

**NEVADA STATE BOARD OF MEDICAL EXAMINERS**  
**FEEES FOR PHYSICIAN ASSISTANT LICENSURE**  
***BETWEEN JULY 1, 2011 AND JUNE 30, 2013***

ONLY original applications for licensure sent from The Nevada State Board of Medical Examiners or downloaded online applications will be accepted. Any applications which appear to have been altered in any form will not be accepted. Applications must be received on single sided white bond paper, 8 ½" x 11" in size.

Applications not completed within six (6) months from date of receipt will be rejected per NAC 630.180(2).

**PHYSICIAN ASSISTANT LICENSURE FEES:**

**\$300 Application Fee    \$400 Registration Fee    \$75 Criminal Background Investigation Fee    =    \$775.00**

**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%) service fee will be assessed for payment by credit card.**

The Application fee and Criminal Background Investigation fee will not be refunded.

The Board's staff conducts an investigation into your background 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. Under Nevada law, a public body cannot hold a meeting to consider the character, alleged misconduct, professional competence, or physical or mental health of any person unless it has given written notice to that person of the time and place of the meeting. The written notice must be sent by certified mail to the last known address of that person at least 21 working days before the meeting. A public body must receive proof of service of the notice before such a meeting may be held.

- \*\* 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, 20, 21, 22, 23, 24, 25 and 26.

If, at the time you meet with the Board, the Board votes to deny or not accept your application for licensure, this denial or non-acceptance of your application may become a reportable action to the Healthcare Integrity and Protection Data Bank, Federation of State Medical Boards of the United States, Inc. and American Medical Association, among other entities.

There are **NO** waivers or exceptions to the requirements for physician assistant licensure in the state of Nevada.

**PHYSICIAN ASSISTANT  
APPLICATION CHECKLIST  
TO BE RETURNED DIRECTLY TO BOARD OFFICE BY APPLICANT**

	a.	<p><b>APPLICATION:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Properly completed, signed and notarized application, including pages 1 – 5, Applicant Responsibility statement, and Criminal Background Investigation report authorization form;</li> <li><input type="checkbox"/> Recent passport quality photograph (at least 2”x 2”) attached to application, signed in ink on lower front edge;</li> <li><input type="checkbox"/> Appropriate explanations and copies of all pertinent documentation must be attached for affirmative responses to questions numbered 8, 9, 10, 11, 12, 12a, 13, 20, 21, 22, 23, 24, 25, and 26;</li> <li><input type="checkbox"/> Release form - signed and notarized (Form A);</li> </ul>
	b.	<p><b>FEES:</b></p> <ul style="list-style-type: none"> <li>• Proper application, registration, 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. Note: Application and criminal background investigation fees are <u>non-refundable</u>;</li> </ul>
	c.	<p><b>IDENTITY</b> (Important identity documents will be returned to you via secured mail):</p> <ul style="list-style-type: none"> <li>• U.S. born citizens – Original or Certified Birth Certificate that bears an original seal or stamp of the issuing agency (notarized copies are not acceptable);</li> <li>• Foreign-born citizens - Original Certificate of Naturalization or current U.S. Passport;</li> <li>• Non U.S. citizens - Copy of both sides of Alien Registration card or Employment Authorization card or Visa;</li> </ul>
	d.	<p><b>SUPPLEMENTARY FORM:</b></p> <ul style="list-style-type: none"> <li>• <b>MALPRACTICE INSURANCE CARRIER (Form B): ONLY</b> if you have answered affirmatively to either of the two malpractice questions (questions #12 and #12a) on the application;</li> </ul>
	e.	<p><b>EDUCATION:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Copy of high school transcripts or diploma;</li> <li><input type="checkbox"/> Copy of transcripts or diplomas for degrees other than Physician Assistant degree – an Associates, Bachelors or Masters Degree that you would like added to your educational profile on the Board’s website;</li> </ul>
	f.	<p><b>NOTIFICATION OF SUPERVISION</b></p> <ul style="list-style-type: none"> <li>• Pre-licensure notification for supervision of Physician Assistant to Nevada State Board of Medical Examiners (signed and notarized);</li> </ul>
	g.	<p><b>CONTINUING EDUCATION:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Proof of 4 hours bio-terrorism <u>AMA Category 1</u> continuing medical education (CME) relating to the medical consequences of an act of terrorism that involves the use of a weapon of mass destruction. Search for an online course by entering “AMA Category 1 bioterrorism continuing medical education” or take a classroom course;</li> <li><input type="checkbox"/> Review guidelines of the Centers for Disease Control and Prevention concerning the transmission of infectious agents through safe injection practices; (you will be required to attest within the application that you have reviewed these guidelines.)</li> </ul> <p><a href="http://www.cdc.gov/hicpac/2007IP/2007isolationPrecautions.html">http://www.cdc.gov/hicpac/2007IP/2007isolationPrecautions.html</a> - or - <a href="http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf">http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf</a></p>
	h.	<p><b>EXAMINATION REGARDING NEVADA LAW GOVERNING YOUR MEDICAL PRACTICE:</b></p> <ul style="list-style-type: none"> <li>• Jurisprudence examination familiarizing you with the Medical Practice Act (Nevada Revised Statutes, Chapters 630 and 629 and Nevada Administrative Code, Chapter 630) will <b>be mailed to you upon acknowledgement of receipt of your application and appropriate fees.</b> You must answer correctly at least 75% of the questions.</li> </ul>

