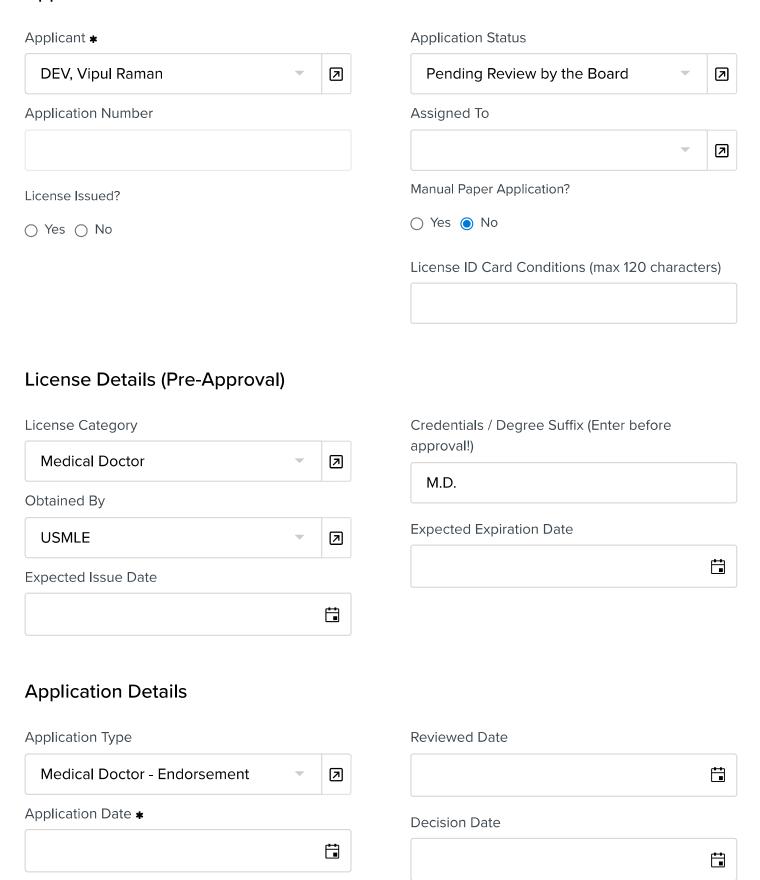
# Demographic Details

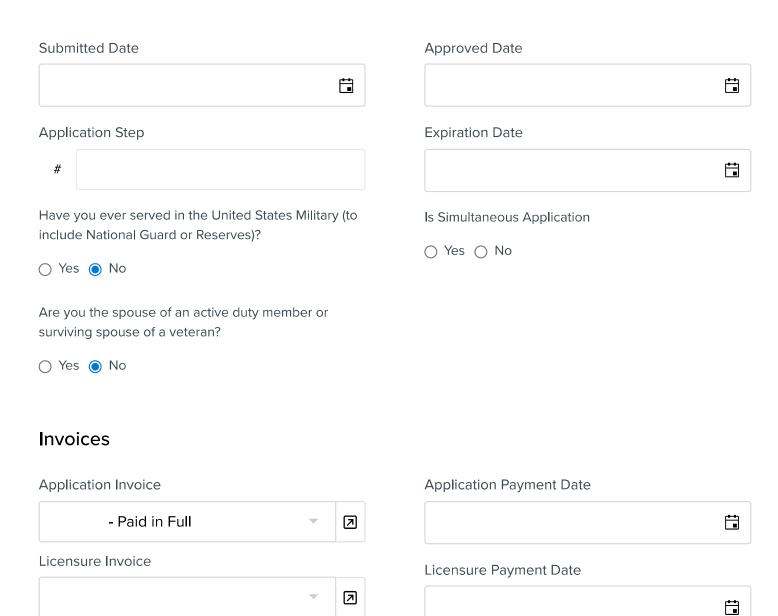
First Name	Gender		
Vipul	Male	~	7
Middle Name	Date of Birth		
Raman	-1965		
Last Name *	Name Suffix		
DEV			
Previous Name(s)	City of Birth		
Social Security Number	Place of Birth		
Tax Identification Number	Weight (in lbs)		
Height	Eye Color		
Hair Color	Comments (non-public information)	)	
	Public Information		
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	
Have you ever served in the United States Military (to in	nclude National Guard or Reserves)?
○ Yes <b>⑥</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

Cell Phone	Fax
#	#
Public Address	
Street Address	ZIP / Postal Code
2901 Sillect Ave.	93308
Address Line 2	State / Province
Suite #201	California
City	Country
Bakersfield	United States   Z
County	Is your physical address different from your mailing address?
	Public Phone
	# (949) 836-1392
Mailing Address	
Street Address	City (Mailing)
Address Line 2	State / Province (Mailing)
ZIP / Postal Code (Mailing)	County (Mailing)
	County (Mailing)

