PERFUSIONIST
APPLICATION FOR REINSTATEMENT
TO ACTIVE STATUS REGISTRATION FORM
FOR THE BIENNIAL REGISTRATION PERIOD 2015 - 2017
NEVADA STATE BOARD OF MEDICAL EXAMINERS
1105 Terminal Way, Ste. 301 Reno, Nevada 89502
Phone (775) 688-2559

Date Received by Board

(For Board Use Only)

License No._____
File No._____

I hereby apply for reinstatement of biennial registration and enclose the appropriate fee as indicated below:

_____REINSTATEMENT FEE $750.00

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:

1. Each license to practice perfusion expires July 1 of every odd-numbered year and may be renewed if, before the license expires, the holder of the license submits to the Board:

(a) A completed application for renewal on a form prescribed by the Board;

(b) Proof of completion of the requirements for continuing education prescribed by regulations adopted by the Board pursuant to NRS 630.269; and

(c) The applicable fee for renewal of the license prescribed by the Board pursuant to NRS 630.2691.

2. A license that expires pursuant to this section not more than 2 years before an application for renewal is made is automatically expired and may be reinstated only if the applicant:

(a) Complies with the provisions of subsection 1; and

(b) Submits to the Board the fees:

(1) For the reinstatement of an expired license, prescribed by regulations adopted by the Board pursuant to NRS 630.269; and

(2) For each biennium that the license was expired, for the renewal of the license.

3. If a license has been expired for more than 2 years, a person may not renew or reinstate the license but must apply for a new license and submit to the examination required pursuant to NRS 630.2692.

The regulation states:

The license of a perfusionist may be renewed biennially. Except as otherwise provided in subsection 2, each person licensed as a perfusionist shall, at the time of the renewal of his or her license, provide satisfactory proof to the Board that he or she has completed during the biennial licensing period at least 30 hours of continuing education units that have been approved for credit by the American Board of Cardiovascular Perfusion (ABCP) at least 15 hours, not less than 2 hours of which are related to medical ethics are Category I approved CEU. Not more than 15 of the required 30 hours are Category II or III approved CEU. The fee for the reinstatement of an expired license pursuant to NRS 630.2695 is an amount equal to twice the current amount of the fee for the biennial renewal of the license.

- YOUR LICENSE WILL NOT BE REINSTATED UNTIL THE BOARD RECEIVES YOUR ORIGINAL SIGNED *APPLICATION FOR REINSTATEMENT TO ACTIVE STATUS REGISTRATION* FORM. **A FAXED COPY IS NOT ACCEPTABLE.**
- YOU WILL NOT BE REINSTATED UNLESS YOU ANSWER ALL QUESTIONS ON THIS *APPLICATION FOR REINSTATEMENT TO ACTIVE STATUS REGISTRATION* FORM.
- YOU MUST PROVIDE WRITTEN EXPLANATIONS FOR ALL QUESTIONS ANSWERED "YES."
- ALL INFORMATION YOU PROVIDE ON THIS *APPLICATION FOR REINSTATEMENT TO ACTIVE STATUS REGISTRATION* FORM IS PUBLIC INFORMATION.

PLEASE TYPE OR PRINT LEGIBLY
PLEASE PROVIDE ALL INFORMATION AS REQUESTED

1. Your application for Reinstatement of Registration of License requires the submission of **proof of current certification by the American Board of Cardiovascular Perfusion AND 30 hours of continuing professional education (CE)** as described in NAC 630 **completed during the preceding 24-month time period of the date of your submission of this form**. Submit your proof of completion of CE with your completed ***APPLICATION FOR REINSTATEMENT TO ACTIVE STATUS REGISTRATION*** form. (See last page of this form for specific CE 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____

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All of the following questions refer to the time period following the issuance of your Nevada perfusionist license through the present date only.

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

"Medical condition" includes physiological, mental or psychological condition or disorders.

"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 REGISTRATION RENEWAL* FORM.

1. Do you currently have a medical condition that in any way impairs or limits your ability to provide perfusionist services 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 provide perfusionist services, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, the manner in which you have chosen to practice, or by any other reasonable accommodation?
______Yes ______No ______N/A

3. If you currently use chemical substances, does your use in any way impair or limit your ability to provide perfusionist services with reasonable skill and safety?
______Yes ______No ______N/A

4. Have you 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

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 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

7. Have you been denied a license or certification/registration to provide perfusionist services or practice any other healing art in any state, country or U.S. territory?
_____Yes _____No

8. Have you had a certificate or license to provide perfusionist services or any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory?
_____Yes _____No

9. Have you voluntarily surrendered a license or certificate to provide perfusionist services or any other healing art in any state, country or U.S. territory?
_____Yes _____No

10. Have you failed the American Board of Cardiovascular Perfusion examination, or any state or other jurisdiction examination for certification, licensure or registration as a perfusionist?
_____Yes _____No

11. Have you had your registration/certification revoked, suspended and/or limited by the American Board of Cardiovascular Perfusion?
_____Yes _____No

12. Have you 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 perfusionist by any medical licensing board, hospital, medical society, governmental entity or other agency <u>other than</u> the Nevada State Board of Medical Examiners?
_____Yes _____No

13. List all hospitals where you have had staff / employment 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. (<u>Please Note</u>: Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance.) (If more space is needed, attach a separate sheet)

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

OTHER STATES OF CURRENT OR PREVIOUS LICENSURE

List any and all licenses you hold or have held to practice medicine in any state, territory.