## PHYSICIAN ASSISTANT APPLICATION CHECKLIST

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

_____	a.	<b>PHYSICIAN ASSISTANT SCHOOL:</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> Verification of completion of Physician Assistant Education (Form 1);</li> <li><input type="checkbox"/> Official transcripts from Physician Assistant program;</li> </ul>
_____	b.	<b>EXAMINATION:</b> <ul style="list-style-type: none"> <li>• Current certification by the National Commission on Certification of Physician Assistants (Form 2);</li> </ul>
_____	c.	<b>STATE LICENSE VERIFICATIONS:</b> <ul style="list-style-type: none"> <li>• Verification of licensure/certification from ALL states where applicant is currently licensed/certified or has ever been licensed/certified (Form 3) [does not include training licenses or temporary permits];</li> </ul>
_____	d.	<b>LETTERS OF REFERENCE FROM PHYSICIANS:</b> <ul style="list-style-type: none"> <li>• Two current, original letters of reference from physicians who have worked with you within the past 12 months on business letterhead and envelope sent directly from the physicians;</li> <li><input type="checkbox"/> Requested letter # 1</li> <li><input type="checkbox"/> Requested letter # 2</li> </ul>
_____	e.	<b>MALPRACTICE INSURANCE CARRIER VERIFICATIONS:</b> <ul style="list-style-type: none"> <li>• 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 occurred within the past 10 years (see Disclaimer below);</li> </ul>
_____	f.	<b>FINGERPRINTS:</b> <ul style="list-style-type: none"> <li>• FBI Criminal history background report – returned directly by the verifying institution to the Board office. <b>(Once application fees have been received, fingerprint cards and instructions will be mailed to the applicant. Note: The Board fingerprint cards contain the necessary Board account numbers required for processing.)</b></li> </ul>

**Disclaimer: Per Nevada Revised Statute 640.173(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.**

# Nevada Administrative Code – Physician Assistant Licensure

**NAC 630.280 Qualifications of applicants. (NRS 630.130, 630.275)** An applicant for licensure as a physician assistant must have the following qualifications:

1. If he has not practiced as a physician assistant for 12 months or more before applying for licensure in this State, he must, at the order of the Board, have taken and passed the same examination to test medical competency as that given to applicants for initial licensure.
2. Be able to communicate adequately orally and in writing in the English language.
3. Be of good moral character and reputation.
4. Have attended and completed a course of training in residence as a physician assistant approved by the Committee on Allied Health Education and Accreditation, the Commission on Accreditation of Allied Health Education Programs or the Accreditation Review Committee on Education for the Physician Assistant, which are affiliated with the American Medical Association.
5. Be certified by the National Commission on Certification of Physician Assistants.
6. Possess a high school diploma, general equivalency diploma or postsecondary degree.

