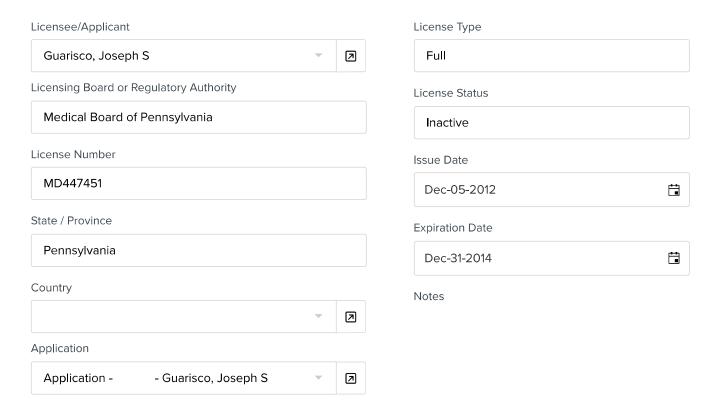
Licensee/Applicant	License Number	License Type	Issue Date	Expiration Date	State / Province †
Guarisco, Joseph S	46563	N/A	Apr-21-2008	Apr-30-2025	Colorado
Guarisco, Joseph S	MD.014157	N/A	Sep-16-1977	Dec-31-2025	Louisiana
Guarisco, Joseph S	SP.SP0725	Supervising Physician	Sep-16-1977	N/A	Louisiana
Guarisco, Joseph S	23638	Full	Jan-26-2015	Jun-30-2016	Mississippi
Guarisco, Joseph S	MD447451	Full	Dec-05-2012	Dec-31-2014	Pennsylvania







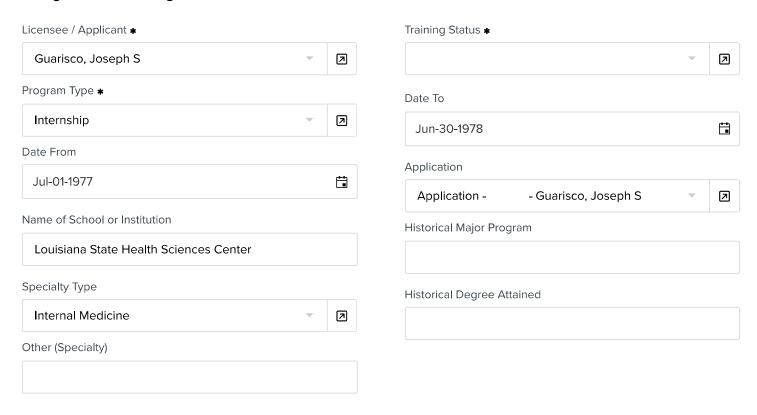




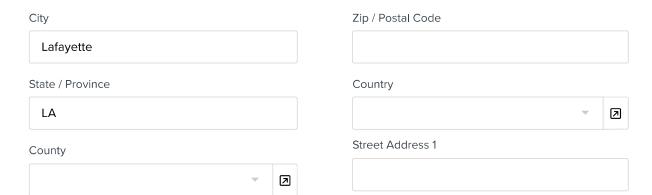
# Postgraduate Training

Licensee / Applicant	Name of School or Institution ▼	Specialty Type	Date From	Date To ↑ ▼	Program Type
Guarisco, Joseph S	Louisiana State Health Sciences Center	Internal Medicine	Jul-01-1977	Jun-30-1978	Internship
Guarisco, Joseph S	Louisiana State Health Sciences Center	Emergency Medicine	Jul-01-1978	Jun-30-1980	Internship/Residency
Guarisco, Joseph S	Ochsner Clinic	Anesthesiology	Jul-01-1990	Jun-30-1991	Residency

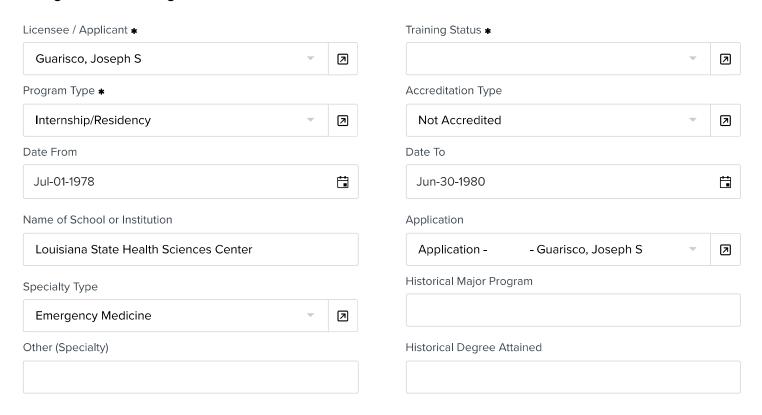
## Postgraduate Training Details



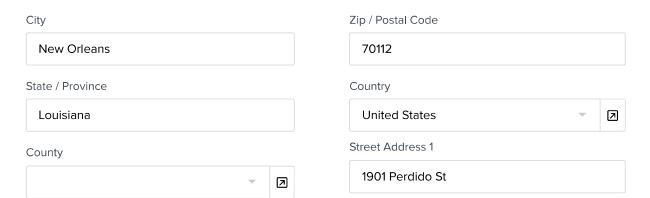
#### **Location Details**



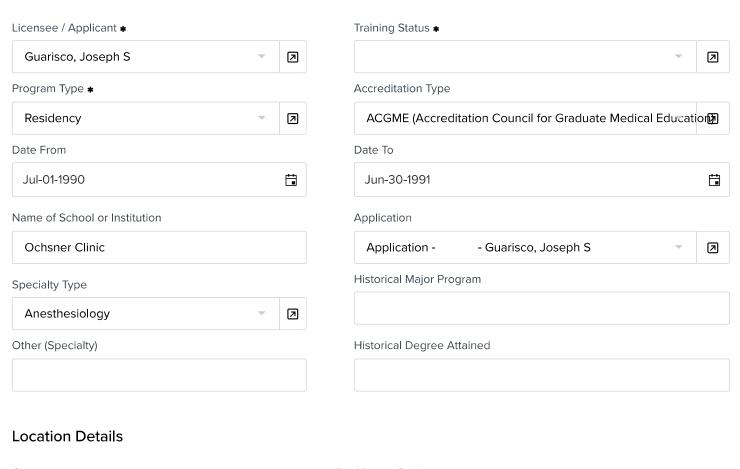
#### Postgraduate Training Details

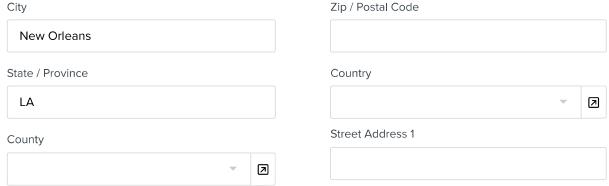


#### **Location Details**



#### Postgraduate Training Details





## Specialties

Licensee / Applicant	Specialty Type	Primary Specialty?	₹	Effective Date	<b>T</b>	End Date
Joseph Guarisco	Emergency Medicine	Yes		Mar-21-1990		N/A

# **Specialty Details**

