

PHYSICIAN
APPLICATION FOR REINSTATEMENT
TO ACTIVE OR INACTIVE STATUS - REGISTRATION FOR THE
BIENNIAL REGISTRATION PERIOD 2009- 2011
NEVADA STATE BOARD OF MEDICAL EXAMINERS
Post Office Box 7238 Reno, Nevada 89510 Phone (775) 688-2559
Physical Address: 1105 Terminal Way, Suite 301 Reno, NV 89502

Date Received by Board _____

License No. _____

File No. _____

(For Board Use Only)

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

_____ REINSTATEMENT TO ACTIVE STATUS \$1,600.00
_____ REINSTATEMENT TO INACTIVE STATUS \$ 800.00 (Inactive reinstatement, No CME's required)

Name: _____

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

PLEASE NOTE:

- **THIS APPLICATION FOR STATUS CHANGE AND/OR REINSTATEMENT TO ACTIVE STATUS REGISTRATION FORM IS THE FORM TO BE COMPLETED FOR CHANGE OF STATUS AND/OR REINSTATEMENT TO ACTIVE STATUS MEDICAL LICENSURE IN THE STATE OF NEVADA.**
- **YOUR STATUS WILL NOT BE CHANGED AND/OR YOU WILL NOT BE REINSTATED UNLESS YOU ANSWER ALL QUESTIONS ON THIS APPLICATION FOR STATUS CHANGE AND/OR REINSTATEMENT TO ACTIVE STATUS REGISTRATION FORM. YOU MUST PROVIDE WRITTEN EXPLANATIONS FOR ALL QUESTIONS ANSWERED "YES."**
- **ALL INFORMATION YOU PROVIDE ON THIS APPLICATION FOR STATUS CHANGE AND/OR REINSTATEMENT TO ACTIVE STATUS REGISTRATION FORM IS PUBLIC INFORMATION.**

PLEASE TYPE OR PRINT LEGIBLY

1. Active status registration requires the submission of proof of completion of 40 hours of AMA Category 1 continuing medical education (CME), which includes 2 hours of CME in medical ethics, 20 hours of CME in your scope of practice or specialty and 18 hours of CME in any other AMA Category 1 course - **completed during the preceding 24-month time period of the date of your submission of this form.** Submit your proof of completion of CME with your completed **APPLICATION FOR STATUS CHANGE AND/OR REINSTATEMENT TO ACTIVE STATUS REGISTRATION** form. (See last page of this form for CME statement.)

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

Name _____

Street _____

City _____ County _____ State _____ Zip _____

Phone Number _____ Fax Number _____

Email address _____

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

Name _____

Street _____

City _____ County _____ State _____ Zip _____

Phone Number _____

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

SCOPES OF PRACTICE CODES

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

Code

Code

Primary Scope of Practice _____

Secondary Scope of Practice _____

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

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

“Ability to practice medicine” is to be construed to include all of the following:

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

“Medical condition” includes physiological, mental or psychological conditions or disorders, such as, but not limited to, orthopedic, vision, speech, hearing, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, emotional or mental illness, HIV disease, tuberculosis, drug addiction, and alcoholism.

“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 AND/OR
REINSTATEMENT TO ACTIVE STATUS REGISTRATION FORM.**

1. Do you 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 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
3. If you use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety? _____Yes _____No
4. Have you been named as a defendant, or been requested to respond as a defendant or potential defendant, to a legal action involving professional liability (malpractice)? _____Yes _____No
5. Have you had a professional liability (malpractice) claim paid on your behalf or paid such a claim yourself (including any military tort claims if applicable)? _____Yes _____No
6. Have you been arrested, investigated for, charged with, convicted of, or pled guilty or nolo contendere to any criminal offense 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
7. Have you been arrested, investigated for, charged with, convicted of, or pled guilty or nolo contendere to any criminal offense other than a criminal offense listed in questions #6? *Please note that you MUST disclose ANY investigation or arrest, including those where the final disposition was dismissal or expungement. _____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 other 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 and all resignations from any medical staff in lieu of disciplinary or administrative action. (Please Note: Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance).

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

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

OTHER STATES OF CURRENT OR PREVIOUS LICENSURE

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

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

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 completed a minimum of 40 hours of AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics and 20 hours of which were in my scope of practice or specialty during the past biennial period of July 1, 2007 through June 30, 2009;

_____ (b) I was initially licensed in Nevada during the time period January 1, 2008 through June 30, 2008, the second six months of the past biennial period, and completed a minimum of 30 hours of AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics 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, 2008 through December 31, 2008, 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 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, 2009 through June 30, 2009, 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 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, 2007 through June 30, 2009.

- **ATTACH COPIES OF PROOF OF YOUR COMPLETION OF CONTINUING MEDICAL EDUCATION (CME) HOURS.**
- **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 AND/OR REINSTATEMENT 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 AND/OR REINSTATEMENT 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 AND/OR REINSTATEMENT 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 UNACCEPTABLE**)