

**REQUEST FOR LICENSURE BY ENDORSEMENT VIA NRS 630.2752
(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 medicine 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 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 a physician assistant. I am currently certified by the National Commission on Certification for Physician 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 medicine in _____,
(State, territory, or District of Columbia)

and that said license to practice medicine 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: _____

State of _____ County of _____

Subscribed and sworn to before me this _____ day of _____, 2_____.

(NOTARY SEAL)

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