

Demographic Details

First Name

Austin

Middle Name

Last Name *

Wand

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

Gender

Male  

Date of Birth

-1946 

Name Suffix

City of Birth

Place of Birth

Weight (in lbs)

Eye Color

Comments (non-public information)

Public Information

Historical File Number

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

ZIP / Postal Code

Address Line 2

City

County

State / Province

Country

Is your physical address different from your mailing address?

Yes No

Public Phone

#

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 *

Reviewed Date

Decision Date

Submitted Date



Approved Date



Application Step

#

Expiration Date



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

Yes No

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



Application Payment Date



Licensure Invoice



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

Board Certifications


Licensee / Applicant ▼	Certifying Board ▼	Other Certifying Board ▼	Specialty ▼	Initial Certification Date ▼	Recertification Date ↑
Wand, Austin N/A	American Board	N/A	Radiology	Dec-10-1976	N/A

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
Austin Wand	Retired	Jun-01-2019	Jul-20-2022	0
Austin Wand	Mount View and Sunrise Hospital GME	Jul-20-2022	Sep-12-2025	0

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 *

#

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

Education

Licensee/Applicant ▼	Education Type ▼	Name of School ▼	Degree Attained ▼	Date From ▼	Date To ↑ ▼	Graduation Date
Wand, Austin N/A	Medical School	University of Cincinnati College of Medicine	Medical Doctor Degree	Sep-16-1968	Jun-09-1972	Jun-11-1972

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 ↑
Wand, Austin N/A	National Board of Medical Examiners (NBME)	Sep-09-1970
Wand, Austin N/A	National Board of Medical Examiners (NBME)	Apr-11-1972
Wand, Austin N/A	National Board of Medical Examiners (NBME)	Mar-07-1973

Examination Details

Licensee / Applicant *

Wand, Austin N/A 


Attended Date

Sep-09-1970 

Number of Attempts

#

Application

Application - - Wand, Austin N/A 

Location

Result

Pass - Two Digit Score 81

Examination Type

National Board of Medical Examiners (NBME) 

Other Exam

Are you currently certified?

Yes No

Steps


Part 1

Certificate Number

Exam Date



Expiration Date




Examination Details

Licensee / Applicant *

Wand, Austin N/A 


Attended Date

Apr-11-1972 

Number of Attempts

#

Application


Application - - Wand, Austin N/A 

Location

Result

Pass - Three Digit Score 500, Two Digit S

Examination Type

National Board of Medical Examiners (NBME) 

Other Exam

Are you currently certified?


Yes No

Steps

Part II

Certificate Number

Exam Date



Expiration Date




Examination Details

Licensee / Applicant *

Wand, Austin N/A 

Attended Date

Mar-07-1973 

Number of Attempts

#

Application

Application - - Wand, Austin N/A 

Location

Result

Pass - Three Digit Score/590, Two Digit S

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



Other Licenses

Licensee/Applicant ▼	License Number ▼	License Type ▼	Issue Date ▼	Expiration Date ▼	State / Province ↑
Wand, Austin N/A	G-25148	N/A	Jul-23-1973	N/A	California
Wand, Austin N/A	D0019388	N/A	Jul-15-1976	Sep-30-1983	Maryland
Austin Wand	145834	N/A	Apr-24-1981	Apr-30-2009	New York
Wand, Austin N/A	35.078200	N/A	Jun-29-2000	Oct-01-2027	Ohio

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
Wand, Austin N/A	University of Cincinnati Medical Center	Internal Medicine	Jul-01-1972	Jun-30-1973	Internship
Wand, Austin N/A	Mount Zion Hospital	Radiology,Diagnostic	Jul-05-1973	Jul-04-1976	Residency
Wand, Austin N/A	Johns Hopkins Hospital	Pediatric, Radiology	Jul-01-1976	Jun-30-1977	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


Zip / Postal Code

State / Province

Country


County

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


Zip / Postal Code

State / Province


Country

County


 

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
Wand, Austin N/A	Radiology, Diagnostic	Yes	Jul-06-1979	N/A

Specialty Details


Licensee / Applicant *

Effective Date



Application

Primary Specialty?

Yes No

Specialty Type *

Other (Specialty)

End Date