



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

Name \_\_\_\_\_  
 Street \_\_\_\_\_  
 City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone Number \_\_\_\_\_

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

**SCOPES OF PRACTICE CODES**

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

Code

Code

Primary Scope of Practice \_\_\_\_\_

Secondary Scope of Practice \_\_\_\_\_

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

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

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

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

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

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

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

1. Do you currently have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? \_\_\_\_\_Yes \_\_\_\_\_No
2. If you currently have a medical condition which in any way impairs or limits your ability to practice medicine, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? \_\_\_\_\_Yes \_\_\_\_\_No \_\_\_\_\_N/A
3. If you currently use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety? \_\_\_\_\_Yes \_\_\_\_\_No \_\_\_\_\_N/A
4. Have you 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
5. 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
6. 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
7. 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
8. 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 state, country or U.S. territory? \_\_\_\_\_Yes \_\_\_\_\_No

9. Have you ever had a medical license or license to practice any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory? \_\_\_\_\_Yes \_\_\_\_\_No

10. Have you ever voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory? \_\_\_\_\_Yes \_\_\_\_\_No

11. Have you ever been denied membership, been asked to resign or expelled from a medical society or other professional medical organization? \_\_\_\_\_Yes \_\_\_\_\_No

12. 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? \_\_\_\_\_Yes \_\_\_\_\_No

13. Have you ever surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? \_\_\_\_\_Yes \_\_\_\_\_No

14. 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.)

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

**OTHER STATES OF CURRENT OR PREVIOUS LICENSURE**

List any and all licenses (including training licenses and permits) YOU HOLD OR HAVE HELD to practice medicine in any state, territory or country. (Current direct source verification of these licenses must be received by the Board prior to any status change.)

State/Territory/Country	License #	Date of Issuance	Dates of Practice From (Mo./Yr.) To (Mo./Yr.)

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

**CHILD SUPPORT STATEMENT**

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

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

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

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

**CONTINUING MEDICAL EDUCATION (CME) STATEMENT**

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

\_\_\_\_\_ (a) I was initially licensed in Nevada prior to January 1, 2010 and completed a minimum of 44 hours of AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics, 4 of which were in bio-terrorism/weapons of mass destruction and 20 hours of which were in my scope of practice or specialty;

\_\_\_\_\_ (b) I was initially licensed in Nevada during the time period January 1, 2010 through June 30, 2010, the second six months of the past biennial period, and completed a minimum of 34 hours of AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics, 4 of which were in bio-terrorism/weapons of mass destruction and 20 hours of which were in my scope of practice or specialty;

\_\_\_\_\_ (c) I was initially licensed in Nevada during the time period July 1, 2010 through December 31, 2010, the third six months of the past biennial period, and completed a minimum of 24 hours of AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics, 4 of which were in bio-terrorism/weapons of mass destruction and 18 hours of which were in my scope of practice or specialty;

\_\_\_\_\_ (d) I was initially licensed in Nevada during the time period January 1, 2011 through June 30, 2011, the fourth six months of the past biennial period, and completed a minimum of 14 hours of AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics, 4 of which were in bio-terrorism/weapons of mass destruction and 8 hours of which were in my scope of practice or specialty, OR

\_\_\_\_\_ (e) I am exempt from submitting proof of completion of continuing medical education (CME) because I have completed a full year of residency or fellowship training during the biennial period July 1, 2009 through June 30, 2011.

- **ATTACH COPIES OF PROOF OF YOUR COMPLETION OF CONTINUING MEDICAL EDUCATION (CME) HOURS OR PROOF OF COMPLETION OF 1 YEAR OF RESIDENCY OR FELLOWSHIP TRAINING OBTAINED DURING THE BIENNIAL.**
- **YOUR COPIES OF PROOF OF CME OR TRAINING COMPLETION WILL NOT BE RETURNED TO YOU.**

**BY SIGNING ON THE SIGNATURE LINE BELOW:**

I HEREBY REPRESENT THAT I AM THE PERSON NAMED IN THIS *APPLICATION FOR STATUS CHANGE TO ACTIVE STATUS REGISTRATION* OF LICENSE TO PRACTICE MEDICINE IN THE STATE OF NEVADA AND THAT ALL STATEMENTS I HAVE MADE HEREIN ARE TRUE;

- 1) I UNDERSTAND THAT THIS *APPLICATION FOR STATUS CHANGE TO ACTIVE STATUS REGISTRATION* WILL BE DENIED IF I HAVE NOT PLACED A CHECK MARK NEXT TO (a), (b), OR (c) UNDER THE CHILD SUPPORT STATEMENT SECTION; AND
- 2) I UNDERSTAND THAT THIS *APPLICATION FOR STATUS CHANGE TO ACTIVE STATUS REGISTRATION* WILL BE DENIED IF I HAVE NOT ANSWERED ALL QUESTIONS THEREON AND/OR ATTACHED THERETO: (a) THE APPROPRIATE COPIES OF PROOF OF CONTINUING MEDICAL EDUCATION (CME); (b) PAYMENT OF THE APPROPRIATE FEE(S); AND (c) WRITTEN EXPLANATION(S) TO ANY "YES" ANSWER(S).

\_\_\_\_\_ Date

\_\_\_\_\_ Signature

\_\_\_\_\_ (SIGNATURE STAMP IS UNACCEPTABLE)

