NEVADA STATE BOARD OF MEDICAL EXAMINERS
FEES FOR TRANSITIONAL LIMITED PHYSICIAN LICENSURE

Applications which appear to have been altered in any form will not be accepted. Applications must be typed or legibly handwritten in ink (illegible or incomplete applications will be returned). Applications must be received on single-sided, white bond paper, 8 ½" x 11" in size. **Your application is a public document.**

Applications not completed within six (6) months from date of receipt may be closed without action pursuant to Nevada Administrative Code (NAC) 630.180(2).

Fees

	Application Fee	Two-year Registration Fee	Criminal Background Investigation Fee	Total
Transitional Limited License	$600	$600	$75	**$ 1,275.00**

The Application fee and Criminal Background Investigation fee will not be refunded. 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 and one-half percent (2.5%) service fee will be assessed for payment by credit card.

The Board's staff investigates your background pursuant to the requirements in Nevada law during the application process. If staff becomes aware of circumstances** warranting a personal appearance at a Board meeting prior to acceptance of your application for licensure, your application must be completed 45 days prior to any regularly scheduled Board meeting in order for your appearance to be scheduled for that meeting for consideration of acceptance of your application. You will receive written notice sent by certified mail at least 14 calendar days prior to the Board meeting that you are scheduled to attend with a courtesy copy sent to you by email.

** You **may** be required to personally appear before the Board for acceptance of your application for licensure if you have in any way ever been involved in any malpractice awards, judgments, or settlements in any amount.

** You **may** be required to personally appear before the Board for acceptance of your application for licensure if you have answered in the affirmative ("Yes") to questions 8, 9, 10, 11, 12, 12a 13, 18, 24, 25, 26, 27, 28, 29, and/or 30.

If, at the time you meet with the Board, the Board votes to deny your application for licensure, this denial of your application may become a reportable action to the National Practitioner Data Bank, Federation of State Medical Boards of the United States, Inc. and American Medical Association, among other entities.

License Description

Transitional Limited Physician (TLP) licenses allow physicians who have graduated medical school in counties other than the United States, Canada, New Zealand, Australia, and the United Kingdom to practice medicine in the State of Nevada under the supervision of an approved supervising physician. Holders of a TLP license may practice internal medicine, family medicine, or pediatrics according to the terms of the written practice agreement and as authorized by their supervising physician and as approved by the Board. TLP licenses are valid for two years and may be renewed upon application prior to their expiration. Holders of TLP licenses may be eligible to apply for unrestricted licenses to practice medicine in the State of Nevada upon completion of at least 3,840 hours of supervised experience and upon meeting the other requirements prescribed by Nevada law at the time of their application for an unrestricted license. Holders of TLP licenses may perform only the tasks authorized by their supervising physicians and may not practice outside of the scope of their approved employment and approved written practice agreement.

THE FOLLOWING CONSTITUTE GROUNDS FOR DENIAL OF LICENSURE, AS SET OUT IN NRS 630.301 THROUGH NRS 630.3065:

NRS 630.301 Criminal offenses; disciplinary action taken by other jurisdiction; surrender of previous license while under investigation; malpractice; engaging in sexual activity with patient; disruptive behavior; violating or exploiting trust of patient for financial or personal gain; failure to offer appropriate care with intent to positively influence financial well-being; engaging in disreputable conduct; engaging in sexual contact with surrogate of patient or relatives of patient. The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure:

1. Conviction of a felony relating to the practice of medicine or the ability to practice medicine. A plea of nolo contendere is a conviction for the purposes of this subsection.
2. Conviction of violating any of the provisions of NRS 616D.200, 616D.220, 616D.240, 616D.300, 616D.310, or 616D.350 to 616D.440, inclusive.
3. Any disciplinary action, including, without limitation, the revocation, suspension, modification or limitation of a license to practice any type of medicine, taken by another state, the Federal Government, a foreign country or any other jurisdiction or the surrender of the license or discontinuing the practice of medicine while under investigation by any licensing authority, a medical facility, a branch of the Armed Services of the United States, an insurance company, an agency of the Federal Government or an employer.
4. Malpractice, which may be evidenced by claims settled against a practitioner, but only if the malpractice is established by a preponderance of the evidence.
5. The engaging by a practitioner in any sexual activity with a patient who is currently being treated by the practitioner.
6. Disruptive behavior with physicians, hospital personnel, patients, members of the families of patients or any other persons if the behavior interferes with patient care or has an adverse impact on the quality of care rendered to a patient.
7. The engaging in conduct that violates the trust of a patient and exploits the relationship between the physician and the patient for financial or other personal gain.
8. The failure to offer appropriate procedures or studies, to protest inappropriate denials by organizations for managed care, to provide necessary services or to refer a patient to an appropriate provider, when the failure occurs with the intent of positively influencing the financial well-being of the practitioner or an insurer.
9. The engaging in conduct that brings the medical profession into disrepute, including, without limitation, conduct that violates any provision of a code of ethics adopted by the Board by regulation based on a national code of ethics.
10. The engaging in sexual contact with the surrogate of a patient or other key persons related to a patient, including, without limitation, a spouse, parent or legal guardian, which exploits the relationship between the physician and the patient in a sexual manner.
11. Conviction of:

(a) Murder, voluntary manslaughter or mayhem;
(b) Any felony involving the use of a firearm or other deadly weapon;
(c) Assault with intent to kill or to commit sexual assault or mayhem;
(d) Sexual assault, statutory sexual seduction, incest, lewdness, indecent exposure or any other sexually related crime;
(e) Abuse or neglect of a child or contributory delinquency;
(f) A violation of any federal or state law regulating the possession, distribution or use of any controlled substance or any dangerous drug as defined in chapter 454 of NRS; or
(g) Any offense involving moral turpitude.

(Added to NRS by 1977, 824; A 1981, 590; 1983, 305; 1985, 2236; 1987, 197; 1991, 1070; 1993, 782; 1997, 684; 2001, 766; 2003, 2707, 3433; 2003, 20th Special Session, 264, 265; 2005, 2522; 2007, 3045; 2011, 847)

NRS 630.304 Misrepresentation in obtaining or renewing license; false advertising; practicing under another name; signing blank prescription forms; influencing patient to engage in sexual activity; discouraging second opinion; terminating care without adequate notice. The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure:

1. Obtaining, maintaining or renewing or attempting to obtain, maintain or renew a license to practice medicine by bribery, fraud or misrepresentation or by any false, misleading, inaccurate or incomplete statement.
2. Advertising the practice of medicine in a false, deceptive or misleading manner.
3. Practicing or attempting to practice medicine under another name.
4. Signing a blank prescription form.
5. Influencing a patient in order to engage in sexual activity with the patient or with others.
6. Attempting directly or indirectly, by way of intimidation, coercion or deception, to obtain or retain a patient or to discourage the use of a second opinion.
7. Terminating the medical care of a patient without adequate notice or without making other arrangements for the continued care of the patient.