## **NAC 630.290 Application for license. (NRS 630.130, 630.275)**

1. An application for licensure as a physician assistant must be made on a form supplied by the Board. The application must state:
  - (a) The date and place of the applicant's birth and his sex;
  - (b) The applicant's education, including, without limitation, high schools and postsecondary institutions attended, the length of time in attendance at each and whether he is a graduate of those schools and institutions;
  - (c) Whether the applicant has ever applied for a license or certificate as a physician assistant in another state and, if so, when and where and the results of his application;
  - (d) The applicant's training and experience as a physician assistant;
  - (e) Whether the applicant has ever been investigated for misconduct as a physician assistant or had a license or certificate as a physician assistant revoked, modified, limited or suspended or whether any disciplinary action or proceedings have ever been instituted against him by a licensing body in any jurisdiction;
  - (f) Whether the applicant has ever been convicted of a felony or an offense involving moral turpitude;
  - (g) Whether the applicant has ever been investigated for, charged with or convicted of the use or illegal sale or dispensing of controlled substances; and
  - (h) The various places of his residence from the date of:
    - (1) Graduation from high school;
    - (2) Receipt of a high school general equivalency diploma; or
    - (3) Receipt of a postsecondary degree, whichever occurred most recently.
2. An applicant must submit to the Board:
  - (a) Proof of completion of an educational program as a physician assistant:
    - (1) If the applicant completed the educational program on or before December 31, 2001, which was approved by the Committee on Allied Health Education and Accreditation or the Commission on Accreditation of Allied Health Education Programs; or
    - (2) If the applicant completed the educational program on or after January 1, 2002, which is accredited by the Accreditation Review Commission on Education for the Physician Assistant or approved by the Commission on Accreditation of Allied Health Education Programs;
  - (b) Proof of passage of the examination given by the National Commission on Certification of Physician Assistants; and
  - (c) Such further evidence and other documents or proof of qualifications as required by the Board.
3. Each application must be signed by the applicant and sworn to before a notary public or other officer authorized to administer oaths.
4. The application must be accompanied by the applicable fee.
5. An applicant shall pay the reasonable costs of any examination required for licensure.

**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)

**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; violating remediation agreement. [Effective through June 30, 2011.]** 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.

(Added to NRS by 1983, 302; A 1985, 2238; 1987, 199, 800, 1554, 1575; 2007, 3046; 2009, 533, 879, 2961, 2962, effective July 1, 2011)

**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)

# ATTENTION APPLICANT!

## RESPONSIBILITY STATEMENT

**Please sign and return this statement with your application for licensure to:  
The Nevada State Board of Medical Examiners,  
P.O. Box 7238, Reno, NV 89510  
or  
1105 Terminal Way, Ste 301, Reno, NV 89502**

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 your 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.

○ ○ ○ ○ ○

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 occur prior to you being granted licensure to practice medicine in the State of Nevada.

APPLICATION FOR LICENSURE

License No. \_\_\_\_\_

NEVADA STATE BOARD OF

MEDICAL EXAMINERS

File No. \_\_\_\_\_

Post Office Box 7238 Reno, Nevada 89510 Phone (775) 688-2559
Physical Address: 1105 Terminal Way, Suite 301 Reno, Nevada 89502

(For Board Use Only)

1. Present Legal Name Last First Middle Maiden

List any other name ever used \_\_\_\_\_

2. Business and/or Mailing Address Street City County State Zip

3. Home Address Street City County State Zip

4. Telephone Number Office Home Fax Number Cellular Number (Optional) Email address

5. Date of Birth (Month / Day / Year) Place of Birth (City / State / Country) Gender F M

6. Citizenship: U.S. Citizen Alien Registration # Employment Authorization # Applying for Visa
Submit a certified birth certificate or original Certificate of Naturalization or current U.S. passport or copy of the front and back of your alien registration card, Employment Authorization or Visa. Please note: Copy of the document authorizing your name change (marriage license, divorce decree, etc) must be included.

7. Social Security Number Height Weight Color of Eyes Color of Hair
NRS 630.165(3) An application submitted pursuant to subsection 1 or 2 must include the social security number of the applicant;
NRS 630.165(5) The applicant bears the burden of proving and documenting his qualifications for licensure.
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.

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

"Ability to practice as a physician assistant" 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 LICENSURE FORM.