## **Application Status**





#### **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.

Ø

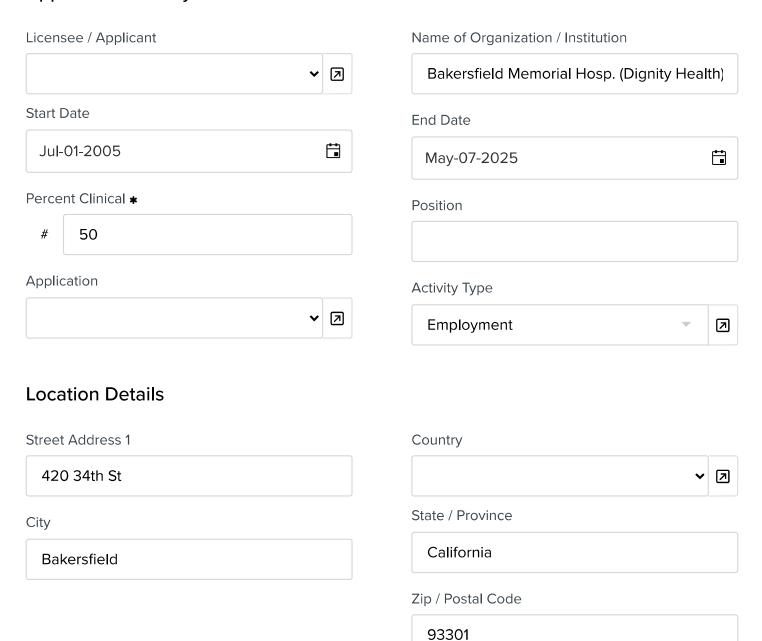
Yes ○ No

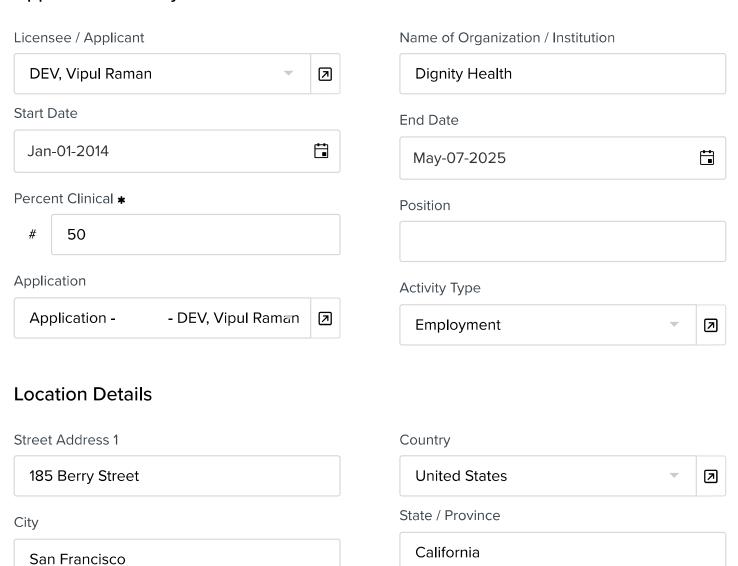
In consideration for processing my application I, the undersigned, whose name and signature voluntarily appears below; do hereby and irrevocably agree to the Civil Applicant Waiver.