State/Territory	License #	Date of Issuance	Dates of Practice

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

14. I am currently certified with the American Board of Cardiovascular Perfusion. _____Yes _____No

PLEASE INDICATE YOUR AMERICAN BOARD OF CARDIOVASCULAR PERFUSION CERTIFICATION & RECERTIFICATION

Date of Initial Certification	**Date of Last Recertification**
(Mo./Yr.)	(Mo./Yr.)

AMERICAN BOARD OF CARDIOVASCULAR PERFUSION CERTIFICATION

<u>Attach Copy</u> Of Proof Of Your Current ABCP Certification ***(YOUR COPY OF PROOF OF CURRENT CERTIFICATION WILL <u>NOT</u> BE RETURNED TO YOU.)***

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.

ATTESTATION REGARDING THE REPORTING OF THE ABUSE OR NEGLECT OF A CHILD

I attest and affirm that I am aware of and understand the reporting requirements found in Nevada Revised Statute 432B.220 regarding the abuse or neglect of a child.

_____**Yes** _____**No**

www.leg.state.nv.us/NRS/NRS-432B.html#NRS432BSec220

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.

_____**Yes** _____**No**

http://www.cdc.gov/injectionsafety/IP07_standardPrecaution.html

MILITARY SERVICE ATTESTATION

Have you ever served in the United States Military (to include National Guard or Reserves)? _____**Yes** _____**No**
If your answer is "No", you do not have to complete the remaining questions for the Military Service Attestation.

If yes, which branch of service did you serve?

- ☐ Air Force
- ☐ Army
- ☐ Navy
- ☐ Marine Corp
- ☐ Coast Guard

Military occupation specialty or specialties?

- ☐ Administration or Personnel
- ☐ Aviation
- ☐ Civil Engineering
- ☐ Communications
- ☐ Infantry or Armor
- ☐ Legal or Chaplin Corps
- ☐ Logistics or Supply
- ☐ Maintenance
- ☐ Medical Services
- ☐ Security Forces or Military Police
- ☐ Other

Dates of service in the Military:

From: _____/ _____/ _____ **To:** _____/ _____/ _____
DD MM YYYY DD MM YYYY

BUSINESS LICENSE ATTESTATION

Do you hold a Nevada state business license issued in your individual name? _____**Yes** _____**No**

If yes, provide the business license number: _____.

CONTINUING EDUCATION (CEU) STATEMENT

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

_____ I was licensed prior to or during the first half of the biennial registration period of July 1, 2013 – June 30, 2014. I have completed at least thirty (30) hours of continuing education units (CEU) accredited by the American Board of Cardiovascular Perfusion (ABCP) as follows:

- Fifteen (15) hours must be Category I approved CEU;
- At least two (2) of the Category I hours must be related to medical ethics or pain management and/or addiction care;
- Fifteen (15) of the 30 hours required continuing education units may be Category I, Category II, or Category III approved CEU.

_____ I was licensed during the second half of the biennial registration period of July 1, 2014 – June 30, 2015. I have completed at least sixteen (16) hours of continuing education units (CEU) accredited by the American Board of Cardiovascular Perfusion (ABCP) as follows:

- Eight (8) hours must be Category I approved CEU;
- At least two (2) hours of the Category I hours must be related to medical ethics or pain management and/or addiction care;
- Eight (8) of the 16 hours required continuing education units may be Category I, Category II, or Category III approved CEU.

Attach copies of proof of your completion of continuing professional education (CEU) hours.
Your copies of proof of CEU completion will not be returned to you.
For a current list of approved continuing professional education sources, you may visit our website at www.medboard.nv.gov and click the "continuing education requirements" for perfusionist license renewal.

Notification of Practice Location(s)

I currently practice perfusion at the following location(s):

Location(s)	Address – use an extra page if necessary	(Include Telephone Number)	(Hours per week)

HOME ADDRESS & PHONE NUMBER

Street_____

City_____ County_____ State_____ Zip_____

Phone Number_____ Fax Number_____

BY SIGNING ON THE SIGNATURE LINE BELOW:

1) I hereby represent that I am the person named in this application for reinstatement of registration of license to provide perfusionist services in the state of Nevada and that all statements I have made herein are true;

2) I understand that this application for reinstatement of registration of license will be rejected if I have not placed a check mark next to (a), (b), or (c) under the child support statement section; and

3) I understand that this application for reinstatement of registration of license will be rejected as incomplete if I have not answered all questions thereon and/or attached thereto: (a) the appropriate copies of proof of continuing education (CE); (b) the appropriate proof of current certification by the American Board of Cardiovascular perfusion; (c) payment of the appropriate fee(s); and (d) written explanation(s) to any "yes" answer(s).

_____ _____

Date Signature (**SIGNATURE STAMP UNACCEPTABLE)**

CREDIT CARD AUTHORIZATION FORM

If mailing or faxing this page separately from the application, please mail to:
Nevada State Board of Medical Examiners
1105 Terminal Way, Suite 301
Reno, NV 89502
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)

For security of your financial information, please do not email this form to the Board; emailed forms will not be accepted.

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: _____