8. Do you currently have a medical condition which in any way impairs or limits your ability to practice as a physician assistant with reasonable skill and safety? Yes No

9. If you currently have a medical condition which in any way impairs or limits your ability to practice as a physician assistant, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? Yes No N/A

10. If you currently use chemical substances, does your use in any way impair or limit your ability to practice as a physician assistant with reasonable skill and safety? 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? Yes No

12. Have you EVER been named as a defendant, or been requested to respond as a defendant or potential defendant, to a legal action involving professional liability (malpractice), including any military tort claims, if applicable? (If "Yes," attach explanation on separate sheet.) (IF ANSWER IS "YES", YOU MUST COMPLETE FORM B AND FORM 6 - see Application Checklist.) Yes No

12a. 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

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. (If "Yes," attach explanation on separate sheet.)  Yes  No

14. Have you previously applied for physician assistant licensure in Nevada?  Yes  No

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

15. List all schools attended (including high school), type of degree received and dates of attendance. Also list your Physician Assistant school information.

Name	City/State	Type of Degree Received	Dates of Attendance From (Mo/Yr) To (Mo/Yr)
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16. Physician Assistant Certificate / Degree granted by:

Physician Assistant School	City / State	Exact Date of Issuance
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17. Account for, in chronological order, all activities since graduation from Physician Assistant School. ALL PERIODS OF TIME MUST BE ACCOUNTED FOR.

Activities	Location (City/State/Country)	From (Mo./Yr.) To (Mo./Yr.)
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18. List any and all licenses (including training licenses and permits) YOU HOLD OR HAVE HELD to practice as a physician assistant in any state, territory or country.

State/Territory/Country	License #	Date of Issuance (Mo/Yr)	Date of Expiration (Mo/Yr)
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19. Are you currently certified by the National Commission for the Certification of Physician Assistants?  Yes  No

If "Yes:" certification number \_\_\_\_\_ certification expires \_\_\_\_\_

If "No:" date scheduled to sit for the examination \_\_\_\_\_

20. Have you ever been denied a license or certificate to practice as a physician assistant, or in any other healing art, or permission to take an examination to practice as a physician assistant or in any other healing art(s) in any state, country or U.S. territory?  Yes  No

21. Have you ever had a physician assistant license or certificate, or license or certificate to practice in any other healing art, revoked, suspended, limited, or restricted in any state, country or U.S. territory?  Yes  No

22. Have you ever voluntarily surrendered a license or certificate to practice as a physician assistant, or in any other healing art, in any state, country or U.S. territory?  Yes  No

23. Have you ever failed the NCCPA examination, or any state or other jurisdiction examination for certification as a physician assistant?  Yes  No

24. 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 assistant by any medical licensing board, hospital, medical society, governmental entity or other agency other than the Nevada State Board of Medical Examiners? \_\_\_\_\_ Yes \_\_\_\_\_ No

25. Have you ever surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? \_\_\_\_\_ Yes \_\_\_\_\_ No

26. 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, please attach separate sheet .)

**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.

**SAFE INJECTION PRACTICE ATTESTATION**

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

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.

Applicant: \_\_\_\_\_ Date: \_\_\_\_\_



**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.

**Please return completed form to:**

Nevada State Board of Medical Examiners  
P.O. Box 7238  
Reno, NV 89510

**or**

1105 Terminal Way #301  
Reno, NV 89502

**LIST OF MALPRACTICE INSURANCE CARRIERS**

If you answered affirmatively to questions #12 and/or #12a on the Application for Licensure, list all malpractice carriers since completion of your postgraduate training.

**Name of Insured:** \_\_\_\_\_

**Insurance Company:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**Fax Number:** \_\_\_\_\_

**Policy Number:** \_\_\_\_\_

**Dates:** \_\_\_\_\_

**Insurance Company:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Fax Number:** \_\_\_\_\_

**Policy Number:** \_\_\_\_\_

**Dates:** \_\_\_\_\_

**Insurance Company:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Fax Number:** \_\_\_\_\_

**Policy Number:** \_\_\_\_\_

**Dates:** \_\_\_\_\_

**Insurance Company:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Fax Number:** \_\_\_\_\_

**Policy Number:** \_\_\_\_\_

**Dates:** \_\_\_\_\_

**Insurance Company:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Fax Number:** \_\_\_\_\_

**Policy Number:** \_\_\_\_\_

**Dates:** \_\_\_\_\_

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

Applicant: Each school where physician assistant education was received must complete this form. If more than one school, photocopies of this blank form may be made and used.