Yes ○ No

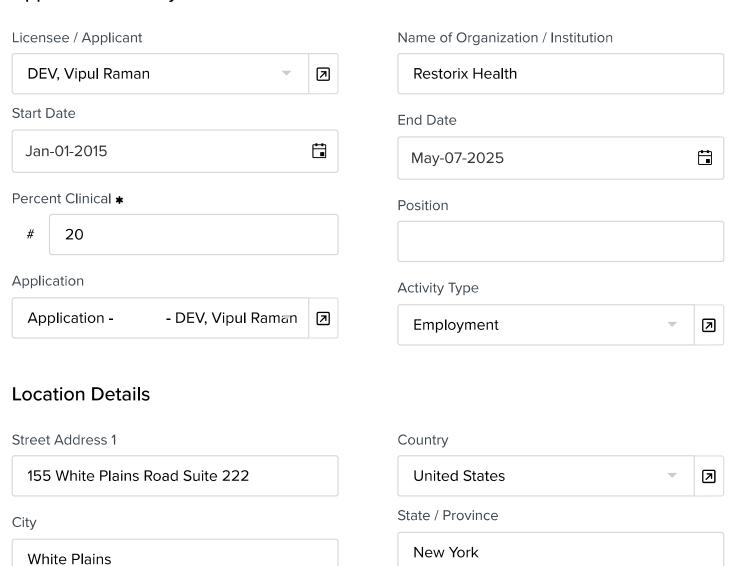
#### Activities

Licensee / Applicant	Name of Organization / Institution	Start Date ↑ ▼	End Date	Percent Clinical
DEV, Vipul Raman	Bakersfield Memorial Hosp. (Dignity Health)	Jul-01-2005	May-07-2025	50
DEV, Vipul Raman	Dignity Health	Jan-01-2014	May-07-2025	50
DEV, Vipul Raman	Restorix Health	Jan-01-2015	May-07-2025	20
DEV, Vipul Raman	VIPMD	Jan-01-2017	May-07-2025	50
DEV, Vipul Raman	Organogenesis, Inc.	Jan-01-2019	May-07-2025	40

