**PHYSICIAN**
**APPLICATION FOR REINSTATEMENT**
**TO ACTIVE OR INACTIVE STATUS REGISTRATION FORM**
**FOR THE BIENNIAL REGISTRATION PERIOD 2021 - 2023**
**NEVADA STATE BOARD OF MEDICAL EXAMINERS**

9600 Gateway Drive, Reno, NV 89521
Phone (775) 688-2559
Fax (775) 688-2321

Date Received by Board

**License No.**_____

File No._____

(For Board Use Only)

I hereby apply for reinstatement to active or inactive status, and enclose the appropriate fee as indicated below:

_____ REINSTATEMENT TO ACTIVE STATUS $1,500.00
_____ REINSTATEMENT TO INACTIVE STATUS $ 750.00 **(Inactive reinstatement – No CME required)**

**NOTE: You must reinstate to the status you held at the time your license became expired.**

**You may pay by cashier's check or money order, payable to "NEVADA STATE BOARD OF MEDICAL EXAMINERS," or by credit card. If paying by credit card, please complete the Credit Card Authorization form on the last page of this application. A two percent (2.5%) service fee will be assessed for payment by credit card.**

**Name:** _____

Make checks payable to:
**NEVADA STATE BOARD OF MEDICAL EXAMINERS**
(Foreign checks must indicate "U.S. FUNDS")

## *PLEASE NOTE:*

NRS 630.267(2) Biennial registration: Submission of list and fee; suspension and reinstatement of license; notice to licensee. (2) When a holder of a license fails to pay the fee for biennial registration and submit all information required to complete the biennial registration after they become due, his or her license to practice medicine in this State is automatically expired. The holder may, within 2 years after the date the license is expired of twice the amount of the current fee for biennial registration to the Secretary-Treasurer and submission of all information required to complete the biennial registration and after he or she is found to be in good standing and qualified under the provisions of this chapter, be reinstated to practice.

; YOUR LICENSE WILL NOT BE REINSTATED UNTIL THE BOARD RECEIVES YOUR SIGNED *APPLICATION FOR REINSTATEMENT TO ACTIVE OR INACTIVE STATUS REGISTRATION* FORM.
; YOU WILL NOT BE REINSTATED UNLESS YOU ANSWER ALL QUESTIONS ON THIS *APPLICATION FOR REINSTATEMENT TO ACTIVE OR INACTIVE STATUS REGISTRATION* FORM.
; YOU MUST PROVIDE WRITTEN EXPLANATIONS FOR ALL QUESTIONS ANSWERED "YES."
; ALL INFORMATION YOU PROVIDE ON THIS *APPLICATION FOR REINSTATEMENT TO ACTIVE OR INACTIVE STATUS REGISTRATION* FORM IS PUBLIC INFORMATION.

## PLEASE TYPE OR PRINT LEGIBLY

1. Active status registration requires the submission of proof of completion of 40 hours of **AMA Category 1** continuing medical education (CME), which includes 2 hours of CME in medical ethics, 20 hours of CME in your scope of practice or specialty and 18 hours of CME in any other AMA Category 1 course - **completed during the preceding 24-month time period of the date of your submission of this form**. Submit your proof of completion of CME with your completed ***APPLICATION FOR REINSTATEMENT TO ACTIVE STATUS REGISTRATION*** form. (See last page of this form for CME statement.) Please note: CME are not required for Inactive Status Reinstatement.

2. If your name and/or address have changed, clearly indicate the change in the space provided below. Please be advised, the address you indicate below is viewable on the NSBME website and is listed as the public address. Also, please indicate your current public telephone and fax numbers. [Please note: if your name has changed, a copy of the document authorizing your name change (marriage license, divorce decree, etc.) must be included.]

