NEVADA STATE BOARD OF MEDICAL EXAMINERS

FEES FOR PHYSICIAN ASSISTANT LICENSURE

Applications which appear to have been altered in any form will not be accepted. Applications must be typed or legibly handwritten in ink (illegible or incomplete applications will be returned). Applications must be received on single-sided, white bond paper, 8 ½" x 11" in size. Your application is a public document.

Applications not completed within six (6) months from date of receipt will be rejected per NAC 630.180(2).

Fees applicable July 1, 2015 – June 30, 2016:

$300 Application Fee $400 Registration Fee $75 Criminal Background Investigation Fee = $775.00

Fees applicable July 1, 2016 – June 30, 2017:

$300 Application Fee $200 Registration Fee $75 Criminal Background Investigation Fee = $575.00

The Application fee and Criminal Background Investigation fee will not be refunded. You may pay by 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.

The Board's staff conducts an investigation into your background during the application process. If staff becomes aware of circumstances** warranting a personal appearance at a Board meeting prior to acceptance of your application for licensure, your application must be completed 45 days prior to any regularly scheduled Board meeting in order for your appearance to be scheduled for that meeting for consideration of acceptance of your application. Under Nevada law, a public body cannot hold a meeting to consider the character, alleged misconduct, professional competence, or physical or mental health of any person unless it has given written notice to that person of the time and place of the meeting. The written notice must be sent by certified mail to the last known address of that person at least 21 working days before the meeting. A public body must receive proof of service of the notice before such a meeting may be held.

** You **may** be required to personally appear before the Board for acceptance of your application for licensure if you have in any way ever been involved in any malpractice awards, judgments, or settlements in any amount.

** You **may** be required to personally appear before the Board for acceptance of your application for licensure if you have answered in the affirmative ("Yes") to questions 8, 9, 10, 11, 12, 12a 13, 20, 21, 22, 23, 24, 25 and/or 26.

If, at the time you meet with the Board, the Board votes to deny or not accept your application for licensure, this denial or non-acceptance of your application may become a reportable action to the National Practitioner Data Bank, Federation of State Medical Boards of the United States, Inc. and American Medical Association, among other entities.

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; 2011, 847)

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; knowingly procuring or administering certain controlled substances or dangerous drugs; failure to supervise medical assistant adequately. 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.
17. Knowingly procuring or administering a controlled substance or a dangerous drug as defined in chapter 454 of NRS that is not approved by the United States Food and Drug Administration, unless the unapproved controlled substance or dangerous drug:

(a) Was procured through a retail pharmacy licensed pursuant to chapter 639 of NRS;

(b) Was procured through a Canadian pharmacy which is licensed pursuant to chapter 639 of NRS and which has been recommended by the State Board of Pharmacy pursuant to subsection 4 of NRS 639.2328; or

(c) Is marijuana being used for medical purposes in accordance with chapter 453A of NRS.

18. Failure to supervise adequately a medical assistant pursuant to the regulations of the Board.

(Added to NRS by 1983, 302; A 1985, 2238; 1987, 199, 800, 1554, 1575; 2007, 3046; 2009, 533, 879, 2961, 2962; 2011, 257, 2612)

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)

