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Date Received by Board

PHYSICIAN

APPLICATION FOR STATUS CHANGE TO ACTIVE STATUS
REGISTRATION FORM FOR THE BIENNIAL PERIOD 2025 - 2027
NEVADA STATE BOARD OF MEDICAL EXAMINERS
9600 Gateway Drive, Reno, NV 89521
Phone (775) 688-2559

JAN 30 2026

NEVADA STATE BOARD OF MEDICAL EXAMINERS
(For Board Use Only)

License No.
File No.

I hereby apply for status change to active status, and enclose the appropriate fee as indicated below:

Table with 4 columns: Fee type, Description, Period, Amount. Includes 'CHANGE FROM INACTIVE TO ACTIVE STATUS' for periods 7/1/2025-6/30/2026 (\$800) and 7/1/2026-6/30/2027 (\$400).

You may pay by cashier's check or money order payable to "NEVADA STATE BOARD OF MEDICAL EXAMINERS," or by credit card. If paying by credit card, please complete the Credit Card Authorization form on the last page of this application. A two-point five percent (2.5%) service fee will be assessed for payment by credit card.

Licensee's Name: AYoola S. Awofadeju, MD

PLEASE NOTE:

NRS 630.255 (4) (5) Inactive licensees: reinstatement.

- 4. Before resuming the practice of medicine in this State, the inactive registrant must: (a) Notify the Board in writing... (b) File an affidavit... (c) Complete the form... (d) Pay the applicable fee... (e) Satisfy the Board...
5. If the Board determines that the conduct or competence of the registrant during the period of inactive status would have warranted denial of an application...
- Your Status Will Not Be Changed Unless You Answer All Questions On This Application For Status Change To Active Status Registration Form.
- You Must Provide Written Explanations For All Questions Answered "Yes."
- All Information You Provide On This Application Is Public Information.

PLEASE TYPE OR PRINT LEGIBLY

- 1. Active status registration requires the submission of proof of completion of AMA Category 1 continuing medical education (CME), completed during the preceding 24-month time period of the date of your submission of this form.
2. If your name and/or address have changed, indicate the change in the space provided below. Please be advised, the address you provide below is viewable on the NSBME website and will become your public address.

Name AYoola S. Awofadeju
Street 3703 BALLANTRAE WAY
City FLOSSMOOR County COOK State IL Zip 60422
Public Phone Number 708 991 2758 Public/Fax Number NA
Cellular Phone: Private [X] Public []
Email address

Questions (continued): The following questions refer to the time period since your last renewal OR within the last 24 months prior to your submission of this form.

Malpractice Questions:

5. Have you 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? Yes No

6. Have you had a professional liability, malpractice, claim paid on your behalf, or paid such a claim yourself including any military tort claims if applicable? Yes No

Malpractice Explanation(s):

List of all claims or suits for medical malpractice made against you. A claim is any formal or informal demand for payment to any person or organization. If have not answered "yes" to questions #5 and/or #6 and do not have any such claims or suits, this section will be left blank. If you have more than 1 claim, make a copy or copies of this page and submit all explanations with your application for licensure.

Name of patient involved:

In which state did the action take place?

Case number (if applicable):

Which court?
(If settled before initiation of civil action, state here.)

Current status of claim:

Open Closed (settled or judgment) Dismissed (no money paid out) Other

Date claim was closed/settled or dismissed: _____
Month/Year

Amount of judgment or settlement \$

Month and year of event precipitating claim:

Month and year of lawsuit:

Insurance carrier at time:

What is/was your status? Primary defendant Co-defendant Other

Please provide specifics in reference to the adverse event including the allegations and your role in the event:

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Questions (continued): The following questions refer to the time period since your last renewal OR within the last 24 months prior to your submission of this form.

7. Have you ever been arrested, investigated for, charged with, convicted of, or pled guilty or nolo contendere to any offense or violation of any federal (including the Uniform Code of Military Justice), state or local law, or the laws of any foreign country, which is a misdemeanor, gross misdemeanor, felony, violation of the Uniform Code of Military Justice, or synonymous thereto in a foreign jurisdiction, excluding any minor traffic offense (driving or being in control of a motor vehicle while under the influence of a chemical substance, including alcohol, is not considered a minor traffic offense), or for any offense which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? *Please note that you MUST disclose ANY investigation or arrest, including those where the final disposition was dismissal, or expungement. (If "Yes," attach explanation on separate sheet.)

Yes No

8. Have you ever been denied a license, permission to practice medicine or any other healing art, or permission to take an examination to practice medicine or any other healing art in any state, country or U.S. territory?