Name_____

Street_____

City_____ County_____ State_____ Zip_____

Phone Number_____ Fax Number_____

Email address _____

3. **IF YOU HAVE RETIRED OR MOVED YOUR PRACTICE,** indicate the location of patient records below:

Name_____

Street_____

City_____County_____State_____Zip_____

Phone Number_____

4. Indicate below your primary and secondary scopes of practice using the following codes:

**SCOPES OF PRACTICE CODES**

| | | | | | |
|---|---|---|---|---|---|
| 1 | ADDICTION MEDICINE | 41 | NEOPLASTIC DISEASES | 81 | PEDIATRIC, RHEUMATOLOGY |
| 2 | ADOLESCENT MEDICINE | 42 | NEPHROLOGY | 82 | PEDIATRIC, SURGERY |
| 3 | AEROSPACE MEDICINE | 43 | NEUROLOGY | 83 | PEDIATRIC, UROLOGY |
| 4 | ALLERGY | 44 | NEURO-OPHTHALMOLOGY | 84 | PEDIATRICS |
| 5 | ALLERGY/IMMUNOLOGY | 45 | NEUROPATHOLOGY | 85 | PHYSICAL MEDICINE/REHABILITATION |
| 6 | AMBULATORY MEDICINE | 46 | NEURORADIOLOGY | 86 | PREVENTIVE MEDICINE |
| 7 | ANESTHESIOLOGY | 47 | NON-CONVENTIONAL MEDICINE | 87 | PSYCHIATRY |
| 8 | BLOODBANKING | 48 | NUCLEAR MEDICINE | 88 | PSYCHOANALYSIS |
| 9 | BRONCO-ESOPHAGOLOGY | 49 | NUTRITION | 89 | PUBLIC HEALTH |
| 10 | CARDIOVASCULAR DISEASES | 50 | OBSTETRICS | 90 | PSYCHOMATIC MEDICINE |
| 11 | CATSCAN/ULTRASOUND | 51 | OBSTETRICS/GYNECOLOGY | 91 | PULMONARY DISEASES |
| 12 | CHILD NEUROLOGY | 52 | OCCUPATIONAL MEDICINE | 92 | RADIOLOGY |
| 13 | CHILD PSYCHIATRY | 53 | ONCOLOGY | 93 | RADIOLOGY, DIAGNOSTIC |
| 14 | CLINICAL PHARMACOLOGY | 54 | ONCOLOGY, GYNECOLOGICAL | 94 | RADIOLOGY, INTERVENTIONAL |
| 15 | CRITICAL CARE | 55 | ONCOLOGY, HEMATOLOGY | 95 | RADIOLOGY, NUCLEAR |
| 16 | DERMATOLOGY | 56 | ONCOLOGY, RADIATION | 96 | RADIOLOGY, THERAPEUTIC |
| 17 | DERMATOPATHOLOGY | 57 | ONCOLOGY, SURGICAL | 97 | RADIOLOGY, VASCULAR |
| 18 | EMERGENCY MEDICINE | 58 | OPHTHALMOLOGY | 98 | RHEUMATOLOGY |
| 19 | ENDOCRINOLOGY | 59 | OTOLARYNGOLOGY | 99 | RHINOLOGY |
| 20 | FAMILY PRACTICE | 60 | OTOLOGY | 100 | SLEEP DISORDERS |
| 21 | GASTROENTEROLOGY | 61 | PAIN MANAGEMENT | 101 | SPORTS MEDICINE |
| 22 | GENERAL PRACTICE | 62 | PATHOLOGY | 102 | SURGERY, ABDOMINAL |
| 23 | GERIATRIC PSYCHIATRY | 63 | PATHOLOGY, ANATOMIC | 103 | SURGERY, CARDIOTHORACIC |
| 24 | GERIATRICS | 64 | PATHOLOGY, CLINICAL | 104 | SURGERY, CARDIOVASCULAR |
| 25 | GYNECOLOGY | 65 | PATHOLOGY, FORENSIC | 105 | SURGERY, COLON/RECTAL |
| 26 | HAIR TRANSPLANTATION | 66 | PEDIATRIC, ALLERGY | 106 | SURGERY, GENERAL |
| 27 | HEMATOLOGY | 67 | PEDIATRIC, CARDIOLOGY | 107 | SURGERY, HAND |
| 28 | HOMEOPATHY | 68 | PEDIATRIC, CRITICAL CARE | 108 | SURGERY, HEAD/NECK |
| 29 | HYPNOSIS | 69 | PEDIATRIC, EMERGENCY MEDICINE | 109 | SURGERY, MAXILLOFACIAL |
| 30 | IMMUNOLOGY | 70 | PEDIATRIC, ENDOCRINOLOGY | 110 | SURGERY, NEUROLOGICAL |
| 31 | INFECTIOUS DISEASES | 71 | PEDIATRIC, GASTROENTEROLOGY | 111 | SURGERY, ORTHOPEDIC |
| 32 | INFERTILITY | 72 | PEDIATRIC, HEMATOLOGY/ONCOLOGY | 112 | SURGERY, PLASTIC |
| 33 | INTERNAL MEDICINE | 73 | PEDIATRIC, INFECTIOUS DISEASES | 113 | SURGERY, THORACIC |
| 34 | LARYNGOLOGY | 74 | PEDIATRIC, INTENSIVIST | 114 | SURGERY, TRANSPLANT |
| 35 | LEGAL MEDICINE | 75 | PEDIATRIC, NEPHROLOGY | 115 | SURGERY, TRAUMATIC |
| 36 | MATERNAL/FETAL MEDICINE | 76 | PEDIATRIC, NEUROLOGY | 116 | SURGERY, UROLOGIC |
| 37 | MEDICAL ACUPUNCTURE | 77 | PEDIATRIC, OPHTHALMOLOGY | 117 | SURGERY, VASCULAR |
| 38 | MEDICAL ETHICS | 78 | PEDIATRIC, PHYSIATRY | 118 | TOXICOLOGY |
| 39 | MEDICAL GENETICS | 79 | PEDIATRIC, PULMONARY | 119 | URGENT CARE |
| 40 | NEO/PERINATAL MEDICINE | 80 | PEDIATRIC, RADIOLOGY | 120 | UROLOGY |