PHYSICIAN ASSISTANT
APPLICATION CHECKLIST
TO BE RETURNED DIRECTLY TO BOARD OFFICE BY APPLICANT

____	a.	APPLICATION: ☐ Properly completed, signed and notarized application, including Applicant Responsibility statement; ☐ Recent passport quality photograph (at least 2"x 2") attached to application; ☐ Appropriate explanations and copies of all pertinent documentation must be attached for affirmative responses to questions numbered 8, 9, 10, 11, 12, 12a, 13, 20, 21, 22, 23, 24, and 25; ☐ Release form - signed and notarized (Form A);
____	b.	FEES: • Proper application, registration, AND criminal background investigation fees – cashier's check or money order made payable to Nevada State Board of Medical Examiners (NSBME) or by credit card as instructed. Credit cards will only be accepted by receipt of the signed credit card authorization form. Note: Application and criminal background investigation fees are non-refundable;
____	c.	IDENTITY (Important identity documents will be returned to you via secured mail): • U.S. born citizens – Original or Certified Birth Certificate that bears an original seal or stamp of the issuing agency (notarized copies are not acceptable); • Foreign-born citizens - Original Certificate of Naturalization or current U.S. Passport; • Non U.S. citizens - Copy of both sides of Alien Registration card or Employment Authorization card or Visa; • Non U.S. citizens - Copy of foreign passport;
____	d.	SELF-QUERY VERIFICATION: • Self-query response from the National Practitioner Data Bank (NPDB); The NPDB will send the report directly to you and you will forward the final report to the Board office; The request form for the National Practitioner Data Bank (NPDB) is available at http://www.npdb.hrsa.gov. Click on 'Self-Query' for Healthcare Professionals on the right side of the page and follow the instructions provided. If you require additional information, please call the NPDB at (800) 767-6732. Once you have received the final report or self-query response from the NPDB, forward a copy of this report to the Board office.
____	e.	SUPPLEMENTARY FORM: • FORM B: ONLY if you have answered affirmatively to either of the two malpractice questions on the application; Also include: o Copy of the legal Complaint o Copy of the Settlement and/or filed Dismissal
____	f.	EDUCATION: ☐ Copy of high school transcripts or diploma; ☐ 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;
____	g.	NOTIFICATION OF SUPERVISION • Notification for supervision of Physician Assistant to Nevada State Board of Medical Examiners (signed and notarized); *Please note: If you do not yet have a supervising physician who is a Nevada licensed Medical Doctor, you can obtain licensure; however you cannot practice in the state of Nevada until such time as you have a supervising physician agreement (Notification for Supervision of a Physician Assistant) approved by the Board.*
____	h.	CONTINUING EDUCATION: • Proof of 4 hours bioterrorism AMA Category 1 continuing medical education (CME) relating to the medical consequences of an act of terrorism that involves the use of a weapon of mass destruction. Search for an online course by entering "AMA Category 1 bioterrorism continuing medical education" or take a classroom course;
____	i.	EXAMINATION REGARDING NEVADA LAW GOVERNING YOUR MEDICAL PRACTICE: • Jurisprudence examination familiarizing you with the Medical Practice Act (Nevada Revised Statutes Chapters 630 and 629 and Nevada Administrative Code Chapter 630) will **be mailed to you upon acknowledgement of receipt of your application and appropriate fees**. You must answer correctly at least 75% of the questions**.**
____	j.	FINGERPRINTING: • Once the application and criminal background investigation fee have been received, a fingerprint card and instructions will be mailed to you. The fingerprint card you receive from the Board contains the necessary account numbers required for processing. The completed card must be returned to the Board as well as the signed Civil Applicant Waiver (included in your application package) prior to licensure. Note: Receipt of the Criminal history background results will not delay licensure.

PHYSICIAN ASSISTANT
APPLICATION CHECKLIST

DIRECT SOURCE VERIFICATIONS
TO BE SOLICITED BY APPLICANT FOR DIRECT RETURN BY THE VERIFYING INSTITUTION TO BOARD OFFICE

Verifying agencies may charge a fee. ***Do not provide pre-stamped or pre-addressed envelopes for direct source verifications.***

_____	a.	PHYSICIAN ASSISTANT SCHOOL: ☐ Verification of completion of Physician Assistant Education (Form 1) to be completed by your Physician Assistant program; ☐ Official transcripts from Physician Assistant program;
_____	b.	EXAMINATION: • Current certification by the National Commission on Certification of Physician Assistants (Form 2);
_____	c.	STATE LICENSE VERIFICATIONS: • Verification of licensure/certification from ALL states where applicant is currently licensed/certified or has ever been licensed/certified (Form 3) [does not include training licenses or temporary permits];
_____	d.	MALPRACTICE INSURANCE CARRIER VERIFICATIONS: • Malpractice insurance carrier verification (Form 4) to be completed by appropriate entity and returned directly by the verifying institution to the Board office and must include the loss history report for any and all malpractice cases that occurred within the past 10 years (see Disclaimer below);

Disclaimer: Per Nevada Revised Statute 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.

APPLICATION GUIDE

Identity - Licenses will be issued in the applicant's name as it is indicated on the submitted documented proof of such name i.e. U.S. Birth Certificate, Certificate of Naturalization, Alien Registration card, Employment Authorization card, and/or other legal documentation reflecting name change.

