

## 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

Gender

Male  

Date of Birth

-1967 

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

#

Primary Phone Extension

Primary E-mail Address



Cell Phone

#

Secondary Phone

#

Secondary Phone Extension

Mail should be directed to



Fax

#

## Public Address

Street Address

29911 Niguel Rd. #6850

Address Line 2

City

Laguna Niguel

County

Orange

ZIP / Postal Code

92607

State / Province

California

Country

United States 

Is your physical address different from your mailing address?

Yes  No

Public Phone

# (949) 433-7159

## 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

#

Reviewed Date

Decision Date

Approved Date

Expiration Date

Have you ever served in the United States Military (to include National Guard or Reserves)?

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	
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Licensure Invoice

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Is Simultaneous Application

Yes  No

Application Payment Date

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Licensure Payment Date

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## 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

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	
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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

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

## Board Certifications

Licensee / Applicant ▼	Certifying Board ▼	Other Certifying Board ▼	Specialty ▼	Initial Certification Date ▼	Recertification Date
Gerayli, Afshin N/A	American Board	N/A	Anesthesiology	Apr-24-1998	N/A
Gerayli, Afshin S	American Board	N/A	Pain Medicine	Sep-12-1998	Jan-01-2019

## 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


  

## 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
AFSHIN GERAYLI	Mission Anesthesiology Group	Sep-01-1998	Jun-01-2002	100
AFSHIN GERAYLI	N/A	Jun-01-2002	Jun-05-2023	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

City

Country



▼ 

State / Province

Zip / Postal Code

## Application Activity Details

Licensee / Applicant

Start Date


 

Percent Clinical \*

#

100

Application



Name of Organization / Institution

End Date

Position

Activity Type



  

## Location Details

Street Address 1

City

Country

State / Province


Zip / Postal Code

## Declarations

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

## Declaration

Licensee/Applicant

Gerayli, Afshin S	▼	
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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 -	- Gerayli, Afshin S	▼	
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Renewal


	▼	
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## Declaration

Licensee/Applicant

Gerayli, Afshin S	▼	
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Declaration Question

ALL – Q6 – Malpractice Claim Paid	▼	
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Answer

Yes  No

Answer Details

Ordinal

#	6
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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 -	- Gerayli, Afshin S	▼	
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Renewal


	▼	
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## Declaration

Licensee/Applicant

Gerayli, Afshin S	▼	
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Declaration Question

MD – Q13 – Investigation – Respond To/Notify Of	▼	
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Answer

Yes  No

Answer Details

Ordinal

#	14
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Declaration Text


Have you EVER been: a) asked to respond to an investigation; b) notified that you were under investigation for; c) investigated for; d) charged with; or e) convicted of any violation of a statute, rule or regulation governing your practice as a physician by any medical licensing board, hospital, medical society, governmental entity or agency other than the Nevada State Board of Medical Examiners?

## Related To

Application

Application -	- Gerayli, Afshin S	▼	
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Renewal


	▼	
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## Education

Licensee/Applicant ▼	Education Type ↑ ▼	Name of School ▼	Degree Attained ▼	Date From ▼	Date To ↑ ▼	Graduation Date
Gerayli, Afshin S	College/University	University of California Los Angeles	Bachelor of Science	Sep-01-1987	Jun-16-1989	Jun-16-1989
Gerayli, Afshin S	Medical School	University of California San Diego School of Medicine	Medical Doctor Degree	Sep-25-1989	Jun-06-1993	Jun-06-1993

## 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

## Education Details

Licensee/Applicant \*

Gerayli, Afshin S 

Address

City


San Diego

State / Province

California

Zip / Postal Code

Country

United States 

Application

Application - - Gerayli, Afshin S 

Specialty Type




Name of School

University of California San Diego School of Me

Education Type

Medical School 

Degree Attained

Medical Doctor Degree 

Date From

Sep-25-1989 


Date To

Jun-06-1993 

Did you graduate from the program?

Yes  No

Graduation Date

Jun-06-1993 


Major Program

## Examinations


Licensee / Applicant	Examination Type	Attended Date ↑
Gerayli, Afshin S	National Board of Medical Examiners (NBME)	Jun-11-1991
Gerayli, Afshin S	United States Medical Licensing Examination (USMLE)	Sep-24-1992
Gerayli, Afshin S	National Board of Medical Examiners (NBME)	Mar-02-1994

## Examination Details

Licensee / Applicant \*

Gerayli, Afshin S 

Attended Date

Jun-11-1991 

Number of Attempts

# 1

Application


Application - - Gerayli, Afshin S 

Location

Result

209

Examination Type

National Board of Medical Examiners (NBME) 

Other Exam

Are you currently certified?


Yes  No

Steps

Part I

Certificate Number

Exam Date



Expiration Date



## Examination Details

Licensee / Applicant \*

Gerayli, Afshin S 

Attended Date

Sep-24-1992 

Number of Attempts

# 1

Application

Application - - Gerayli, Afshin S 

Location

Result

200

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 \*

Gerayli, Afshin S 


Attended Date

Mar-02-1994 

Number of Attempts

# 1

Application


Application - - Gerayli, Afshin S 

Location

Result

480

Examination Type

National Board of Medical Examiners (NBME) 

Other Exam

Are you currently certified?


Yes  No

Steps

Part III

Certificate Number

Exam Date



Expiration Date




## Hospitals

Licensee / Applicant	Name of Organization	Start Date	End Date
AFSHIN GERAYLI	Providence Mission Hospital Medical Center	Sep-01-1998	N/A
AFSHIN GERAYLI	Saddleback Memorial Medical Center	Sep-01-2002	Sep-30-2020

## Hospital Details

Licensee / Applicant

Application


 

End Date

Name of Organization

Start Date

## Address Details

Street Address Line 1


Street Address Line 2

City

State / Province

ZIP / Postal Code

Country

## Hospital Details

Licensee / Applicant

Application

End Date

Name of Organization

Start Date

## Address Details

Street Address Line 1


Street Address Line 2

City

State / Province

ZIP / Postal Code

Country


 

## Other Licenses

Licensee/Applicant	License Number	License Type	Issue Date	Expiration Date	State / Province
Gerayli, Afshin S	G80098	N/A	Oct-26-1994	Sep-30-2026	California

## 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
Gerayli, Afshin S	University of California San Diego Medical Center	Internal Medicine	Jun-24-1993	Jun-27-1994	Internship
Gerayli, Afshin S	University of California San Diego Medical Center	Anesthesiology	Jul-01-1994	Jun-30-1997	Residency
Gerayli, Afshin S	University of California San Francisco Medical Center	Pain Medicine	Jul-01-1997	Jun-30-1998	Fellowship

## 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

Zip / Postal Code

Country



Street Address 1

## 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

Zip / Postal Code

Country



Street Address 1

## 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

Zip / Postal Code

Country



Street Address 1

## Specialties

Licensee / Applicant	Specialty Type	Primary Specialty?	Effective Date	End Date
Gerayli, Afshin N/A	Pain Management	Yes	Apr-24-1998	N/A

## Specialty Details

Licensee / Applicant \*

Gerayli, Afshin S  

Effective Date

Apr-24-1998 



Application

Application - - Gerayli, Afshin S  

Primary Specialty?

Yes  No

Specialty Type \*

Pain Management  

Other (Specialty)

End Date