**FORM 1**

**NEVADA STATE BOARD OF MEDICAL EXAMINERS  
PHYSICIAN ASSISTANT EDUCATION VERIFICATION**

I certify that \_\_\_\_\_  
(name of applicant)  
DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

.....  
**The following information to be completed by program only!**

was enrolled in: \_\_\_\_\_  
(name of school/program)

located at: \_\_\_\_\_  
(complete address)

from: \_\_\_\_\_ to \_\_\_\_\_  
(date of enrollment for PA Degree) (ending date of attendance for PA Degree)

The applicant was granted:

- \_\_\_\_\_ Physician Assistant Certificate
- \_\_\_\_\_ Physician Assistant Degree
- \_\_\_\_\_ Bachelor's Degree
- \_\_\_\_\_ Combined Physician Assistant/Bachelor's Degree
- \_\_\_\_\_ Combined Physician Assistant/Masters Degree
- \_\_\_\_\_ other (please attach explanation)

on the \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_  
(day) (month) (year)

**NOTE:** If any portion of this form is deleted or modified, please attach an explanation.

Signed and the institutional seal affixed this  
\_\_\_\_\_ day of \_\_\_\_\_, 2\_\_\_\_\_.

Affix Seal Here

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

\_\_\_\_\_  
(signature of President, Registrar or Dean)

\*\* 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 returned by the verifying institution directly to:**

**Nevada State Board of Medical Examiners  
PO Box 7238  
Reno, NV 89510  
(775) 688 – 2559**

**NEVADA STATE BOARD OF MEDICAL EXAMINERS  
NCCPA CERTIFICATION**

National Commission on Certification  
Of Physician Assistants, Inc.  
12000 Findley Rd., Ste 100  
Johns Creek, GA 30097  
(678) 417-8100

**Part 1 – to be completed by applicant**

I, \_\_\_\_\_ am in the process  
(name of applicant)  
of applying for physician assistant licensure in the state of Nevada and hereby authorize release of  
the following information directly to the Nevada State Board of Medical Examiners.

\_\_\_\_\_  
(signature of applicant)

**Part 2 – to be completed by NCCPA and returned directly to the Nevada State Board of Medical Examiners**

I, the undersigned, certify that \_\_\_\_\_  
(name of applicant)  
was granted initial certification by the National Commission of Certification of Physician Assistants  
on: date issued \_\_\_\_\_  
certificate number \_\_\_\_\_.

The above certificate is: \_\_\_\_\_ current, in good standing \_\_\_\_\_ not current.

Expiration date of current certification: \_\_\_\_\_.

Signed and the institutional seal affixed this

\_\_\_\_\_ day of \_\_\_\_\_, 2\_\_\_\_\_

Affix Seal Here

By: \_\_\_\_\_  
(typed name and title of certifying agent)

\_\_\_\_\_  
(signature of certifying agent)

**Completed form is to be returned by the verifying institution directly to:**

**Nevada State Board of Medical Examiners  
PO Box 7238  
Reno, NV 89510  
(775) 688 – 2559**

Applicant: Each state where licensure/certification **is or ever was** held must complete this form. If more than one state, photocopies of this blank form may be made and used.

# FORM 3

## NEVADA STATE BOARD OF MEDICAL EXAMINERS VERIFICATION OF STATE LICENSURE/CERTIFICATION

### PART 1 – TO BE COMPLETED BY APPLICANT

Printed Name of Applicant: \_\_\_\_\_

Address: \_\_\_\_\_  
(street) (apt. or suite #) (city) (state) (zip)

Date of Birth: \_\_\_\_\_  
(month) (day) (year)

I am in the process of applying for physician assistant licensure in the state of Nevada. I hereby authorize release of the following information directly to the Nevada State Board of Medical Examiners at the above address.