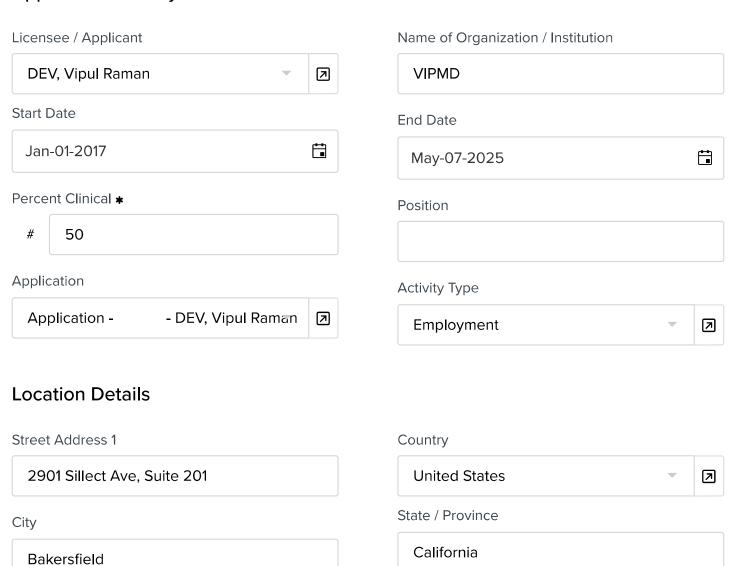




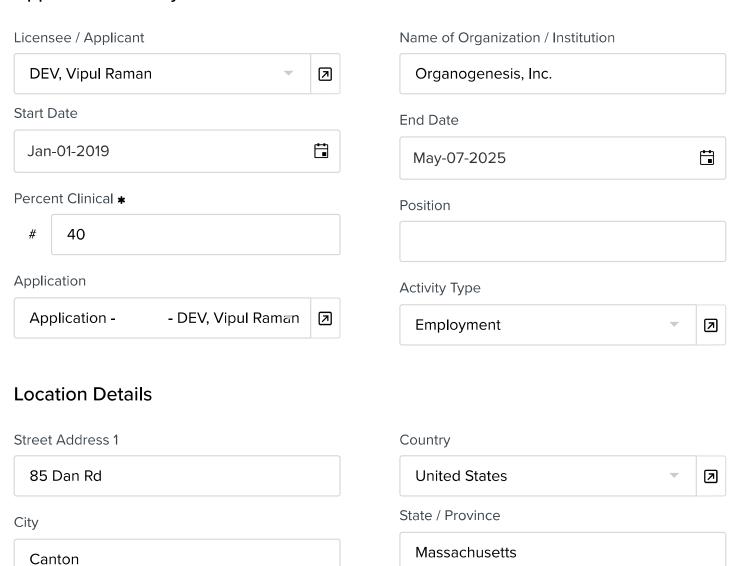
Zip / Postal Code



Zip / Postal Code



Zip / Postal Code



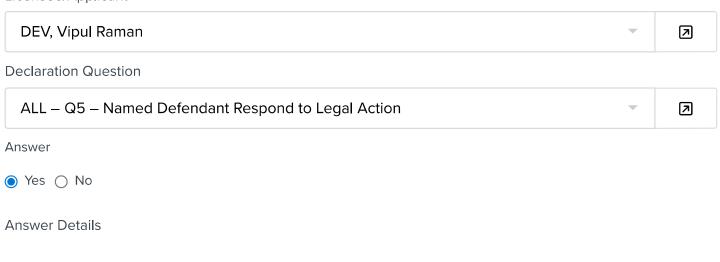
Zip / Postal Code

#### Declarations

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

#### **Declaration**

Licensee/Applicant



#### Ordinal

# 5

#### **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?

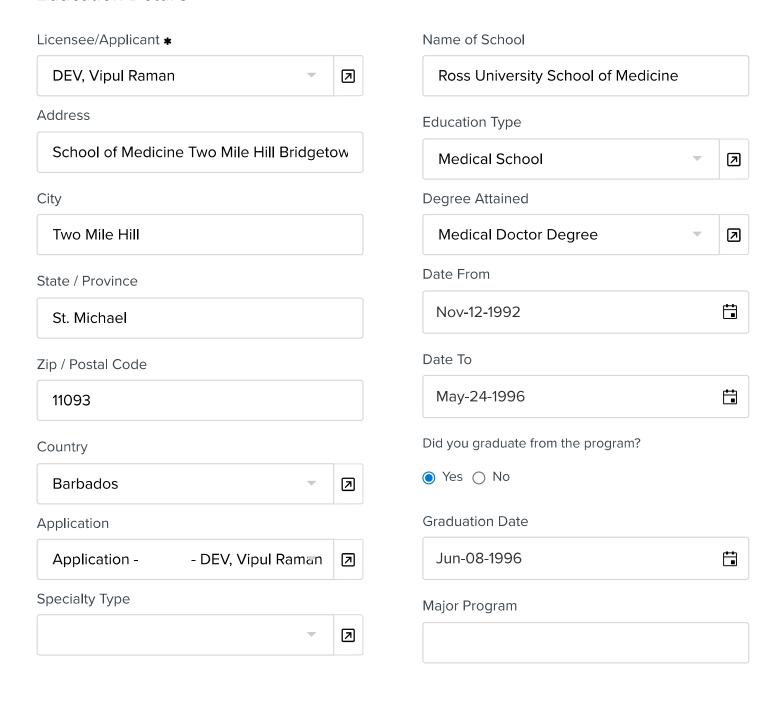
#### Related To



#### Education

Licensee/Applicant	Education Type	Name of School	Degree Attained	Date From	Date To ↑ ▼	Graduatio
DEV, Vipul Raman	Medical School	Ross University School of Medicine	Medical Doctor Degree	Nov-12-1992	May-24-1996	Jun-08-199

#### **Education Details**

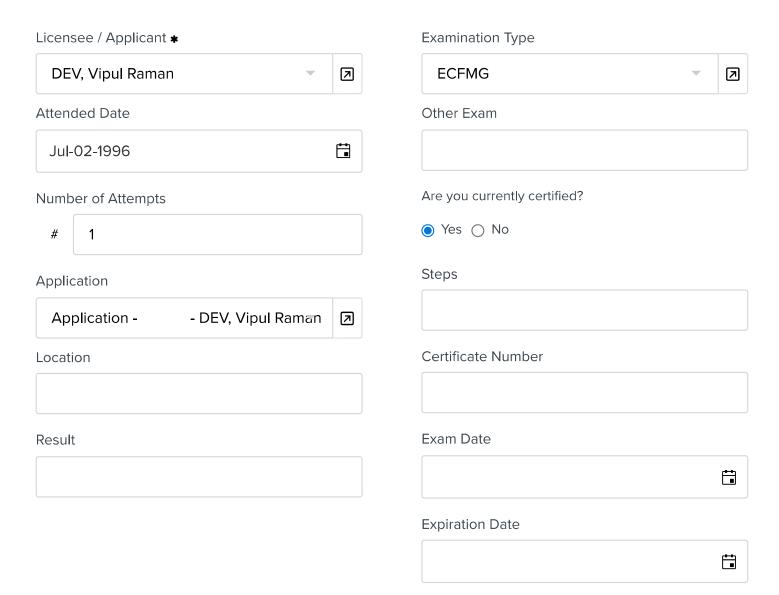


#### Examinations

Licensee / Applicant	Examination Type	Attended Date †
DEV, Vipul Raman	United States Medical Licensing Examination (USMLE)	Jun-08-1994
DEV, Vipul Raman	United States Medical Licensing Examination (USMLE)	Mar-01-1995
DEV, Vipul Raman	ECFMG	Jul-02-1996
DEV, Vipul Raman	United States Medical Licensing Examination (USMLE)	May-13-1997

Licensee / Applicant *	Examination Type
DEV, Vipul Raman	<b>~ 7</b>
Attended Date	Other Exam
Jun-08-1994 É	
Number of Attempts	Are you currently certified?
# 1	○ Yes ○ No
Application	Steps
Application DEV, Vipul Raman (	Step 1
Location	Certificate Number
Result	Exam Date
194	
	Expiration Date