(Added to NRS by 1983, 301; A 1985, 2236; 1987, 198)

NRS 630.305 Accepting compensation to influence evaluation or treatment; inappropriate division of fees; inappropriate referral to health facility, laboratory or commercial establishment; charging for services not rendered; aiding practice by unlicensed person; delegating responsibility to unqualified person; failing to disclose conflict of interest; failing to initiate performance of community service; exception.

1. The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure:

(a) Directly or indirectly receiving from any person, corporation or other business organization any fee, commission, rebate or other form of compensation which is intended or tends to influence the physician's objective evaluation or treatment of a patient.

(b) Dividing a fee between licensees except where the patient is informed of the division of fees and the division of fees is made in proportion to the services personally performed and the responsibility assumed by each licensee.

(c) Referring, in violation of NRS 439B.425, a patient to a health facility, medical laboratory or commercial establishment in which the licensee has a financial interest.

(d) Charging for visits to the physician's office which did not occur or for services which were not rendered or documented in the records of the patient.

(e) Aiding, assisting, employing or advising, directly or indirectly, any unlicensed person to engage in the practice of medicine contrary to the provisions of this chapter or the regulations of the Board.

(f) Delegating responsibility for the care of a patient to a person if the licensee knows, or has reason to know, that the person is not qualified to undertake that responsibility.

(g) Failing to disclose to a patient any financial or other conflict of interest.

(h) Failing to initiate the performance of community service within 1 year after the date the community service is required to begin, if the community service was imposed as a requirement of the licensee's receiving loans or scholarships from the Federal Government or a state or local government for the licensee's medical education.

2. Nothing in this section prohibits a physician from forming an association or other business relationship with an optometrist pursuant to the provisions of NRS 636.373.

(Added to NRS by 1983, 301; A 1985, 2237; 1987, 198; 1989, 1114; 1991, 2437; 1993, 2302, 2596; 1995, 714, 2562)

THE FOLLOWING CONSTITUTE GROUNDS FOR DENIAL OF LICENSURE, AS SET OUT IN NRS 630.301 THROUGH NRS 630.3065 (cont.):

NRS 630.306 Inability to practice medicine; deceptive conduct; violation of regulation governing practice of medicine or adopted by State Board of Pharmacy; unlawful distribution of controlled substance; injection of silicone; practice beyond scope of license; practicing experimental medicine without consent of patient or patient's family; lack of skill or diligence; habitual intoxication or dependency on controlled substances; filing of false report; failure to report certain changes of information or disciplinary or criminal action in another jurisdiction; failure to be found competent after examination; certain operation of a medical facility; prohibited administration of anesthesia or sedation; engaging in unsafe or unprofessional conduct; knowingly procuring or administering certain controlled substances or dangerous drugs; failure to supervise medical assistant adequately. The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure:

1. Inability to practice medicine with reasonable skill and safety because of illness, a mental or physical condition or the use of alcohol, drugs, narcotics or any other substance.
2. Engaging in any conduct:

(a) Which is intended to deceive;

(b) Which the Board has determined is a violation of the standards of practice established by regulation of the Board; or

(c) Which is in violation of a regulation adopted by the State Board of Pharmacy.

3. Administering, dispensing or prescribing any controlled substance, or any dangerous drug as defined in chapter 454 of NRS, to or for himself or herself or to others except as authorized by law.
4. Performing, assisting or advising the injection of any substance containing liquid silicone into the human body, except for the use of silicone oil to repair a retinal detachment.
5. Practicing or offering to practice beyond the scope permitted by law or performing services which the licensee knows or has reason to know that he or she is not competent to perform or which are beyond the scope of his or her training.
6. Performing, without first obtaining the informed consent of the patient or the patient's family, any procedure or prescribing any therapy which by the current standards of the practice of medicine is experimental.
7. Continual failure to exercise the skill or diligence or use the methods ordinarily exercised under the same circumstances by physicians in good standing practicing in the same specialty or field.
8. Habitual intoxication from alcohol or dependency on controlled substances.
9. Making or filing a report which the licensee or applicant knows to be false or failing to file a record or report as required by law or regulation.
10. Failing to comply with the requirements of NRS 630.254.
11. Failure by a licensee or applicant to report in writing, within 30 days, any disciplinary action taken against the licensee or applicant by another state, the Federal Government or a foreign country, including, without limitation, the revocation, suspension or surrender of a license to practice medicine in another jurisdiction.
12. Failure by a licensee or applicant to report in writing, within 30 days, any criminal action taken or conviction obtained against the licensee or applicant, other than a minor traffic violation, in this State or any other state or by the Federal Government, a branch of the Armed Forces of the United States or any local or federal jurisdiction of a foreign country.
13. Failure to be found competent to practice medicine as a result of an examination to determine medical competency pursuant to NRS 630.318.
14. Operation of a medical facility at any time during which:

(a) The license of the facility is suspended or revoked; or

(b) An act or omission occurs which results in the suspension or revocation of the license pursuant to NRS 449.160.

This subsection applies to an owner or other principal responsible for the operation of the facility.

15. Failure to comply with the requirements of NRS 630.373.
16. Engaging in any act that is unsafe or unprofessional conduct in accordance with regulations adopted by the Board.
17. Knowingly procuring or administering a controlled substance or a dangerous drug as defined in chapter 454 of NRS that is not approved by the United States Food and Drug Administration, unless the unapproved controlled substance or dangerous drug:

(a) Was procured through a retail pharmacy licensed pursuant to chapter 639 of NRS;

(b) Was procured through a Canadian pharmacy which is licensed pursuant to chapter 639 of NRS and which has been recommended by the State Board of Pharmacy pursuant to subsection 4 of NRS 639.2328; or

(c) Is marijuana being used for medical purposes in accordance with chapter 453A of NRS.

18. Failure to supervise adequately a medical assistant pursuant to the regulations of the Board.

(Added to NRS by 1983, 302; A 1985, 2238; 1987, 199, 800, 1554, 1575; 2007, 3046; 2009, 533, 879, 2961, 2962; 2011, 257, 2612)

NRS 630.3062 Failure to maintain proper medical records; altering medical records; making false report; failure to file or obstructing required report; failure to allow inspection and copying of medical records; failure to report other person in violation of chapter or regulations. The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure:

1. Failure to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of a patient.
2. Altering medical records of a patient.
3. Making or filing a report which the licensee knows to be false, failing to file a record or report as required by law or willfully obstructing or inducing another to obstruct such filing.
4. Failure to make the medical records of a patient available for inspection and copying as provided in NRS 629.061.
5. Failure to comply with the requirements of NRS 630.3068.
6. Failure to report any person the licensee knows, or has reason to know, is in violation of the provisions of this chapter or the regulations of the Board within 30 days after the date the licensee knows or has reason to know of the violation.