\_\_\_\_\_  
(signature of applicant)

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### PART 2 – TO BE COMPLETED BY LICENSING AGENCY and returned directly to the Nevada State Board of Medical Examiners

I certify that \_\_\_\_\_ was  
(name of applicant)

granted license/certificate number \_\_\_\_\_ by the state of \_\_\_\_\_ on \_\_\_\_\_  
(date of issuance)

on the basis of \_\_\_\_\_  
(examination: NCCPA / State Licensing/Certifying examination)

I certify that the above license/certificate is:

_____	current, in good standing
_____	not current, due to non-payment of fees
_____	subject to pending disciplinary charges
_____	subject to restriction of licensure/certification or practice
_____	other (please attach explanation)

I certify that the records in this office indicate that there are not now nor have there ever been any charges filed against the holder of this license/certificate.

**NOTE:** If any portion of this form is deleted or modified, please attach an explanation.

\_\_\_\_\_  
(signature of certifying individual)

\_\_\_\_\_  
(title of certifying individual)

\_\_\_\_\_  
(licensing/certifying agency name)

**Completed form is to be returned by the verifying institution directly to:**

**Nevada State Board of Medical Examiners  
PO Box 7238  
Reno, NV 89510  
(775) 688 – 2559**

If you answered affirmatively to questions #12 and/or #12a on the Application for Licensure, submit this form to all malpractice carriers verifying all coverage within the past 10 years. If more than one malpractice carrier, photocopies of the blank form may be made and used.

**FORM 4**

# MALPRACTICE CLAIM VERIFICATION REQUEST

**Insurance Carrier Information:**

Name of Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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**(To be completed by verifying agency only)**

Policy Number: \_\_\_\_\_

Policy Period From: \_\_\_\_\_ To: \_\_\_\_\_

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

**Name of Insured**

**Physician Assistant:** \_\_\_\_\_

Policy Number: \_\_\_\_\_

Policy Period From: \_\_\_\_\_ To: \_\_\_\_\_

**Claims Experience:**

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

\_\_\_\_\_ No \_\_\_\_\_ Yes

If "yes", please provide the following information:

<i>Occurrence Date</i>	<i>Status</i>	<i>Date Closed</i>	<i>Indemnity Amount</i>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

*Description of Claim:* \_\_\_\_\_

<i>Occurrence Date</i>	<i>Status</i>	<i>Date Closed</i>	<i>Indemnity Amount</i>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

*Description of Claim:* \_\_\_\_\_

**Insurance Carrier Agent:**

\_\_\_\_\_  
*Print Name and Title*

\_\_\_\_\_  
*Telephone*

\_\_\_\_\_  
*Signature of Agent*

**Please return completed form to:**

Nevada State Board of Medical Examiners  
P.O. Box 7238, Reno, NV 89510 (Mailing Address)  
1105 Terminal Way #301  
Reno, NV 89502 (Physical Address)  
Phone: (775) 688-2559

**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.

\_\_\_\_\_  
*Physician Assistant (applicant) signature and date*

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

By: \_\_\_\_\_

Notary Public for State of: \_\_\_\_\_

My Commission Expires: \_\_\_\_\_

\_\_\_\_\_  
**Signature and Seal of Notary Public**



**NAC 630.370 Supervising physician: Duties; qualifications. (NRS 630.130, 630.275)**

1. The supervising physician is responsible for all the medical activities of his physician assistant. The supervising physician shall ensure that:

- (a) The physician assistant is clearly identified to the patients as a physician assistant;
- (b) The physician assistant performs only those medical services which have been approved by his supervising physician;
- (c) The physician assistant does not represent himself in any manner which would tend to mislead the general public, the patients of the supervising physician or any other health professional; and
- (d) There is strict compliance with:
  - (1) The provisions of the certificate of registration issued to his physician assistant by the State Board of Pharmacy pursuant to NRS 639.1373; and
  - (2) The regulations of the State Board of Pharmacy regarding controlled substances, poisons, dangerous drugs or devices.

2. Except as otherwise required in subsection 3 or 4, the supervising physician shall review and initial selected charts of the patients of the physician assistant. He shall be available at all times that his physician assistant is providing medical services to consult with his assistant. Those consultations may be indirect, including, without limitation, by telephone.

3. At least once a month, the supervising physician shall spend part of a day at any location where the physician assistant provides medical services to act as a consultant to the physician assistant and to monitor the quality of care provided by the physician assistant.