Licensee / Applicant *	Examination Type
DEV, Vipul Raman	United States Medical Licensing Examination (USML日)
Attended Date	Other Exam
Mar-01-1995	
Number of Attempts	Are you currently certified?
# 1	○ Yes ○ No
Application	Steps
Application DEV, Vipul Raman	Step 2CK
Location	Certificate Number
Result	Exam Date
173	
	Expiration Date



Licensee / Applicant *		Examination Type	
	<b>~</b> 7		<b>~</b>
Attended Date		Other Exam	
May-13-1997	ä		
Number of Attempts		Are you currently certified?	
# 2		○ Yes ○ No	
Application		Steps	
	<b>~</b> 7	Step 3	
Location		Certificate Number	
Result		Exam Date	
179			
		Expiration Date	

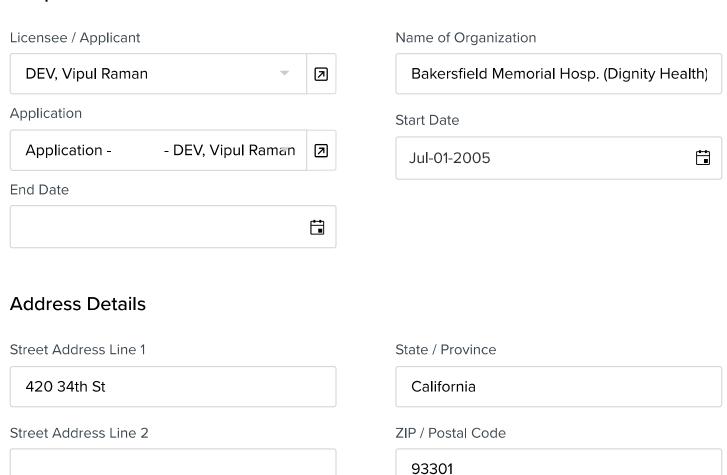
#### Hospitals

Licensee / Applicant	7	Name of Organization	▼	Start Date	<b>T</b>	End Date
DEV, Vipul Raman		Bakersfield Memorial Hosp. (Dignity Health)		Jul-01-2005		N/A