(Added to NRS by 1985, 2223; A 1987, 199; 2001, 767; 2002 Special Session, 19; 2003, 3433; 2009, 2963)

NRS 630.3065 Willful disclosure of privileged communication; willful failure to comply with statute or regulation governing practice of medicine. The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure:

1. Willful disclosure of a communication privileged pursuant to a statute or court order.
2. Willful failure to comply with:

(a) A regulation, subpoena or order of the Board or a committee designated by the Board to investigate a complaint against a physician;

(b) A court order relating to this chapter; or

(c) A provision of this chapter.

3. Willful failure to perform a statutory or other legal obligation imposed upon a licensed physician, including a violation of the provisions of NRS 439B.410.

(Added to NRS by 1983, 302; A 1985, 2238; 1987, 200; 1989, 1663; 1993, 2302)

TRANSITIONAL LIMITED PHYSICIAN LICENSE
APPLICATION CHECKLIST

____	a.	APPLICATION: ☐ Properly completed, signed and notarized application, including Applicant Responsibility statement; ☐ Recent passport quality photograph (at least 2"x 2") attached to application; ☐ Appropriate explanations and copies of all pertinent documentation must be attached for affirmative responses to questions numbered 8, 9, 10, 11, 12, 12a, 13, 14a, 14b, 14c, 18, 24, 25, 26, 27, 28, 29, and 30; ☐ Release form, signed and notarized (Form A);
____	b.	FEES: • Application and criminal background investigation fees – cashier's check or money order made payable to Nevada State Board of Medical Examiners (NSBME) or by credit card as instructed. Credit cards will only be accepted by receipt of the signed credit card authorization form. This form **cannot** be accepted via email. **Note:** Application and criminal background investigation fees are <u>non</u>-refundable;
____	c.	IDENTITY: • **U.S. born citizens** – Photocopy of U.S. Birth Certificate or current (unexpired) U.S. passport <u>with</u> ***notarized*** Certificate of Identification • **Foreign-born citizens** – Photocopy of current (unexpired) U.S. passport or Certificate of Naturalization <u>with</u> ***notarized*** Certificate of Identification • **Non U.S. citizens –** Copy of foreign passport <u>with</u> ***notarized*** Certificate of Identification ***Note:*** *FCVS verification packet may provide appropriate "Seal verified" Identity documentation*
____	d.	SELF-QUERY VERIFICATION: • Self-query response from the National Practitioner Data Bank (NPDB) - see enclosed "Instructions" page. The NPDB will send the report directly to you and you will forward <u>the final report</u> to the Board office;
____	e.	SUPPLEMENTARY FORMS: • FORM B: ONLY if you have answered affirmatively to either of the two malpractice questions on the application; Also include: o Copy of the complaint o Copy of the settlement and/or order of dismissal
____	f.	FINGERPRINTING: • Once the application and criminal background investigation fee have been received, fingerprint instructions will be sent to you. Applicants within the State of Nevada may complete a physical fingerprint card or may obtain electronic fingerprints (i.e., LiveScan). Applicants outside of Nevada must complete a physical fingerprint card. You will take the fingerprint instructions to a fingerprinting service or Law Enforcement agency so they may use the correct card (if applicable) and enter the necessary information. Completed card or Fingerprint Request Form <u>must</u> be returned to the Board. Fingerprints must be accompanied by a signed Civil Applicant Waiver, dated on or before the fingerprint date.

TRANSITIONAL LIMITED PHYSICIAN LICENSE
APPLICATION CHECKLIST

DIRECT SOURCE VERIFICATIONS TO BE SOLICITED BY APPLICANT FOR DIRECT RETURN BY THE VERIFYING INSTITUTION TO BOARD OFFICE

Verifying agencies may charge a fee. ***Do not provide pre-stamped or pre-addressed envelopes for direct source verifications.***

_____	*	a.	MEDICAL SCHOOL: ☐ Verification of Medical Education (Form 1) to be completed by medical school(s); ☐ Official transcripts from all schools where professional medical instruction was received (if transcripts are not in English, a certified original and official English translation is required from an entity recognized by the National Association of Credential Evaluation Services);
_____	*	b.	POSTGRADUATE TRAINING PROGRAM: • Certificate of Completion of Progressive Postgraduate Training (Form 2) to be completed by all institutions where any training occurred (internship, residency, fellowship and research fellowship), if applicable;
_____	*	c.	EXAMINATION: ☐ Certification of USMLE scores - see "Instructions" page; **Note: Generally, the Board requires that physician applicants pass the United States Medical Licensing Examination (USMLE) Steps I, II and III of the USMLE within 7 years after the date on which the applicant first passes any step of the USMLE and the applicant is limited to a combined maximum of 9 attempts to pass steps I, II, and III and no more than 3 attempts at step III of the USMLE. However, applicants for transitional limited physician (TLP) licenses may be exempted from these requirements for good cause shown.** ☐ Certification status report from the Educational Commission for Foreign Medical Graduates (ECFMG) – see "Instructions" page;
_____		d.	MALPRACTICE INSURANCE CARRIER VERIFICATIONS: • Malpractice insurance carrier verification (Form 4) to be completed by appropriate entity and returned directly by the verifying institution to the Board office and must include the loss history report for any and all malpractice cases that involved you and that occurred within the past 10 years. If you have not had any malpractice insurance payouts on your behalf, this form is not required.
_____		e.	HOSPITAL VERIFICATIONS: • Verification of hospital privileges (Form 5) to be completed by appropriate entity and returned directly by the verifying institution to the Board office if you answered affirmatively to having had any disciplinary issues regarding your hospital privileges within the past 10 years;
_____		f.	WRITTEN AFFIDAVIT FROM PROPOSED SUPERVISING PHYSICIAN: • Prior to issuing a TLP license pursuant to NRS 630.2667, the Board requires a written affidavit from your proposed supervising physician indicating that he or she has had substantial direct contact with you and evaluated your skills and knowledge and is willing to supervise you as a transitional limited physician license holder. You may not provide clinical services or other care that requires a TLP license to patients prior to receiving a license. This affidavit must be sent directly to the Board from the proposed supervising physician.

***** Federation Credentials Verification Service (FCVS) packet may verify these documents.

Please Note: Pursuant to NRS 630.173(2), the Board has the right to consider information for any malpractice history or derogatory hospital privilege history that is more than 10 years old. This means that, even though the questions above limit the time frame to the most recent 10 years, the Board may ask for malpractice or hospital privileges history that is older than 10 years when reviewing your application if it is deemed necessary.

APPLICATION GUIDE

Requirements for Licensure. For full review of requirements and Nevada law governing your practice as a transitional physician, please review the Board's website: https://medboard.nv.gov/ and review NRS and NAC Chapters 630, 629, 639, 453, and 454.

Identity. Licenses will be issued in the applicant's name as it is indicated on the submitted documented proof of such name, i.e., U.S. Birth Certificate, Certificate of Naturalization, U.S. Passport, Foreign-Passport, or other legal document submitted with your application.

