FORM C

REQUEST FOR LICENSURE BY ENDORSEMENT

(ENDORSEMENT IS NOT THE SAME AS RECIPROCITY)

State your Name, and fill in the state, territory, or District of Columbia in which licensed:

I, ____________________________________ , being first duly sworn, do hereby swear or affirm under the penalties of perjury that the statements contained herein are true and correct to the best of my knowledge.

That I am now, and have been continuously, licensed to practice as an Anesthesiologist Assistant by the licensing agency of

____ , since ______________________________ .
(state, territory, or District of Columbia) **(month / day / year)**

That I have never had a license to practice any type of medicine, or assist in the practice of medicine, in any jurisdiction, country, state, territory, or District of Columbia, revoked for gross medical negligence. That I am an active member of, or the spouse of an active member of, the Armed Forces of the United States, a veteran or the surviving spouse of a veteran. I have not been disciplined and am not currently under investigation by the corresponding regulatory authority of the District of Columbia or any state or territory in which I hold a license to practice as an Anesthesiologist Assistant. I am currently certified by the National Commission for Certification of Anesthesiologist Assistants and I have not been held civilly or criminally liable for malpractice in the District of Columbia or any state or territory of the United States.

That I am the person named in the license to practice as an Anesthesiologist Assistant in ____, and that said license to practice as an Anesthesiologist
(State, territory, or District of Columbia)
Assistant was obtained by me without fraud or misrepresentation or any mistake of which I am aware, and that all information contained in this application for licensure by Endorsement, and any accompanying materials, are complete and correct.

DATED this ___________day of ______________________________ , 2________.

Signature:____

Typed or Printed Name:____

(NOTARY SEAL)

State of________________ County of ________________

Subscribed and sworn to before me this ___________day of

______________________________ , 2____________ .

Notary Public for the State of ________________________

My Commission Expires: ___________________________

Residing at: ____________________________________
City State

____
Signature of Notary

Please return completed form to:

Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521