PHYSICIAN
***APPLICATION FOR STATUS CHANGE TO ACTIVE STATUS REGISTRATION* FORM FOR THE BIENNIAL PERIOD 2011 - 2013**

Date Received by Board

License No._____

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

File No. _____
(For Board Use Only)

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

_____CHANGE FROM INACTIVE TO ACTIVE STATUS $ 800.00 if during 7/1/2011 - 6/30/2012
$ 400.00 if during 7/1/2012 - 6/30/2013

You may pay by check, 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.

Name: _____

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

PLEASE NOTE:

NAC 630.178 Change of status of license after suspension for nonpayment of fee.
If a person whose license to practice medicine was suspended pursuant to NRS 630.267 for nonpayment of the fee for biennial registration wishes to change the status of his license from inactive to active, he must within 2 years after the date on which his license was suspended, submit:

1. Twice the amount of the fee for biennial registration applicable to the status of his license at the time of the suspension for nonpayment; and
2. Any other information or documentation required to complete the biennial registration.
   - Your status will not be changed unless you answer all questions on this *application for status change to active status registration* form.
   - You must provide written explanations for all questions answered "yes."
   - All information you provide on this application is public information.

PLEASE TYPE OR PRINT LEGIBLY

1. Active status registration requires the submission of proof of completion of 44 hours of **AMA Category 1** continuing medical education (CME), which includes 2 hours of CME in medical ethics, 4 hours of CME in bio-terrorism or weapons of mass destruction, 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 TO ACTIVE STATUS REGISTRATION*** form. (See last page of this form for CME statement.)

2. If your name and/or address have 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, a 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** _____

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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 state licenses YOU HOLD OR HAVE HELD to practice medicine in any state, territory or country with the exception of training licenses. (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.

SAFE INJECTION PRACTICE ATTESTATION

Attestation to knowledge of and compliance with the guidelines of the Centers for Disease Control and Prevention for applicant physicians

I hereby attest to knowledge of and compliance with the guidelines of the Centers for Disease Control and Prevention concerning the prevention of transmission of infectious agents through safe and appropriate injection practices. I also attest that any person who is currently, or will be under my control as their supervising physician in the future, and who is not licensed pursuant to chapter 630 of the Nevada Revised Statutes and whose duties involve injection practices, has knowledge of and is in compliance with the guidelines of the Centers for Disease Control and Prevention concerning the prevention of transmission of infectious agents through safe and appropriate injection practices.

http://www.cdc.gov/hicpac/2007IP/2007isolationPrecautions.html – or – http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf

Applicant: _____ Date: _____

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)

CHECKLIST FOR STATUS CHANGE APPLICATION
REQUESTING CHANGE FROM INACTIVE TO ACTIVE STATUS

____	a.	**APPLICATION** ☐ Properly completed, signed and notarized application ☐ Appropriate explanations and copies of all pertinent documentation must be attached for any affirmative responses to questions 1 through 14, pages 3 and 4
____	b.	**FEES** • Proper application, registration, AND criminal background investigation fees payable by: o Cashier's check made payable to Nevada State Board of Medical Examiners (NSBME); or o Money order made payable to Nevada State Board of Medical Examiners (NSBME); or o Credit card – acceptable with signed credit card authorization form; [an additional 2% service fee will be charged for credit card payment] **Note: Application and criminal background investigation fees are non-refundable;**
____	c.	**CONTINUING MEDICAL EDUCATION** • Proof of completion of 44 hours of AMA Category 1 continuing medical education (CME) completed during the preceding 24-month time period of the date of submission of this application for Status Change which must include (refer to page 5 if you were initially licensed after January 1, 2010): o 2 hours of CME in medical ethics o 4 hours of CME in bio-terrorism or weapons of mass destruction o 20 hours of CME in your scope of practice / specialty o 18 hours of CME in any other AMA Category 1 course o If you have completed a full year of residency or fellowship training during the time period July 1, 2009 through June 30, 2011 provide proof of completion in lieu of CME
____	d.	**ADDITIONAL REQUIREMENTS** ☐ A signed statement notifying the Board of your intent to resume the practice of medicine in the state of Nevada. ☐ A Notarized sworn affidavit to the Board describing your activities during your Inactive status.
____	e.	**STATE LICENSE VERIFICATIONS** • Direct source verification of all other state licenses that you hold or have held. This does not include training licenses.
____	f.	**SELF-QUERY VERIFICATION** • National Practitioner Data Bank (NPDB) AND the Healthcare Integrity and Protection Data Bank (HIPDB) report; The NPDB and HIPDB will send the combined report directly to you and you will forward the final report to the board office; The request form for the NPDB and HIPDB is available at www.npdb-hipdb.hrsa.gov/welcomesq.html. Click on "Individual Self-Query" in the center of the page and follow the instructions provided. If you require additional information, please call the NPDB/HIPDB at (800) 767-6732. Once you have received the final report or self-query response from the NPDB and HIPDB, forward a copy of this report to the Board office.

CREDIT CARD AUTHORIZATION FORM

If mailing or faxing this page separately from the application, please mail to:
Nevada State Board of Medical Examiners
P.O. Box 7238
Reno, NV 89510-7238
or fax to:
775-688-2321

Please type or print legibly.

Name of Applicant: _____

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

Name on Credit Card: _____

Business Name (if applicable): _____

Credit Card Billing Address:

_____

_____

_____

Phone Number: _____

Credit Card Number: _____

Expiration Date: _____ / _____
(MM) (YYYY)

I authorize the Nevada State Board of Medical Examiners to charge the above credit card for a one-time payment in the amount of $ _____, and an additional 2% service fee.

Printed Name: _____

Authorized Signature: _____ Date: _____