Postgraduate Training. If you have ever had any actions, restrictions or limitations imposed on you, or have been placed on probation while participating in any type of training program, you should answer affirmatively to question #19. Please submit a signed and dated explanation addressed to the Board for any postgraduate training issues and include copies of documentation you received from your program.

Malpractice. If you have ever been named in a legal action involving professional liability (malpractice), whether or not you have ever had a professional liability, settlement, claim paid on your behalf, or paid such a claim yourself, provide signed and dated explanations for all malpractice cases throughout your career. Provide copies of legal documentation for malpractice cases that occurred within the past 10 years unless otherwise instructed, which includes copies of complaints, settlements and/or orders of dismissal. If you have a pending case or cases, request a letter from your attorney to be sent directly to the Board describing the current status of the case(s). In summary:

- Provide descriptive explanations for any and all malpractice cases (who, what, where, when and why)
- Complete Form B listing all malpractice insurance carriers since completion of postgraduate training and/or the beginning of your licensure outside of the United States
- Provide copies of legal documentation for cases that occurred within the past 10 years
    - Complaint
    - Settlement, and/or
    - Order dismissing the action
- Request Form 4 malpractice carrier verifications from all malpractice insurance carriers within the past 10 years (only required if you have ever had a malpractice payout on your behalf)
- For any pending case(s), request a status letter to be sent directly to the Board from your attorney

Investigation. If you have ever been notified that you were under investigation by any professional licensing board, hospital, medical society, governmental entity or other agency, whether or not you were charged with or convicted of any violations of a statute, rule or regulation governing your practice as a physician or practice as another provider of health care, you should answer affirmatively to question #31 and submit the appropriate documentation. Provide signed and dated explanations and copies of any related documentation you received regarding any investigation unless otherwise instructed.

Arrest. If you have ever been arrested, please read question #13 carefully. You will be expected to provide a signed and dated explanation addressed to the Nevada State Board of Medical Examiners for any arrest(s) no matter how long ago it may have occurred, whether it was expunged or not. Please be prepared to provide a copy of the arrest report, proof of completion of probation and/or time served, community service, fines paid and any other documentation applicable to the incident(s).

Please Note: Pursuant to NRS 630.173(2), Board staff may ask for more information from you regarding malpractice or hospital privileges history that is older than 10 years when reviewing your application if the Board receives information from you or any other source indicating that there are relevant malpractice or hospital privileges history incidents that should be reviewed further.

More information may be required from you, if either of the following apply:

- Observerships, Externships, Research positions or Research Fellowships prior to completion of your postgraduate training.
- Employment in a medical setting between medical school and postgraduate training or in between postgraduate training years and prior to completion of your postgraduate training.

Release for Communication with a Person other than the Applicant. If you wish to authorize the Board to communicate about the status of your application for licensure with someone other than you, please provide a brief signed written release that includes the name of that individual and that authorizes the Board to communicate information about your application status to that individual.

INSTRUCTIONS
FOR REQUESTING

NATIONAL PRACTITIONER DATA BANK SELF QUERY, ECFMG VERIFICATION AND EXAMINATION SCORES

NATIONAL PRACTITIONER DATA BANK SELF-QUERY:

The request form for the National Practitioner Data Bank (NPDB) is available at http://www.npdb.hrsa.gov. Click on 'Self-Query' for Healthcare Professionals on the right side of the page and follow the instructions provided. If you require additional information, call the NPDB at (800) 767-6732. Once you have received the final report or self-query response from the NPDB, forward a copy of this report to the Board office either by mail, fax or email.

ECFMG VERIFICATIONS

International medical graduates must contact the ECFMG for certification status to be sent to the Nevada State Board of Medical Examiners. The request form can be found on ECFMG's website at www.ecfmg.org. If you are using FCVS, you do not need to contact the ECFMG; FCVS will coordinate with the ECFMG to obtain your certification. For questions or assistance, call ECFMG's Applicant Information Services at (215) 386-5900 or email info@ecfmg.org.

USMLE:

The Federation of State Medical Boards of the United States, Inc.'s (FSMB) will certify a complete history of your scores for a designated examination(s). The FSMB maintains scores for FLEX, SPEX, and the USMLE Steps 1, 2, and 3 electronically. Request transcripts at https://www.fsmb.org/transcripts/. For questions or assistance, call (817) 868-4041 or email usmle@fsmb.org.

ATTENTION APPLICANT!

RESPONSIBILITY STATEMENT

Please sign and return this statement with your application for licensure to:
The Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521

Because you are applying for the privilege of practicing medicine in Nevada, you should know that our state has some of the most stringent licensing requirements and comprehensive investigation programs in the United States.

Via FBI fingerprinting and other investigative modalities, our licensing specialists are likely to discover if data you have submitted on your application is erroneous or incomplete; therefore, you must answer all questions truthfully and completely. Specifically, this includes any sanctions or disciplinary actions you may have experienced during medical school or your postgraduate training, or any involvement you may have had with the legal system, either civil or criminal — criminal to include charges that may have ultimately been expunged, lessened, or dismissed, and no matter how long ago the event(s) occurred.

Explaining and documenting a problem to your licensing specialist will be much less painful than discussing your veracity before the entire Board of Medical Examiners due to inconsistencies between your application and incongruent input from outside sources.

ONLY YOU — NOT A LAWYER, DOCTOR, SPOUSE, OR CREDENTIALING COMPANY — ARE RESPONSIBLE FOR READING AND ANSWERING EVERY QUESTION ACCURATELY AND COMPLETELY.

If you have *any* questions about your application, ASK YOUR LICENSING SPECIALIST. Our licensing specialists are here to help you.

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I have read this responsibility statement and understand that I alone am accountable for completing my application for medical licensure in Nevada.

Print your name _____

Sign your name _____

Date _____

Note: It is your responsibility to keep the Board informed of any circumstance or event that would require a change to your initial responses provided to the Board in your application for licensure, and which occurs prior to you being granted licensure to practice medicine in the state of Nevada.

Nevada Department of
Public Safety

CIVIL APPLICANT WAIVER

NOTICE OF NONCRIMINAL JUSTICE APPLICANT'S RIGHTS

As a applicant who is subject pursuant to NRS 630.167, and who is the subject of a national fingerprint-based criminal history record check for a noncriminal justice purpose (such as an application for employment or a license, an immigration or naturalization matter, security clearance, or adoption), you have certain rights which are discussed below. All notices must be provided to you in writing. These obligations are pursuant to the Privacy Act of 1974, Title 5, United States Code (U.S.C.) Section 552a, and Title 28 Code of Federal Regulations (CFR), 50.12, among other authorities.

1.You must be notified by Nevada State Board of Medical Examiners that your fingerprints will be used to check the criminal history records of the FBI and the State of Nevada.

2.Authority: The FBI's acquisition, preservation, and exchange of fingerprints and associated information is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include Federal statutes, State statutes pursuant to Pub. L. 92-544, Presidential Executive Orders, and federal regulations. Providing your fingerprints and associated information is voluntary; however, failure to do so may affect completion or approval of your application.