**Code** **Code**

**Primary Scope of Practice** _____ **Secondary Scope of Practice** _____

////////////////////////////////////////////////////////////////////////////////////////////////////////////////////////////////////////////////////////////////////////////////

## *All of the following questions refer to the preceding 24-month time period of the date of your submission of this form or since your last renewal.*

### For the purposes of the following questions, these phrases or words have these meanings:

**"Ability to practice medicine"** is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments;
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks such as physician examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

**"Medical condition"** includes physiological, mental or psychological condition or disorder.

**"Chemical substances"** is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction.

## FOR ALL "YES" RESPONSES TO THE FOLLOWING QUESTIONS, YOU MUST SUBMIT YOUR WRITTEN EXPLANATION(S) ON A SEPARATE SHEET ATTACHED TO YOUR COMPLETED APPLICATION FOR REINSTATEMENT TO ACTIVE OR INACTIVE STATUS REGISTRATION FORM.

1. Do you currently have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety?
_____Yes _____No

2. If you currently have a medical condition which in any way impairs or limits your ability to practice medicine, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, the manner in which you have chosen to practice, or by any other reasonable accommodation? _____Yes _____No _____N/A

3. If you currently use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety?
_____Yes _____No _____N/A

4. Have you been named as a defendant, or been requested to respond as a defendant, to a legal action involving professional liability, or malpractice, including any military tort claims if applicable? _____Yes _____No

5. Have you had a professional liability, malpractice, claim paid on your behalf, or paid such a claim yourself including any military tort claims if applicable?
_____Yes _____No

6. Have you been arrested, investigated for, charged with, convicted of, or pled guilty or nolo contendere to any offense or violation of any federal (including the Uniform Code of Military Justice), state or local law, or the laws of any foreign country, which is a misdemeanor, gross misdemeanor, felony, violation of the Uniform Code of Military Justice, or synonymous thereto in a foreign jurisdiction, excluding any minor traffic offense (driving or being in control of a motor vehicle while under the influence of a chemical substance, including alcohol, is not considered a minor traffic offense), or for any offense which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? *Please note that you **MUST disclose ANY** investigation or arrest, including those where the final disposition was dismissal, or expungement. (If "Yes," attach explanation on separate sheet.)
_____Yes _____No

7. Have you been denied a license, permission to practice medicine or any other healing art, or permission to take an examination to practice medicine or any other healing art in any state, country or U.S. territory?
_____Yes _____No

8. Have you had a medical license or license to practice any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory?
_____Yes _____No

9. Have you voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory?
_____Yes _____No

10. Have you been denied membership, been asked to resign or expelled from a medical society or other professional medical organization?

_____Yes _____No

11. Have you been: a) asked to respond to an investigation; b) notified that you were under investigation for; c) investigated for; d) charged with; or e) convicted of any violation of a statute, rule or regulation governing your practice as a physician by any medical licensing board, hospital, medical society, governmental entity or other agency other than the Nevada State Board of Medical Examiners?

