

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 physician submitted an application to

obtain a medical 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.

Physician's Name: _____

Physician'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 and 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

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