3.Principal Purpose: Certain determinations, such as employment, licensing, and security clearances, may be predicated on fingerprint-based background checks. Your fingerprints and associated information/biometrics may be provided to the employing, investigating, or otherwise responsible agency, and/or the FBI for the purpose of comparing your fingerprints to other fingerprints in the FBI's Next Generation Identification (NGI) system or its successor systems (including civil, criminal, and latent fingerprint repositories) or other available records of the employing, investigating, or otherwise responsible agency. The FBI may retain your fingerprints and associated information/biometrics in NGI after the completion of this application and, while retained, your fingerprints may continue to be compared against other fingerprints submitted to or retained by NGI.

4.Routine Uses: During the processing of this application and for as long thereafter as your fingerprints and associated information/biometrics are retained in NGI, your information may be disclosed pursuant to your consent, and may be disclosed without your consent as permitted by the Privacy Act of 1974 and all applicable Routine Uses as may be published at any time in the Federal Register, including the Routine Uses for the NGI system and the FBI's Blanket Routine Uses. Routine uses include, but are not limited to, disclosures to: employing, governmental or authorized non-governmental agencies responsible for employment, contracting, licensing, security clearances, and other suitability determinations; local, state, tribal, or federal law enforcement agencies; criminal justice agencies; and agencies responsible for national security or public safety.

5. If you have a criminal history record, you should be afforded a reasonable amount to time to correct or complete the record (or decline to do so) before the officials deny you the employment, license, or other benefit based on information in the FBI criminal history record. The procedures for obtaining a change, correction, or update of your FBI criminal history record as set forth at, 28 CFR 16.34 provides for the proper procedure to do so.

Applicant's Initials: _____ Date:_____

6. If agency policy permits, the officials may provide you with a copy of your FBI criminal history record for review and possible challenge. If agency policy does not permit it to provide you a copy of the record,

you may obtain a copy of the record by submitting fingerprints and a fee to the FBI. Information regarding this process may be obtained at https://www.fbi.gov/services/cjis/identity-history-summary-checks and https://www.edo.cjis.gov .

7. If you decide to challenge the accuracy or completeness of your FBI criminal history record, you should send your challenge to the agency that contributed the questioned information to the FBI. Alternatively, you may send your challenge directly to the FBI by submitting a request via https://www.edo.cjis.gov . The FBI will then forward your challenge to the agency that contributed the questioned information and request the agency to verify or correct the challenged entry. Upon receipt of an official communication from that agency, the FBI will make any necessary changes/corrections to your record in accordance with the information supplied by that agency. (See 28 CFR 16.30 through 16.34.)

8. You have the right to expect that officials receiving the results of the fingerprint-based criminal history record check will use it only for authorized purposes and will not retain or disseminate it in violation of federal or state statute, regulation or executive order, or rule, procedure or standard established by the National Crime Prevention and Privacy Compact Council.

9. I hereby authorize Nevada State Board of Medical Examiners to submit a set of my fingerprints to the Nevada Department Public Safety, Records Bureau for the purpose of accessing and reviewing State of Nevada and FBI criminal history records that may pertain to me.

10. I hereby release from liability and promise to hold harmless under any and all causes of legal action, the State of Nevada, its officer(s), agent(s) and/or employee(s) who conducted my criminal history records search and provided information to the submitting agency for any statement(s), omission(s), or infringement(s) upon my current legal rights. I further release and promise to hold harmless and covenant not to sue any persons, firms, institutions or agencies providing such information to the State of Nevada on the basis of their disclosures. I have signed this release voluntarily and of my own free will.

A reproduction of this authorization for release of information by photocopy, facsimile or similar process, shall for all purposes be as valid as the original. In consideration for processing my application I, the undersigned, whose name and signature voluntarily appears below; do hereby and irrevocably agree to the above.

Applicant's Name: _____
PLEASE PRINT Last Name First Name Middle

Applicant's Signature: _____

Date: _____

Agency Account #: 881183

Agency Representative: _____
PLEASE PRINT Linn Kory

Agency Representative Signature: *K. Linn, Chief of Licensing*

Date: 1.31.23

TRANSITIONAL LIMITED PHYSICIAN (M.D.)
APPLICATION FOR LICENSURE
NEVADA STATE BOARD OF
MEDICAL EXAMINERS

9600 Gateway Drive Reno, Nevada 89521
Phone (775) 688-2559

Date Received by Board

License No._____

File No._____

For Board Use Only

Identity:

1. Present Legal Name _____
Last First Middle Maiden

List any other name(s) ever used _____

Address:

The **Public Address** you provide will be displayed on the Board's website and will serve as your official contact address once licensed.
The **Mailing Address** is used for Board correspondence and will remain confidential unless it is also designated as your Public Address. You may use the same address for both your Public Address and Mailing Address. **Any change to either address must be reported to the Board within 30 days.**

2. Public Address _____
Street City County State Zip

☐ Please check if you choose to have your Mailing Address the same as the Public Address you have entered above.

3. Mailing Address _____
Street City County State Zip

4. TelephoneNumbers _(____)_____(____)_____ _(____)_____ _(____)_____
Office Fax Home Cellular (Optional)

Email address _____

5. Date of Birth _____Place of Birth _____Gender____F____M
(Month / Day / Year) (City, State, Country)

6. Citizenship: U.S. Citizen _____ Non-U.S. Citizen (please indicate country of citizenship) _____

Non U.S. Citizen: Individual Taxpayer Identification Number (TIN) _____

To prove your identity, you must submit a copy of your birth certificate or certificate of naturalization, or a copy of your current U.S. passport or a current foreign passport. The copy of your identification document(s) must be submitted with a notarized Certificate of Identification.
Please note: If you name has been legally changed and does not match the name on your identity document, you must include a copy of the legal document that changes your name (marriage license, divorce decree, court order, or other document).

7. Social Security Number/ITIN_____ Color of Eyes _____ Color of Hair _____ Height _____ Weight _____

NRS 630.197 and NRS 622.238 require that all applicants provide a social security number or a ITIN in their applications for licensure in the State of Nevada.

Questions:

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 SIGNED WRITTEN EXPLANATION(S) ON A SEPARATE SHEET ATTACHED TO YOUR COMPLETED *APPLICATION FOR LICENSURE* FORM.

8. Do you currently have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety?
(If "Yes," attach explanation on separate sheet.) _____Yes _____No

9. 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?
(If "Yes," attach explanation on separate sheet.) _____Yes _____No _____N/A

10. 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?
(If "Yes," attach explanation on separate sheet.) _____Yes _____No _____N/A

11. Have you failed to initiate the performance of public service within one year after the date the public service is required to begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local government for your medical education?
(If "Yes," attach explanation on separate sheet.) _____Yes _____No

Malpractice Questions:

12. Have you EVER 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

12a. Have you EVER 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

Malpractice Explanation(s):

List of all claims or suits for medical malpractice made against you. A claim is any formal or informal demand for payment to any person or organization. If have not answered "yes" to questions #12 and/or #12a and do not have any such claims or suits, this section will be left blank. If you have more than 1 claim, make a copy or copies of this page and submit all explanations with your application for licensure.