Yes No

9. Have you ever had a medical license or license to practice any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory?

Yes No

10. Have you ever voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory?

Yes No

11. Have you ever been denied membership, been asked to resign or expelled from a medical society or other professional medical organization?

Yes No

12. 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?

Yes No

13. Have you ever surrendered your state or federal controlled substance registration or had it revoked or restricted in any way?

Yes No

14. List all hospitals where you have had staff privileges denied, suspended, limited, revoked or not renewed by the hospital. List any (all) resignations from any medical staff in lieu of disciplinary or administrative action. (Please Note: Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance).

| Hospital | Mailing Address | Type of Action | Dates of Action From (Mo./Yr.) To (Mo./Yr.) |
|----------|-----------------|----------------|--|
| N/A | N/A | N/A | N/A |

(If more space is needed, attach a separate sheet.)

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Attestations/Affirmations:

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CHILD SUPPORT STATEMENT

NEVADA STATE BOARD OF
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I UNDERSTAND THAT THIS APPLICATION FOR STATUS CHANGE TO ACTIVE STATUS REGISTRATION WILL BE DENIED IF I HAVE NOT PLACED A CHECK MARK NEXT TO (a), (b), OR (c) UNDER THE CHILD SUPPORT STATEMENT SECTION.

Please place a check mark next to one of the following statements:

(a) I am not subject to a court order for the support of a child;

(b) I am subject to a court order for the support of one or more children and am in compliance with the order or am in compliance with a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order; OR

(c) I am subject to a court order for the support of one or more children and am NOT in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

APPLICATION AFFIRMATION

I, AYOOLA SAMUEL AWOFAYEJU, MD
(Print your full name)

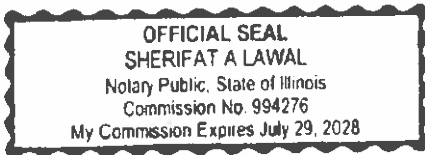
being duly sworn, depose and say: That the answers to the foregoing questions and statements made in the above application, as well as any and all further explanations contained on any separate attached pages, are true and correct, that I am the person named in the credentials to be submitted, and that 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.

01/14/2026
Date

Signature of applicant

(NOTARY SEAL)



State of IL County of COOK
Subscribed and sworn to before me this 14 day of
Jan, 2026

Notary Public for the State of IL
My Commission Expires: 07-29-2028
Residing at: Country Club Hills IL
City State

[Signature]
Signature of Notary

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Continuing Education:

CONTINUING MEDICAL EDUCATION (CME) STATEMENT:

Note: If you have previously submitted proof of 4 hours AMA Category 1 continuing medical education regarding bioterrorism or relating to medical consequences of act of terrorism involving use of weapon of mass destruction, you will not be responsible to do so again. For your information, this requirement became effective October 2003.

Please place a check mark next to one of the following statements:

_____ (a) I was initially licensed in Nevada prior to or during the time period July 1, 2023 through December 31, 2023 and completed a minimum of 44 hours of AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics or pain management and/or addiction care, 20 hours of which were in my scope of practice or specialty and 4 of which were in bio-terrorism/weapons of mass destruction *(if applicable)*;

_____ (b) I was initially licensed in Nevada during the time period January 1, 2024 through June 30, 2024, the second six months of the past biennial period, and completed a minimum of 34 hours of AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics or pain management and/or addiction care, 20 hours of which were in my scope of practice or specialty and 4 of which were in bio-terrorism/weapons of mass destruction *(if applicable)*;

_____ (c) I was initially licensed in Nevada during the time period July 1, 2024 through December 31, 2024, the third six months of the past biennial period, and completed a minimum of 24 hours of AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics or pain management and/or addiction care, 18 hours of which were in my scope of practice or specialty and 4 of which were in bio-terrorism/weapons of mass destruction *(if applicable)*;

(d) I was initially licensed in Nevada during the time period January 1, 2025 through June 30, 2025, the fourth six months of the past biennial period, and completed a minimum of 14 hours of AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics or pain management and/or addiction care, 8 hours of which were in my scope of practice or specialty and 4 of which were in bio-terrorism/weapons of mass destruction *(if applicable)*, OR

_____ (e) I am exempt from submitting proof of completion of continuing medical education (CME) because I have completed a full year of residency or fellowship training during the biennial period July 1, 2023 through June 30, 2025.

Attach copies of proof of your completion of continuing medical education (CME) hours

or

Proof of completion of 1 year of residency or fellowship training obtained during the biennial.

Your copies of proof of CME or training completion will not be returned to you.

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END OF STATUS CHANGE APPLICATION