STATE OF NEVADA
BOARD OF MEDICAL EXAMINERS

APPLICATION FOR PHYSICIAN ASSISTANT LICENSURE
INSTRUCTIONS

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. Pages 1 through 4 of the application for licensure received from any source other than the Nevada State Board of Medical Examiners will be rejected. **The completion of ALL items of this application for licensure is mandatory**. Failure to provide any of the requested information will result in the application not being processed or being rejected as incomplete. **APPLICATIONS NOT COMPLETED WITHIN SIX (6) MONTHS FROM DATE OF RECEIPT BY THE BOARD, WILL BE REJECTED per NAC 630.180(2).** Information provided will be used for identification and to determine qualification for licensure under Nevada Revised Statutes, Chapter 630, which authorizes the collection of this information.

The application, Applicant Responsibility Statement, and Form A are to be completed by the applicant, notarized as indicated, and returned to the Nevada State Board of Medical Examiners.

NOTE: **The application must be either typed or legibly handwritten (illegible or incomplete applications will be returned). The application MUST also be signed under oath before a notary. The Nevada State Board of Medical Examiners conducts its own independent investigation into the background of each applicant.** ***Any false, fraudulent, misleading, inaccurate or incomplete answer on the application IS ONE OF THE GROUNDS FOR DENIAL OF LICENSURE.***

All forms and documents that are required to be sent to agencies or individuals for their completion, must be separated and mailed individually to the agencies or individuals responsible for their completion for return directly to the office of the Nevada State Board of Medical Examiners. Please do not provide the sending agency/individual with a return envelope, as the required documentation **MUST** come to the Nevada State Board of Medical Examiners in the agency's/individual's envelope. **Verifying documentation cannot be accepted if received directly from the applicant.** Photocopies of required verifications and documentation are not acceptable. It is the responsibility of the applicant to ensure that the completed forms are promptly returned to the Nevada State Board of Medical Examiners. If additional forms are needed, the applicant may photocopy the individual forms.

PLEASE BE ADVISED:

1) *DENIAL OF LICENSURE:* **Nevada Revised Statutes, Sections 630.301 through 630.3065, set out the grounds for denial of licensure. Enclosed are copies of these sections for your review.**
2) *PERSONAL APPEARANCE BEFORE THE BOARD FOR ACCEPTANCE OF AN APPLICATION FOR LICENSURE:*
   a. **MAY BE REQUIRED if the applicant has in any way ever been involved in any malpractice awards, judgments, settlements, etc. in any amount; and**
   b. **MAY BE REQUIRED if questions 8, 9, 10, 11, 12, 12a, 13, 20, 21, 22, 23, 24, 25 and 26 are answered in the affirmative ("Yes").**

Any "YES" response to questions numbered 8, 9, 10, 11, 12, 12a, 13, 20, 21, 22, 23, 24, 25 and 26 must include a detailed explanation and be submitted along with the application, including any charges, dates of such charges, the complete name and address of all bodies of jurisdiction, the results of any hearings, if any, and the disposition of such charges. **ALL EXPLANATIONS MUST BE SIGNED AND DATED BY THE APPLICANT AND SUBMITTED ON SEPARATE SHEETS ATTACHED TO THE APPLICATION.**

FEES ARE TO BE PAID BY MONEY ORDER OR CASHIER'S CHECK AT THE TIME THE APPLICATION IS SUBMITTED. PERSONAL CHECKS WILL NOT BE ACCEPTED. See fees on enclosed application checklist. The application fee and criminal background investigation fee are non-refundable.

Please submit the completed application and Form A, along with all required fees, to:

Nevada State Board of Medical Examiners
P O Box 7238
Reno NV 89510
(775) 688-2559

OR

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

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. $300 application fee, $75 criminal background investigation fee and $400 registration fee (covering fees thru June 30, 2013) payable by cashier's check or money order only;

_____ b. Properly completed, signed and notarized application, pages 1 - 4, including Applicant Responsibility Statement and criminal background investigation release;

_____ c. Recent photo taken within the past 60 days, (at least 2"x 2") attached to application, signed in ink on lower edge of photograph;

_____ d. Written explanation(s) (signed and dated) attached for all affirmative responses to questions numbered 8, 9, 10, 11, 12, 12a, 13, 20, 21, 22, 23, 24, 25, and 26;

_____ e. Release form - signed and notarized (Form A);

_____ f. Form B – if you have answered affirmatively to questions #12 or #12a on the application;

_____ g. U.S. born citizens - Certified Birth Certificate that bears an original seal or stamp of the issuing agency (notarized copies are not acceptable). This document will be returned to you via secured mail;

_____ h. Foreign-born citizens - Original Certificate of Naturalization or current U.S. Passport. This document will be returned to you via secured mail;

_____ i. Non U.S. Citizens - Copy of both sides of alien registration card, employment authorization card or Visa

_____ j. Copy of high school transcripts or diploma;

_____ k. 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;

_____ l. Notification to Nevada State Board of Medical Examiners of Supervision of Physician Assistant (signed and notarized);

_____ m. 4 hours bio-terrorism AMA Category 1 CME relating to the medical consequences of an act of terrorism that involves the use of a weapon of mass destruction (NRS 630.253(2)(b)).

TO BE SOLICITED BY APPLICANT FOR DIRECT RETURN TO BOARD OFFICE

(Verifying agencies may charge a fee.)

Do not provide pre-stamped or pre-addressed envelopes.