# **Hospital Details**

City

Bakersfield

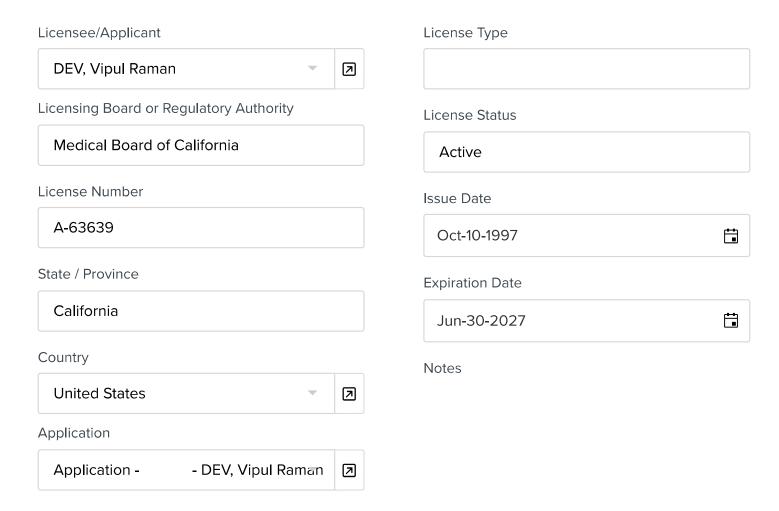


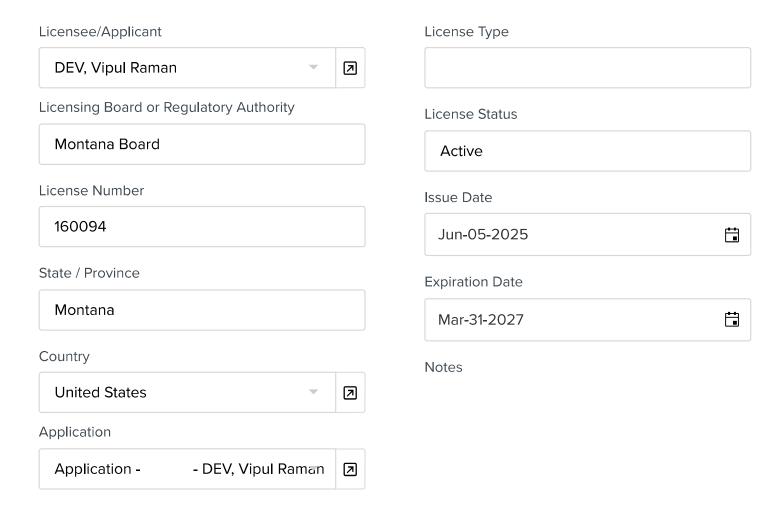
Country

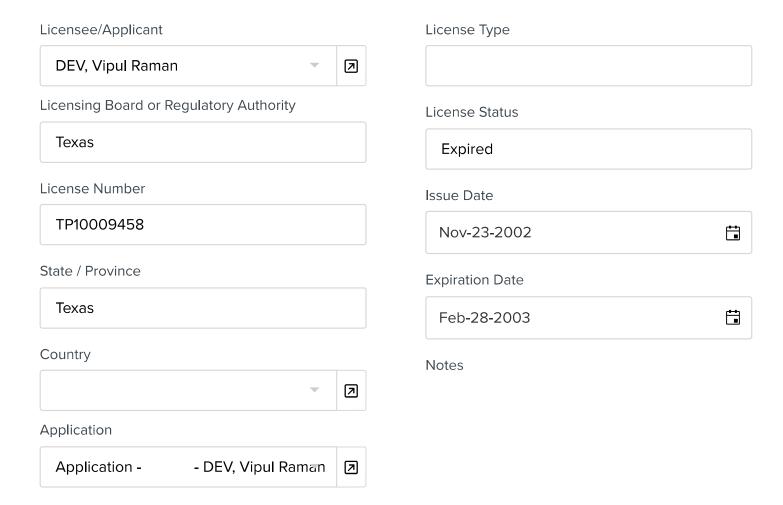
**United States** 

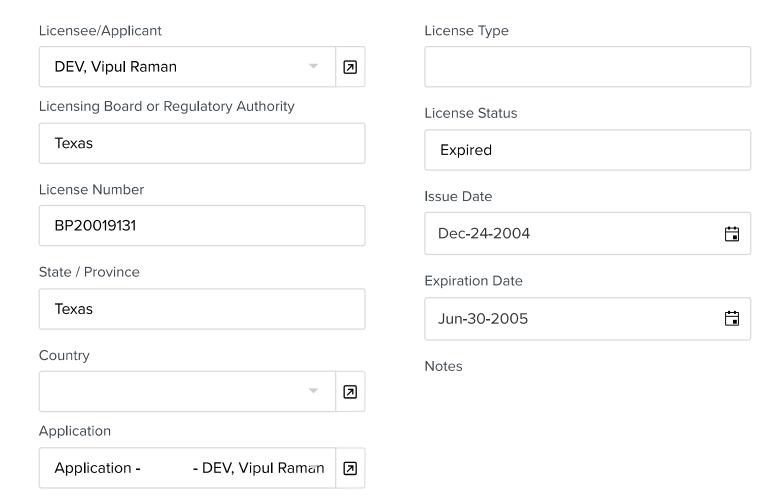
#### Other Licenses

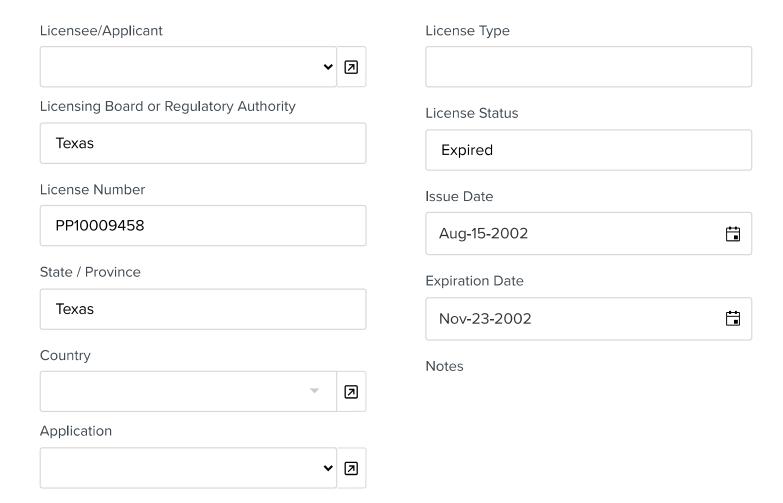
Licensee/Applicant	License Number	License Type	Issue Date	Expiration Date	State / Province †
DEV, Vipul Raman	A-63639	N/A	Oct-10-1997	Jun-30-2027	California
DEV, Vipul Raman	160094	N/A	Jun-05-2025	Mar-31-2027	Montana
DEV, Vipul Raman	TP10009458	N/A	Nov-23-2002	Feb-28-2003	Texas
DEV, Vipul Raman	BP20019131	N/A	Dec-24-2004	Jun-30-2005	Texas
DEV, Vipul Raman	PP10009458	N/A	Aug-15-2002	Nov-23-2002	Texas
DEV, Vipul Raman	TP20009458	N/A	Feb-28-2003	Jun-08-2003	Texas
DEV, Vipul Raman	BP10009458	N/A	Jun-26-2003	Oct-25-2004	Texas
DEV, Vipul Raman	TL8784	N/A	May-30-2025	Aug-01-2025	Wyoming