Name of patient involved:

In which state did the action take place?

Case number (if applicable):

Which court?
(If settled before initiation of civil action, state here.)

Current status of claim:

☐ Open ☐ Closed (settled or judgment) ☐ Dismissed (no money paid out) ☐ Other

Date claim was closed/settled or dismissed: _____
Month/Year

Amount of judgment or settlement $

Month and year of event precipitating claim:

Month and year of lawsuit:

Insurance carrier at time:

What is/or was your status? ☐ Primary defendant ☐ Co-defendant ☐ Other

Please provide specifics in reference to the adverse event including the allegations and your role in the event:

Arrest Question:

13. Have you EVER 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. _____Yes _____No

(If "Yes," attach explanation on separate sheet.)

License History:

14a. Have you applied for a license to practice medicine or as another health care provider in a country other than the United States?

_____Yes _____No

If yes, please list the countries, application dates, and results of those applications (i.e., licensure granted, denied, or other action taken). If licensure was granted, please include the dates of licensure and the status of the license that was issued.

Country	Application Date	Result	Issue Date	Expiration Date	Current Status

(All information must begin on the application. If more space is needed, please attach separate sheet.)

14b. Have you previously applied for medical licensure or for licensure as another health care provider in Nevada? _____Yes _____No

If yes, please list the licensing boards, application dates, and licensing categories that you have applied for in Nevada and the results of those applications, (i.e., licensure granted, denied, or other action taken). If licensure was granted, please include the dates of licensure and the status of the license that was issued.

Licensing Board	Application Date	Category	Result	Issue Date	Expiration Date	Current Status

(All information must begin on the application. If more space is needed, please attach separate sheet.)

14c. Have you previously applied for medical licensure or for licensure as another health care provider in another state or territory of the United States?

_____Yes _____No

If yes, please list the states or territories, licensing board, and licensing categories that you have applied for in those jurisdictions and the results of those applications (i.e., licensure granted, denied, or other action taken). If licensure was granted, please include the dates of licensure and the status of the license that was issued.

.

State/Territory	Application Date	Category	Result	Issue Date	Expiration Date	Current Status

(All information must begin on the application. If more space is needed, please attach separate sheet.)

Medical School and Postgraduate Training History:

15. List names and addresses of all medical schools attended. **HAVE EACH MEDICAL SCHOOL SUBMIT AN OFFICIAL VERIFICATION AND TRANSCRIPT DIRECTLY TO THE BOARD.**

Medical School Name	City/State/Country	Place Where Instruction Received	Dates of Attendance From (Mo./Yr.) To (Mo./Yr.)

(All information must begin on the application. If more space is needed, please attach separate sheet.)

16. Doctor of Medicine Degree granted by:

Medical School Name	City/State/Country	Exact Date of Issuance (Month/Day/Year)

17. List all postgraduate medical education you have received as an Intern, Resident or Fellow **in any country**, if applicable.

Postgraduate Year (e.g. PGY1, PGY2, etc.)	Hospital/ Institution	City/State/Country	Specify (I =Internship or R = Residency) (F = Fellowship)	Type of Specialty	Dates of Attendance From (Mo./Yr.)	To (Mo./Yr.)

(All information must begin on the application. If more space is needed, please attach separate sheet.)

18. Have you EVER been the subject of an investigation (including matters that resulted in no adverse action or outcome to you), have you resigned, been dismissed, or have any actions, restrictions, limitations, probations, terminations or any other disciplinary actions ever been imposed on you while participating in any type of training program? (If "Yes," attach explanation on separate sheet.) _____Yes _____No

19. List your ECFMG#:_____

Examinations:

20. List the location, steps, dates taken, and scores obtained. (Also include failed examinations) **HAVE TRANSCRIPT SUBMITTED FROM USMLE DIRECTLY TO THE BOARD OFFICE.**

USMLE (United States Medical Licensing Examination): (ALSO INCLUDE ALL INFORMATION PERTAINING TO ANY AND ALL FAILED EXAMS)

Step Taken	Number of Attempts	Date (Mo./Yr.)	Results (Three Digit Scores)

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

Specialty:

21. **A transitional limited physician may practice only in the specialties of internal medicine, family medicine or pediatrics**.

Please list your specialty_____

Activities and Work Experience:

22. Account for, **in chronological order**, all activities and/or work experience for the five (5) years preceding your application submission date. **ALL PERIODS OF TIME MUST BE ACCOUNTED FOR.** This may include Postgraduate Training, Medical Practice/Physician, Non-Medical (such as seeking employment or vacation), Military Assignment, Research/Observership, and Working at a Federal Facility. For work activities, please include your job title and employer name. If you have engaged in medical practice or practice as a licensed health care provider in this time period, please include the percentage of time that your work has involved clinical practice or patient care. **Curriculum Vitae cannot be submitted in lieu of your answer to this question.**

Activity/Employment Information	Location (City/State/Country)	From (Mo./Yr.) To (Mo./Yr.)	Percent Clinical (%)

(All information must begin on the application. If more space is needed, please attach separate sheet.)

23. List below the requested information for all hospitals or surgery centers in which you **ARE, OR HAVE EVER BEEN** a staff member at any level during the last ten years. If none, please indicate. Do not list internship, residency or fellowship affiliation.

Hospital	Complete Mailing Address	Dates of Appointment From (Mo./Yr.)	To (Mo./Yr.)

(All information must begin on the application, if more space is needed, please attach separate sheet.)

Disciplinary Questions:

24. Have you EVER 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 U.S. state or territory or other country or jurisdiction? (If "Yes," attach explanation on separate sheet.) _____Yes _____No

25. Have you EVER had a medical license or license to practice any other healing art revoked, suspended, limited, or restricted any U.S. state or territory or other country or jurisdiction? (If "Yes," attach explanation on separate sheet.) _____Yes _____No

26. Have you EVER voluntarily surrendered a license to practice medicine or any other healing art any U.S. state or territory or other country or jurisdiction in lieu of disciplinary action? (If "Yes," attach explanation on separate sheet.) _____Yes _____No

27. Have you EVER been denied membership, asked to resign, or expelled from a medical society or other professional medical organization? (If "Yes," attach explanation on separate sheet.) _____Yes _____No

28. Have you EVER 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 agency other than the Nevada State Board of Medical Examiners? (If "Yes," attach explanation on separate sheet.) _____Yes _____No

29. If you have held a state or federal controlled substance registration, have you EVER surrendered it or had it revoked or restricted in any way? (If you have not held a controlled substance registration in the past, please answer No.) _____Yes _____No

(If "Yes," attach explanation on separate sheet.)