_____Yes _____No

12. Have you surrendered your state or federal controlled substance registration or had it revoked or restricted in any way?

_____Yes _____No

13. List all hospitals where you have had staff privileges denied, suspended, limited, revoked or not renewed by the hospital. List any and all resignations from any medical staff in lieu of disciplinary or administrative action. (Please Note: Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance).

| Hospital | Mailing Address | Type of Action | Dates of Action From (Mo./Yr.) To (Mo./Yr.) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

(If more space is needed, attach a separate sheet.)

## OTHER STATES OF CURRENT OR PREVIOUS LICENSURE

List any and all licenses (including training licenses and permits) YOU HOLD OR HAVE HELD to practice medicine in any state, territory.

| State/Territory | License # | Date of Issuance | Dates of Practice |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

(If more space is needed, attach a separate sheet.)

## CHILD SUPPORT STATEMENT

**Please place a check mark next to one of the following statements:**

_____ (a) I am not subject to a court order for the support of a child;

_____ (b) I am subject to a court order for the support of one or more children and am in compliance with the order or am in compliance with a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order; **OR**

_____ (c) I am subject to a court order for the support of one or more children and am NOT in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

## ATTESTATION REGARDING THE REPORTING OF THE ABUSE OR NEGLECT OF A CHILD

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**

www.leg.state.nv.us/NRS/NRS-432B.html#NRS432BSec220

## SAFE INJECTION PRACTICE ATTESTATION

**ATTESTATION TO KNOWLEDGE OF AND COMPLIANCE WITH THE GUIDELINES OF THE CENTERS FOR DISEASE CONTROL AND PREVENTION FOR APPLICANT PHYSICIANS**

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**

http://www.cdc.gov/injectionsafety/IP07_standardPrecaution.html

## MILITARY SERVICE ATTESTATION

1-Have you ever served in the United States Military (to include National Guard or Reserves)? _____Yes _____No
*If your answer is "No", you do not have to complete the remaining questions for the Military Service Attestation.*

2-If yes, which branch of service did you serve?
- ☐ Air Force
- ☐ Army
- ☐ Navy
- ☐ Marine Corps
- ☐ Coast Guard

3-Military occupation specialty or specialties?
- ☐ Administration or Personnel
- ☐ Aviation
- ☐ Civil Engineering
- ☐ Communications
- ☐ Infantry or Armor
- ☐ Legal or Chaplin Corps
- ☐ Logistics or Supply
- ☐ Maintenance
- ☐ Medical Services
- ☐ Security Forces or Military Police
- ☐ Other

4&5-Dates of service in the Military:
**4-From:** _____/_____/_____ (DD/MM/YYYY) **5-To:** _____/_____/_____ (DD/MM/YYYY)

6-Are you still serving? _____Yes _____No

7-Have you ever served on active duty in the Armed Forces of the United States? _____Yes _____No

8-Have you ever been assigned to duty for a minimum of 6 continuous years in the National Guard or a reserve component of the Armed Forces of the United States? _____Yes _____No

9-Have you ever served the Commissioned Corps of the United States Public Health Service or the Commissioned Corps of the National Oceanic and Atmospheric Administration of the United States in the capacity of a commissioned officer while on active duty in defense of the United States? _____Yes _____No

10-If the answer to question(s) 7, 8 and/or 9 is "yes," did you separate from such service under conditions other than dishonorable? _____Yes _____No _____N/A

## BUSINESS LICENSE ATTESTATION

Do you hold a Nevada state business license issued in your individual name? _____Yes _____No

If yes, provide the business license number: _____.

## CONSCIOUS SEDATION DEEP SEDATION OR GENERAL ANESTHESIA ATTESTATION

Nevada Revised Statutes (NRS) require the Nevada State Board of Medical Examiners to obtain from each applicant who seeks renewal of his or her license to practice medicine, a report stating the number and type of surgeries requiring conscious sedation, deep sedation or general anesthesia performed by the holder of the license at his or her office or any other facility, excluding any surgical care performed at a medical facility as defined in NRS 449.0151, or outside the state of Nevada.