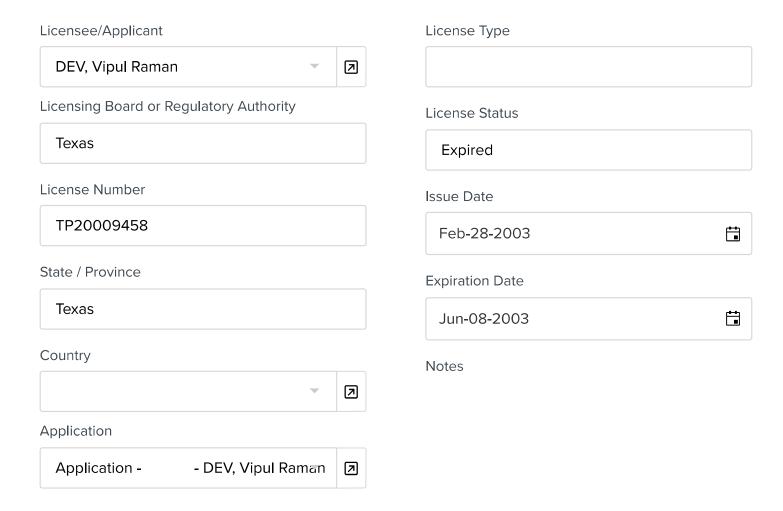


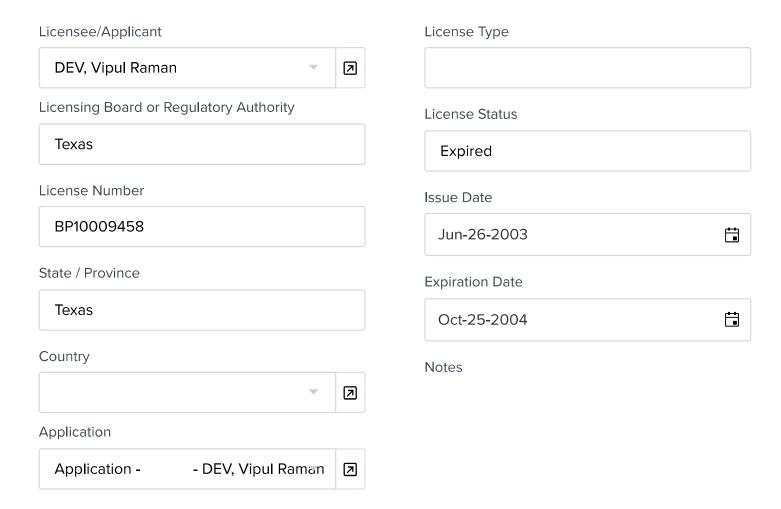


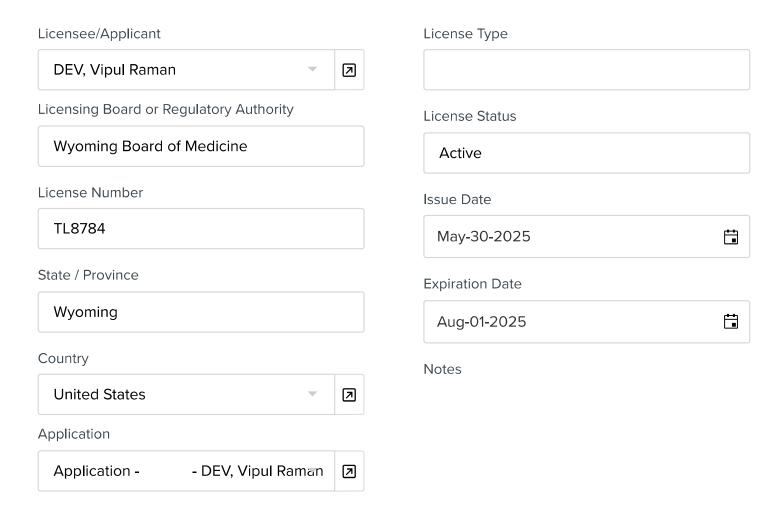








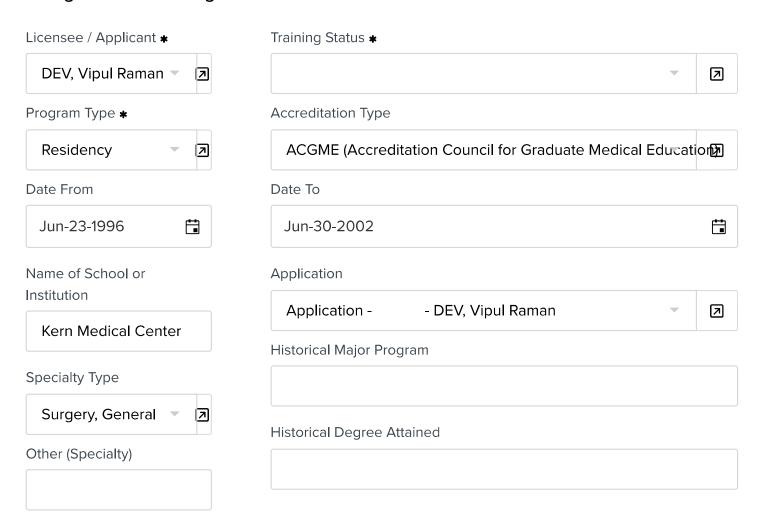




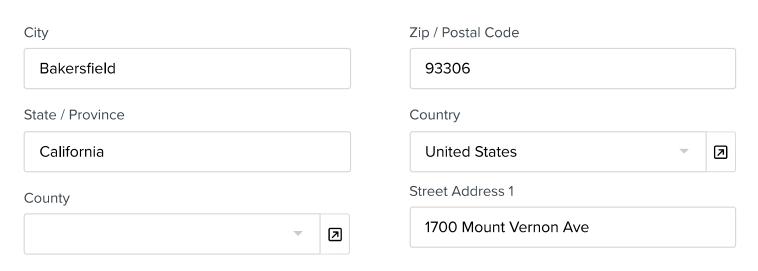
#### Postgraduate Training

Licensee / Applicant	Name of School or Institution	Specialty Type	Date From ↑ ▼	Date To ↑ ▼	Program Type
DEV, Vipul Raman	Kern Medical Center	Surgery, General	Jun-23-1996	Jun-30-2002	Residency