4. If the supervising physician is unable to supervise the physician assistant as required by this section, he shall designate a qualified substitute physician, who practices medicine in the same specialty as the supervising physician, to supervise the assistant.

5. A physician who supervises a physician assistant shall develop and carry out a program to ensure the quality of care provided by a physician assistant. The program must include, without limitation:

5. A physician who supervises a physician assistant shall develop and carry out a program to ensure the quality of care provided by a physician assistant. The program must include, without limitation:

- (a) An assessment of the medical competency of the physician assistant;
- (b) A review and initialing of selected charts;
- (c) An assessment of a representative sample of the referrals or consultations made by the physician assistant with other health professionals as required by the condition of the patient;
- (d) Direct observation of the ability of the physician assistant to take a medical history from and perform an examination of patients representative of those cared for by the physician assistant; and
- (e) Maintenance by the supervising physician of accurate records and documentation regarding the program for each physician assistant supervised.

6. Except as otherwise provided in subsection 7, a physician may supervise a physician assistant if the physician:

- (a) Holds an active license in good standing to practice medicine issued by the Board;
- (b) Actually practices medicine in this State; and
- (c) Has not been specifically prohibited by the Board from acting as a supervising physician.

7. If the Board pursuant to NAC 630.410 has disciplined a physician assistant, a physician shall not supervise that physician assistant unless the physician has been specifically approved by the Board to act as the supervising physician of that physician assistant.

[Bd. of Medical Exam'rs, § 630.370, eff. 12-20-79]—(NAC A 6-23-86; 11-21-88; 9-12-91; 1-13-94; R149-97, 3-30-98; R108-01, 11-29-2001; R145-03, 12-16-2003)

**NAC 630.360 Performance of authorized medical services; identification; misrepresentation; notification of change regarding supervising physician. (NRS 630.130, 630.275)**

1. The medical services which a physician assistant is authorized to perform must be:

- (a) Commensurate with his education, training, experience and level of competence; and
- (b) Within the scope of the practice of his supervising physician.

2. The physician assistant shall wear at all times while on duty a placard, plate or insigne which identifies him as a physician assistant.

3. No physician assistant may represent himself in any manner which would tend to mislead the general public or the patients of the supervising physician.

4. A physician assistant shall notify the Board in writing within 72 hours after any change relating to his supervising physician.

[Bd. of Medical Exam'rs, § 630.360, eff. 12-20-79]—(NAC A 6-23-86; 9-12-91; 1-13-94; R149-97, 3-30-98; R108-01, 11-29-2001)

**PERMISSION TO SEEK  
CRIMINAL BACKGROUND INVESTIGATION REPORT  
AND TO OBTAIN AND USE A SET OF MY FINGERPRINTS IN THIS REGARD**

I understand that all applicants applying for licensure with the Nevada State Board of Medical Examiners, pursuant to the Nevada Revised Statutes, Chapter 630, must submit a full set of his/her fingerprints, along with an authorization for the Nevada State Board of Medical Examiners to forward his/her fingerprints to the Department of Public Safety Records and Technology Division and to the Federal Bureau of Investigation for a state and federal criminal background investigation and report.

**I herewith and hereby grant permission and fully authorize the Nevada State Board of Medical Examiners to submit a complete set of my fingerprints to the Department of Public Safety Records and Technology Division for submission to the Federal Bureau of Investigation for their reports.**

I UNDERSTAND THAT THE COSTS OF FINGERPRINTING, THE BACKGROUND CHECK AND THE REPORT SHALL BE AT MY OWN EXPENSE.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 2\_\_\_\_\_

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Print Name

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By signing my signature on the line below, I do hereby understand that I must timely submit my fingerprints to the Nevada State Board of Medical Examiners in order for the Board to submit a complete set of my fingerprints to the Department of Public Safety Records and Technology Division for submission to the Federal Bureau of Investigation for their reports. Failure to do so could result in disciplinary action up to and including immediate summary suspension of my license. NRS 630.167.

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Signature of Applicant

Date

***Return this form to:***

Nevada State Board of Medical Examiners  
1105 Terminal Way, Ste. 301, Reno, NV 89502

Or

P.O. Box 7238  
Reno, NV 89510