**I hereby attest that I am in compliance with the reporting requirements of NRS 630.30665, and am aware that failure to submit a report or filing false information in a report is grounds for disciplinary action under Nevada's Medical Practice Act.**

_____**Yes** _____**No**

## CONTINUING MEDICAL EDUCATION (CME) STATEMENT *(Inactive reinstatement – No CME required)*

**Please place a check mark next to one of the following statements:**

_____ (a) I was initially licensed in Nevada prior to or during the time period July 1, 2019 through December 31, 2019 and completed a minimum of forty (40) hours of AMA Category 1 continuing medical education (CME), two (2) hours of which were in medical ethics or pain management and/or addiction care and twenty (20) hours of which were in my scope of practice or specialty;

_____ (b) I was initially licensed in Nevada during the time period January 1, 2020 through June 30, 2020 the second six months of the past biennial period, and completed a minimum of thirty (30) hours of AMA Category 1 continuing medical education (CME), two (2) hours of which were in medical ethics or pain management and/or addiction care and twenty (20) hours of which were in my scope of practice or specialty;

_____ (c) I was initially licensed in Nevada during the time period July 1, 2020 through December 31, 2020, the third six months of the past biennial period, and completed a minimum of twenty (20) hours of AMA Category 1 continuing medical education (CME), two (2) hours of which were in medical ethics or pain management and/or addiction care and eighteen (18) hours of which were in my scope of practice or specialty;

_____ (d) I was initially licensed in Nevada during the time period January 1, 2021 through June 30, 2021, the fourth six months of the past biennial period, and completed a minimum of ten (10) hours of AMA Category 1 continuing medical education (CME), two (2) hours of which were in medical ethics or pain management and/or addiction care and eight (8) hours of which were in my scope of practice or specialty, OR

_____ (e) I am exempt from submitting proof of completion of continuing medical education (CME) because I have completed a full year of residency or fellowship training during the biennial period July 1, 2019 through June 30, 2021.

*Pursuant to NRS 630.253(5) a physician assistant must complete at least 2 hours of CME on Suicide Prevention and Awareness every 4 years.

**; ATTACH COPIES OF PROOF OF YOUR COMPLETION OF CONTINUING MEDICAL EDUCATION (CME) HOURS OR PROOF OF COMPLETION OF 1 YEAR OF RESIDENCY OR FELLOWSHIP TRAINING OBTAINED DURING THE BIENNIAL.**

**; YOUR COPIES OF PROOF OF CME OR TRAINING COMPLETION WILL NOT BE RETURNED TO YOU.**

## BY SIGNING ON THE SIGNATURE LINE BELOW:

1) I hereby represent that I am the person named in this application for reinstatement to active or inactive status registration of license to practice medicine in the state of Nevada and that all statements I have made herein are true;

2) I understand that this application for reinstatement to active or inactive status registration will be rejected if I have not placed a check mark next to (a), (b), or (c) under the child support statement section; and

3) I understand that this application for reinstatement to active or inactive status registration will be rejected as incomplete if I have not answered all questions thereon and/or attached thereto: (a) the appropriate copies of proof of continuing medical education (CME); (b) payment of the appropriate fee(s); and (c) written explanation(s) to any "yes" answer(s).

_____ _____

Date Signature **(SIGNATURE STAMP IS UNACCEPTABLE)**

# CREDIT CARD AUTHORIZATION FORM

*If mailing or faxing this page separately from the application, please mail to:*
*Nevada State Board of Medical Examiners*
*9600 Gateway Drive*
*Reno, NV 89521*
*or fax to:*
*775-688-2321*

## ***Please type or print legibly*.**

Name of Applicant: _____

Method of Payment: ☐ MasterCard ☐ Visa ☐ American Express ☐ Discover

Name on Credit Card: _____

Business Name (if applicable): _____

Credit Card Billing Address:

_____

_____

_____

Phone Number: _____

Credit Card Number: _____

Expiration Date: _____ / _____ (MM) (YYYY)

Credit Card Verification Code: CVC: _____
(Three or four digit code found on the front or back of the card)

***For security of your financial information, please do not email this form to the Board; emailed forms will not be accepted.***

I authorize the Nevada State Board of Medical Examiners to charge the above credit card for a one-time payment in the amount of $ _____, and an additional 2.5% service fee.

Printed Name: _____

Authorized Signature: _____ Date: _____

Email Address for receipt: _____

Disclosure: By continuing, you will be charged a non-refundable card payment-processing fee of 2.5% for debit and credit cards by our payment processor. If you don't wish to pay the fee, you can select another payment option.