***Applicant**: If you answered affirmatively with regard to any type of hospital investigation or violation and/or have had staff privileges denied,suspended, limited, revoked or not renewed by a hospital and/or if you resigned from any medical staff position in lieu of disciplinary action, submit this form to all hospitals where you have had privileges within the past 10 years. If more than one hospital or surgery center, photocopies of the blank form may be made and used.*
(Please note: do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department of staff meetings or maintaining required malpractice insurance)

FORM 5

NEVADA STATE BOARD OF MEDICAL EXAMINERS
VERIFICATION OF HOSPITAL OR SURGERY CENTER PRIVILEGES

Attn: Medical Staff Office

Hospital: ______________________

Address: ______________________

____

Hospital Chief-of-Staff or Administrator:

The above named applicant submitted an application to obtain an Anesthesiologist Assistant license in Nevada. The applicant has indicated that he/she holds or has held staff privileges at your hospital. In order that the processing of the application may be completed, we ask that you provide us with the information requested below.

Applicant's Name: ______________________

Applicant's DOB: ______________________

Specialty: ______________________

Affiliation dates: ______________________

1. What privileges are/were extended to the applicant?

____

2. Dates of hospital privileges: From ______________ To ______________
   Month / Year — Month / Year

3. Have staff privileges ever been limited, restricted, suspended or revoked? No _ ___ _ Yes ___ _

If Yes, please explain: ____

____

4. Is there any derogatory information on file? No Yes If Yes, please explain:

____

____

5. Do your records indicate applicant having privileges at any other hospitals in your area? No ______ _ Yes _ ___ _

If Yes, please list hospitals and/or attach a list.

____

____

____

Signature of Hospital Chief-of-Staff or Administrator

____

Printed Name, Title, and Date

Phone #: ______________________

Fax #: ______________________

Email: ______________________

Please return completed form to:

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

RELEASE

I hereby authorize the above named institution to release any information, files, or records required by the Nevada State Board of Medical Examiners for licensure in the state of Nevada.

____

Medical Doctor (applicant) signature <u>and</u> date

State of______________ County of ________________

Subscribed and sworn to before me this __________ day of

______________________________, 20 ___________ .

Notary Public for the State of ______________________

My Commission Expires: ______________________

Residing at: ______________________
City — State

____

Signature of Notary

<u>Hospital Administrator:</u> *If you have questions, you may contact the Nevada Board at (775) 688-2559.*