30. List all hospitals where you have had staff privileges denied, suspended, limited, revoked or not renewed by the hospital. List any (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.)

(All information must begin on the application, if more space is needed, please attach separate sheet.)

Attestations/Affirmations:

CHILD SUPPORT STATEMENT

The law of the state of Nevada requires that all applicants for issuance of a license be required to provide the following information concerning the support of a child. You are advised that this questions is part of your application, your response is given under oath, and any response hereto which is false, fraudulent, misleading, inaccurate or incomplete, may result in your application being denied. You must mark one of the following responses, and failure to mark one of the responses may result in denial of your application.

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

http://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

COMMUNICATIONS AFFIRMATION

Consent to accept communications and service of process from the Nevada State Board of Medical Examiners (Board) by electronic mail, for physicians and physician assistants who practice medicine in the state of Nevada or via telemedicine and whose physical presence exists outside the state of Nevada or the United States.

I am willing to accept Board communications to me, to include service of process as defined under Nevada Revised Statute (NRS) 630.344, via electronic mail (more commonly known as e-mail). Further, should the electronic mail address provided below change for any reason, I agree to apprise the Board in writing of my new electronic mail address within 30 days after the change.

Printed Name of Applicant/Licensee: _____

Signature of Applicant/Licensee: _____

Electronic Mail Address: _____

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
- ☐ Space Force

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? (Unless you were dishonorably discharged, your answer should be "Yes.") _____Yes _____No_____N/A

APPLICANT PHOTOGRAPH

ATTACH A FINISHED PHOTOGRAPH OF PASSPORT QUALITY OF YOUR HEAD AND SHOULDERS ONLY.

PHOTOGRAPH MUST HAVE BEEN TAKEN WITHIN THE LAST SIX MONTHS AND BE AT LEAST 2" x 2" IN SIZE.

CENTER AND ATTACH PHOTOGRAPH HERE.

I hereby certify that the attached photograph is a true likeness of me taken within the last six months.

_____ _____

Signature of applicant **Date**

TRANSITIONAL LIMITED PHYSICIAN LICENSE ATTESTATION

I hereby affirm that I understand that, if my application is granted, I will have a transitional limited physician (TLP) license to practice medicine in the State of Nevada. I understand that I will not be able to practice medicine outside of the supervision of my approved supervising physician, my approved written practice agreement, and my approved employment. I further understand that my practice in the State of Nevada will be limited to the specialty of my supervising physician and as designated on my TLP license which must be family medicine, internal medicine, or pediatrics. I understand that I must have (1) an approved supervising physician, (2) an approved written practice agreement on file with the Board, and (3) approved employment pursuant to NRS 630.2667(2)(b) prior to providing medical services as a TLP in the State of Nevada, and I must cease providing medical services as a TLP if any of these three items is terminated and notify the Board of that fact within 72 hours.

APPLICATION AFFIRMATION

I, _____,
(Print your full name)

being duly sworn, depose and say: That the answers to the foregoing questions and statements made in the above application, as well as any and all further explanations contained on any separate attached pages, are true and correct, that I am the person named in the credentials to be submitted, and that the same were procured in the regular course of instruction and examination without fraud or misrepresentation. I understand that if any of my responses on this application are false, fraudulent, misleading, inaccurate, or incomplete, my application for licensure will be denied.

I am responsible to keep the Board informed of any circumstance or event that would require a change to my initial responses provided to the Board in my application for licensure, and which occurs prior to my being granted licensure to practice medicine in the State of Nevada.

_____ _____
Signature of applicant **Date**

(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

END OF APPLICATION

FORM A

RELEASE

I hereby authorize all hospitals, medical institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Nevada State Board of Medical Examiners any information, files or records required by the Nevada State Board of Medical Examiners for its evaluation of my professional, ethical, physical, and mental qualifications for licensure in the state of Nevada.

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

A photocopy of this form will serve as an original (Board use only).

Please return completed form to:

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

FORM B

LIST OF MALPRACTICE INSURANCE CARRIERS

If you answered affirmatively to questions #12 and/or #12a on the Application for Licensure, list all malpractice carriers you have held within the past ten (10) years.

Name of Insured: ______________________________

Insurance Company: ______________________________
Address: ______________________________
____
Phone Number: ______________________________
Fax Number: ______________________________
Policy Number: ______________________________
Dates: ______________________________

Insurance Company: ______________________________
Address: ______________________________
____
Phone Number: ______________________________
Fax Number: ______________________________
Policy Number: ______________________________
Dates: ______________________________

Insurance Company: ______________________________
Address: ______________________________
____
Phone Number: ______________________________
Fax Number: ______________________________
Policy Number: ______________________________
Dates: ______________________________

Insurance Company: ______________________________
Address: ______________________________
____
Phone Number: ______________________________
Fax Number: ______________________________
Policy Number: ______________________________
Dates: ______________________________

Insurance Company: ______________________________
Address: ______________________________
____
Phone Number: ______________________________
Fax Number: ______________________________
Policy Number: ______________________________
Dates: ______________________________

(If more space is needed, please copy this page or attach a separate sheet.)

Applicant: *Each medical school where instruction was received must complete this form. If more than one medical school was attended, photocopies of this blank form may be made and used. The Board also requires medical school transcripts to be sent directly from the medical school to the Nevada State Board of Medical Examiners.*

FORM 1

NEVADA STATE BOARD OF MEDICAL EXAMINERS
VERIFICATION OF MEDICAL EDUCATION

This certifies that _____
(name of applicant)

was enrolled in _____
(name of Medical School) (Location – City / State / Country)

The following information is to be completed by the medical school only.

The undersigned further certifies that the records of this institution show that the applicant attended this institution

from _____ to _____
(month / year) (month / year)

Please check one:

☐ The applicant was granted a medical degree by

☐ The applicant withdrew from

the above named Medical School on _____
(month / day / year)

ADVANCED (TRANSFER) CREDITS – Credits Granted Upon Admission from another Medical Institution

_____ _____ _____
(name of Medical or Professional School) (total credits) (dates attended - month/ year to month/ year)

Signed and the institutional seal affixed this

_____ day of _____ , 2 _____

By: _____
(typed name and title of President, Registrar or Dean)

Affix Seal Here

_____
(signature of President, Registrar or Dean) **

Telephone: _____
Fax: _____
Email: _____

** Signatures by personnel other than the President, Registrar or Dean must attach documentation granting authorization to sign in lieu of the President, Registrar or Dean.