DEV, Vipul Raman	University of Texas Health Science Center San Ant	Residency			

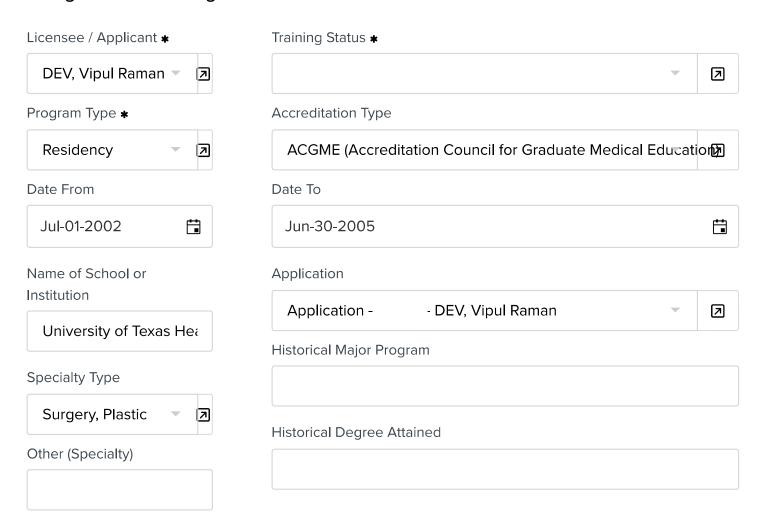
## Postgraduate Training Details



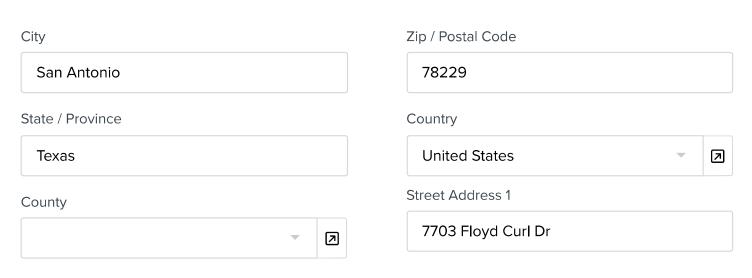
#### **Location Details**



## Postgraduate Training Details



#### **Location Details**



#### Specialties

Licensee / Applicant	₹	Specialty Type 🍸	Primary Specialty?	Effective Date	<b>T</b>	End Date
DEV, Vipul Raman		Surgery, Plastic	Yes	Jun-16-2025		N/A

# **Specialty Details**