_____ a. Current certification by the National Commission on Certification of Physician Assistants (Form 1);

_____ b. Verification of completion of physician assistant program (Form 2) including transcripts;

_____ c. Verification of licensure/certification from ALL states where applicant is currently licensed/certified or has ever been licensed/certified (Form 3);

_____ d. Form 4 – if you have answered affirmatively to question #12 and or 12a on the application, which should include a loss history report;

_____ e. 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;

_____ f. FBI Criminal history background report – returned directly by the verifying institution to the Board office. (Once application fees have been received, fingerprint cards and instructions will be mailed to the applicant).

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.

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

7/1/2011 – 6/30/2013 PHYSICIAN ASSISTANT
APPLICATION FOR LICENSURE
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, Nevada 89502

Date Received by Board

License No._____

File No._____

(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 _(_____)_____ _(_____)_____ Fax Number _(_____)_____
Office Home

Cellular Number (Optional) _____ Email address_____

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

6. Citizenship: U.S. Citizen _____ Alien Registration #_____ Employment Authorization # _____Applying for Visa_____
Submit a certified copy of 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 <u>must</u> 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)

16. Physician Assistant Certificate / Degree granted by:

Physician Assistant School	City / State	Exact Date of Issuance

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.)

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)

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.

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

_____ _____
Signature of applicant 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: _____
_____
Signature of Notary: _____

(NOTARY SEAL)

APPLICANT PHOTOGRAPH:

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

PHOTOGRAPH MUST HAVE BEEN TAKEN WITHIN THE LAST SIXTY (60) DAYS AND BE AT LEAST 2" x 2" IN SIZE.

SIGN THE PHOTOGRAPH IN INK ACROSS THE LOWER PORTION OF ITS FRONT SIDE.

CENTER AND ATTACH PHOTOGRAPH HERE.

I hereby certify that the attached photograph is a true likeness of myself taken within the last sixty (60) days.

_____ _____

Signature of applicant Date

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.

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

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, past and present.

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: _____

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

Applicant: *This form is to be mailed to the NCCPA for completion.*

FORM 1

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 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 2

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

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)

- -

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: _____

(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:

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

Description of Claim: _____

_____

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

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

NOTIFICATION TO NEVADA STATE BOARD OF MEDICAL EXAMINERS OF SUPERVISION OF PHYSICIAN ASSISTANT

STATE OF NEVADA)
) ss. NOTE: NO FEE REQUIRED
COUNTY OF)

COMES NOW _____, **being first duly sworn who deposes and says that:** I, the undersigned physician, am duly licensed to practice medicine in the state of Nevada by the Nevada State Board of Medical Examiners (Board), possess an active license to practice medicine in the state of Nevada, license number_____, and am in good standing with the Board. I am engaged in the full time practice of medicine in the state of Nevada, am current on all my required CME and am not aware of any disciplinary action, formal or informal; pending against me by the Board or any other jurisdiction's medical licensing entity.

I have read and am aware of the provisions of Chapter 630 of the Nevada Revised Statutes concerning the duties of a supervising physician, as well as Chapter 630 of the Nevada Administrative Code which are the regulations adopted by the Board concerning a physician's relationship with a physician assistant and/or advanced practitioner of nursing. I have read and am aware of the regulation of the Nevada State Board of Medical Examiners under Chapter 630 of the Nevada Administrative Code that precludes a physician from simultaneously supervising more than three physician assistants or collaborating with more than three advanced practitioners of nursing, or with a combination of more than three physician assistants and advanced practitioners of nursing, without first filing a petition with the Board for approval to supervise more, and the requirement that I prove to the satisfaction of the Board that the circumstances of my practice necessitate more and that I will be able to supervise/collaborate with the greater number in a satisfactory manner.

I hereby certify that this relationship does not violate the limitation cited above concerning the total number of physician assistants or advanced practitioners of nursing with whom I may simultaneously supervise or collaborate. Further, this relationship will not begin until I am in receipt of a file stamped copy of this Notification bearing the receipt stamp of the Board. Upon receipt of same, I will be supervising the following named physician assistant at the following practice location(s):

_____ _____
Name of Physician Assistant _____
_____
Practice Location(s) (use extra page if necessary) (Telephone#)

I am aware that the **original** copy of this Notification will be placed in my licensing file at the offices of the Nevada State Board of Medical Examiners, and that I must immediately notify the board, in writing, of the termination of this relationship.

WHEREFORE, I set my hand this _____ day of _____, 2_____

_____ _____
Supervising Physician Name (Print or Type) Supervising Physician (Signature)

COMES NOW _____, **being first duly sworn who deposes and says that:** I, the undersigned physician assistant have submitted an application for licensure in the state of Nevada and this agreement becomes effective upon being granted active licensure by the Board. That I have read and am aware of the provisions of Chapter 630 of the Nevada Revised Statutes and the Nevada Administrative Code as those laws apply to physician assistants. I am aware that a copy of this Notification will be placed in my licensing file at the offices of the Board, and, that the provisions of the Nevada Administrative Code require that if this supervising relationship is terminated my failure to immediately notify the Board of the termination or my continuing to practice this portion of my practice until such time as I advise the Board of my new supervising physician, is grounds for disciplinary action against me.

WHEREFORE, I set my hand this _____ day of _____, 2_____.

_____ _____
Physician Assistant Name (Print or Type) Physician Assistant (Signature)

The above named _____,
(Print Physician Name)
being first duly sworn, appeared before me on the _____ day of _____, 2_____, and, in my presence, executed this document consisting of one (1) page.

_____
Notary Public

The above named _____,
(Print Physician Assistant Name)
being first duly sworn, appeared before me on the _____ day of _____, 2_____, and, in my presence, executed this document consisting one (1) page.

_____
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

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.

_____

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