Completed form is to be mailed by the verifying institution directly to:

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

Medical School : *If you have questions, you may contact the Board at (775) 688-2559. The Board requires that this verification form be received by mail and NOT by facsimile.* ***Emails may be sent to nsbme@medboard.nv.gov***

Applicant: *Send verification form to each postgraduate institution wherein you received Internship, Residency, and/or Fellowship training. Each separate program/department will complete and send the form to the Board directly via mail/email.*

FORM 2

NEVADA STATE BOARD OF MEDICAL EXAMINERS
VERIFICATION OF POSTGRADUATE TRAINING

Institution: _____ **Street Address:** _____

Affiliated University: _____ **City/State/Zip:** _____

Accredited by: ☐ ACGME ☐ Not Accredited ☐ Other: Choose an item. **Accreditation Code** *(if applicable)*: _____

Physician Name: _____ **DOB**: _____ **SSN/ITIN:** _____
(Last four digits only)

The following is to be completed by the postgraduate training program only.

Program Participation:
–IMPORTANT–

Report Internships, Residencies, and Fellowships separately.

Report incomplete postgraduate years (PGY) separately from those that were successfully completed.

If the postgraduate year is currently "In Progress", report the expected completion date in the 'End Date' Field.

Separate verification forms must be provided for each Department/Specialty.

PG/Year(s): _____ *(e.g. 1, 2-5)*
☐ Internship
☐ Residency
☐ Fellowship
☐ Research

Specialty/Subspecialty: _____

Start Date: _____ *(mm/dd/yyyy)* **End Date:** _____ *(mm/dd/yyyy)*

Successfully Completed? ☐Yes ☐No ☐In Progress

If "No", was credit awarded? ☐Yes ☐No

PG/Year(s): _____ *(e.g. 1, 2-5)*
☐ Internship
☐ Residency
☐ Fellowship
☐ Research

Specialty/Subspecialty: _____

Start Date: _____ *(mm/dd/yyyy)* **End Date:** _____ *(mm/dd/yyyy)*

Successfully Completed? ☐Yes ☐No ☐In Progress

If "No", was credit awarded? ☐Yes ☐No

PG/Year(s): _____ *(e.g. 1, 2-5)*
☐ Internship
☐ Residency
☐ Fellowship
☐ Research

Specialty/Subspecialty: _____

Start Date: _____ *(mm/dd/yyyy)* **End Date:** _____ *(mm/dd/yyyy)*

Successfully Completed? ☐Yes ☐No ☐In Progress

If "No", was credit awarded? ☐Yes ☐No

Unusual Circumstances: *Check the correct response to the following questions.*

1. Did this individual ever take a leave of absence or break from their training? ☐Yes ☐No
   If "Yes", please include dates: mm/yyyy – mm/yyyy
2. Was this individual ever disciplined or placed under investigation/on probation? ☐Yes ☐No
3. Were any negative reports/limitations/special requirements for behavioral reasons/academic incompetence/disciplinary problems/etc. ever filed? ☐Yes ☐No

Provide a written explanation for any "Yes" responses *(a separate page may be used, if necessary):*

_____

_____

Signatory: *This section **MUST** be signed by the Program Director (M.D. or D.O.) or the Designated Institutional Officer (DIO).*
†*Any other signatory must include a letter of authorization.*

I CERTIFY THAT, to the best of my knowledge and belief, the foregoing is a true, accurate, and complete statement of the record of the individual named on this form.

Name *(Print)*: _____ ☐M.D. ☐D.O. **Signature:** _____
(wet/handwritten or authenticated digital signature)

Title: ☐Program Director ☐DIO ☐ Other† *(specify):* _____ **Date of Signature:** _____

Telephone: _____ **Fax:** _____ **Email:** _____

The completed verification form must be sent by the verifying institution directly to the Board by mail or email only.

Mail: *Nevada State Board of Medical Examiners, 9600 Gateway Drive, Reno, NV 89521*
Email: *nsbme@medboard.nv.gov* or the Applicant's License Specialist

Training Program: *If you have any questions, please contact the Board at (775) 688-2559 or the Applicant's License Specialist.*

Revised 1.13.2026

Applicant: *If you answered affirmatively to questions #12 and #12a on the Application for Licensure, complete both the top portion and release area of this form; have this form notarized, and submit this form to all malpractice carriers verifying coverage within the past 10 years. Copies of this form may be used if you have more than one malpractice carrier.*

FORM 4

MALPRACTICE CLAIM VERIFICATION REQUEST

Insurance Carrier Information:

Name of Insured Physician**:** _____

Name of Insurance Company: _____

Address: _____

_____

_____

Phone: _____ Fax: _____

To be completed by verifying agency only

Policy Number: _____

Policy Period From: _____ To: _____

**Please provide a loss history report with this verification.

Claims Experience:

Has this Physician had a settlement paid on his/her behalf? _____Yes _____No

If "yes", please provide the following information:

Occurrence Date	*Status*	*Date Closed*	*Indemnity Amount*
_____	_____	_____	_____

Description of Claim:

_____

_____

_____

Insurance Carrier Agent:

_____
Print Name and Title

_____
Signature of Agent

_____
Telephone

_____
Email address

Please mail 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

Subscribed and sworn to before me this _____ day of

_____, 2_____,

Notary Public for the State of _____

My Commission Expires: _____

Residing at: _____
City State

_____
Signature and Seal of Notary Public

Malpractice Insurance Carrier: *If you have questions, you may contact the Nevada Board at (775) 688-2559.*

Applicant: *If you answered affirmatively to questions #31 (with regard to hospital investigations) and/or #33 on the Application for Licensure, 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.*

FORM 5

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

Attn: Medical Staff Office

Hospital: _____

Address: _____

_____

Physician's Name: _____

Physician's DOB: _____

Specialty: _____

Affiliation dates: _____

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.

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: _____

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

_____, 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

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

CERTIFICATION OF IDENTIFICATION

Certification by Notary Public Is Required

Applicant Full Legal Name: _____
Last First Middle

Applicant:

1. **COMPLETE** this document in the presence of a Notary.
2. **SELECT** the identity document used:

- ☐ Birth Certificate
- ☐ Passport
- ☐ Certificate of Naturalization

3. **ATTACH** a photocopy of the identity document presented to the Notary.

Notary Public: Please complete the section below.

Notary Exception – A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of _____ County of _____

On the date set forth below, the individual named above, did appear personally before me and presented one of the following forms of identification as proof of his/her identity (Birth Certificate, Current Passport or Certificate of Naturalization). I identified this applicant by comparing his/her physical appearance with the photograph on a government issued photo identification presented by the applicant.

(Day)_____, of (Month)_____, (Year)_____.

Notary Public Signature: _____

Commission Expiration Date* (Month)_____/ (Day)_____/ (Year)_____

***The notary's commission expiration date must be current and legible. If no expiration date, such as 'lifetime', an explanation must be provided. If you are in California, the notary may attach a California All-Purpose Acknowledgment form to this document.**

Notary Stamp Here

CREDIT CARD AUTHORIZATION FORM

If mailing or faxing this page separately from an application or order form, 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.

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

Name on Credit Card: _____

Business Name (if applicable): _____

Credit Card Billing Address:

_____

_____

_____

Phone Number: _____

Name of Applicant (if applying for licensure): _____

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 $_____.

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 do not wish to pay the fee, you can select another payment option.