PHYSICIAN
APPLICATION FOR REINSTATEMENT
AUTHORIZED FACILITY MD / COUNTY OR RESTRICTED RESEARCH MD
TO ACTIVE OR INACTIVE STATUS REGISTRATION FORM
FOR THE BIENNIAL REGISTRATION PERIOD 2015 - 2017
NEVADA STATE BOARD OF MEDICAL EXAMINERS

1105 Terminal Way, Suite 301 Reno, NV 89502
Phone (775) 688-2559

Date Received by Board

License No._____

File No._____

(For Board Use Only)

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

_____ REINSTATEMENT TO ACTIVE STATUS $ 750.00
_____ REINSTATEMENT TO INACTIVE STATUS $ 375.00 **(Inactive reinstatement – No CME required)**

NOTE: You must reinstate to the status you held at the time your license became expired.

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:

NRS 630.267(2) Biennial registration: Submission of list and fee; suspension and reinstatement of license; notice to licensee. (2) When a holder of a license fails to pay the fee for biennial registration and submit all information required to complete the biennial registration after they become due, his or her license to practice medicine in this State is automatically expired. The holder may, within 2 years after the date the license is expired of twice the amount of the current fee for biennial registration to the Secretary-Treasurer and submission of all information required to complete the biennial registration and after he or she is found to be in good standing and qualified under the provisions of this chapter, be reinstated to practice.

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

PLEASE TYPE OR PRINT LEGIBLY

1. Active status registration requires the submission of proof of completion of 40 hours of **AMA Category 1** continuing medical education (CME), which includes 2 hours of CME in medical ethics, 20 hours of CME in your scope of practice or specialty and 18 hours of CME in any other AMA Category 1 course - **completed during the preceding 24-month time period of the date of your submission of this form**. Submit your proof of completion of CME with your completed ***APPLICATION FOR REINSTATEMENT TO ACTIVE STATUS REGISTRATION*** form. (See last page of this form for CME statement.) Please note: CME are not required for Inactive Status Reinstatement.

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 24-month time period of the date of your submission of this form or since your last renewal.

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

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

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

"Medical condition" includes physiological, mental or psychological 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 REINSTATEMENT TO ACTIVE OR INACTIVE 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, 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 practice medicine 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, 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

8. Have you 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

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

10. Have you been denied membership, been asked to resign or expelled from a medical society or other professional medical organization? _____Yes _____No

11. 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 physician by any medical licensing board, hospital, medical society, governmental entity or other agency other than the Nevada State Board of Medical Examiners? _____Yes _____No

12. Have you surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? _____Yes _____No

13. List all hospitals where you have had staff privileges denied, suspended, limited, revoked or not renewed by the hospital. List any and all resignations from any medical staff in lieu of disciplinary or administrative action. (Please Note: Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance).

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

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

OTHER STATES OF CURRENT OR PREVIOUS LICENSURE

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

State/Territory	License #	Date of Issuance	Dates of Practice

(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.

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

COMMUNICATIONS AFFIRMATION

Consent to accept communications and service of process from the Nevada State Board of Medical Examiners (Board) by electronic mail, for physicians and physician assistants who practice medicine in the state of Nevada or via telemedicine and whose physical presence exists outside the state of Nevada or the United States.

I am willing to accept Board communications to me, to include service of process as defined under Nevada Revised Statute (NRS) 630.344, via electronic mail (more commonly known as e-mail). Further, should the electronic mail address provided below change for any reason, I agree to apprise the Board in writing of my new electronic mail address within 30 days after the change.

Printed Name of Applicant/Licensee: _____

Signature of Applicant/Licensee: _____

Electronic Mail Address: _____

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: _____/_____/_____ (DD/MM/YYYY) **To:** _____/_____/_____ (DD/MM/YYYY)

CONSCIOUS SEDATION DEEP SEDATION OR GENERAL ANESTHESIA ATTESTATION

Nevada Revised Statutes (NRS) require the Nevada State Board of Medical Examiners to obtain from each applicant who seeks renewal of his or her license to practice medicine, a report stating the number and type of surgeries requiring conscious sedation, deep sedation or general anesthesia performed by the holder of the license at his or her office or any other facility, excluding any surgical care performed at a medical facility as defined in NRS 449.0151, or outside the state of Nevada.

I hereby attest that I am in compliance with the reporting requirements of NRS 630.30665, and am aware that failure to submit a report or filing false information in a report is grounds for disciplinary action under Nevada's Medical Practice Act.

_____Yes _____No

CONTINUING MEDICAL EDUCATION (CME) STATEMENT *(Inactive reinstatement – No CME required)*

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

_____ (a) I was initially licensed in Nevada prior to or during the time period July 1, 2013 through December 31, 2013 and completed a minimum of forty (40) hours of AMA Category 1 continuing medical education (CME), two (2) hours of which were in medical ethics and twenty (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, 2014 through June 30, 2014 the second six months of the past biennial period, and completed a minimum of thirty (30) hours of AMA Category 1 continuing medical education (CME), two (2) hours of which were in medical ethics and twenty (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, 2014 through December 31, 2014, the third six months of the past biennial period, and completed a minimum of twenty (20) hours of AMA Category 1 continuing medical education (CME), two (2) hours of which were in medical ethics and eighteen (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, 2015 through June 30, 2015, the fourth six months of the past biennial period, and completed a minimum of ten (10) hours of AMA Category 1 continuing medical education (CME), two (2) hours of which were in medical ethics and eight (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, 2015 through June 30, 2017.

- **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:

1) I hereby represent that I am the person named in this application for reinstatement to active or inactive status registration of license to practice medicine in the state of Nevada and that all statements I have made herein are true;

2) I understand that this application for reinstatement to active or inactive status registration 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 to active or inactive status registration 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 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)**

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: _____