Malpractice - If you have ever been named in a legal action involving professional liability (malpractice), whether or not you have ever had a professional liability, settlement, claim paid on your behalf, or paid such a claim yourself, provide signed and dated explanations for all malpractice cases throughout your career. Provide copies of legal documentation for malpractice cases that occurred within the past 10 years unless otherwise instructed, which includes copies of Complaints, Settlements and/or Dismissals. If you have a pending case or cases, request a letter from your attorney to be sent directly to the Board describing the current status of the case(s). In summary:

- Provide descriptive explanations for any and all malpractice cases (who, what, where, when and why)
- Complete Form B listing all malpractice insurance carriers since completion of postgraduate training
- Provide copies of legal documentation for cases that occurred within the past 10 years
    - Complaint
    - Settlement
    - and/or Dismissal
- Request Form 4 malpractice carrier verifications from all malpractice insurance carriers within the past 10 years
- For any pending case(s), request a status letter to be sent directly to the Board from your attorney

Investigation - If you have ever been notified that you were under investigation by any medical licensing board, hospital, medical society, governmental entity or other agency, whether or not you were charged with or convicted of any violations of a statute, rule or regulation governing your practice as a physician, you should answer affirmatively to question #24 and submit the appropriate documentation. Provide signed and dated explanations and copies of any related documentation you received regarding any investigation unless otherwise instructed.

Arrest - If you have ever been arrested, read question #13 carefully. You will be expected to provide a signed and dated explanation addressed to the Nevada State Board of Medical Examiners for any arrest(s) no matter how long ago it may have occurred, whether it was expunged or not. Provide a copy of the arrest report, proof of completion of probation and/or time served, community service, fines paid and any other documentation applicable to the incident(s).

Release for Communication with a Person other than the Applicant: If you wish to authorize the Board to communicate about the status of your application for licensure with someone other than yourself, provide a brief signed written release of authorization indicating the specific name of the person thus providing the Board with authority to tender information related to your application status.

Disclaimer: Per Nevada Revised Statute 630.173(2), the Board has the right to consider information that is more than 10 years old regarding malpractice, investigations by another licensing board, complaints or disciplinary actions from a hospital, clinic or medical facility if the Board receives the information from the applicant or any other source from which the Board is verifying the information provided by the applicant.

ATTENTION APPLICANT!

RESPONSIBILITY STATEMENT

Please sign and return this statement with your application for licensure to:
The Nevada State Board of Medical Examiners
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 occurs prior to you being granted licensure to practice medicine in the state of Nevada.

Nevada Department of
Public Safety

CIVIL APPLICANT WAIVER

NOTICE OF NONCRIMINAL JUSTICE APPLICANT'S RIGHTS

As an applicant who is the subject of a Federal Bureau of Investigation (FBI) fingerprint-based criminal history record check for a noncriminal justice purpose you have certain rights which are discussed below.

1. You must be notified by the Nevada State Board of Medical Examiners that your fingerprints will be used to check the criminal history records of the FBI and the State of Nevada.

2. If you have a criminal history record, the officials making a determination of your suitability for the job, license or other benefit for which you are applying must provide you the opportunity to complete or challenge the accuracy of the information in the record. You may review and challenge the accuracy of any and all criminal history records which are returned to the submitting agency. The proper forms and procedures will be furnished to you by the Nevada Department of Public Safety, Records Bureau upon request. If you decide to challenge the accuracy or completeness of your FBI criminal history record, Title 28 of the Code of Federal Regulations Section 16.34 provides for the proper procedure to do so:

> **16.34 – Procedure to obtain change, correction or updating of identification records.**
> If after reviewing his/her identification record, the subject thereof believes that it is incorrect or incomplete in any respect and wishes changes, corrections or updating of the alleged deficiency, he/she should make application directly to the agency which contributed the questioned information. The subject of a record may also direct his/her challenge as to the accuracy or completeness of any entry on his/her record to the FBI, Criminal Justice Information Services (CJIS) Division, ATTN: SCU, Mod. D-2, 1000 Custer Hollow Road, Clarksburg, WV 26306. The FBI will then forward the challenge to the agency which submitted the data requesting that agency to verify or correct the challenged entry. Upon the receipt of an official communication directly from the agency which contributed the original information, the FBI CJIS Division will make any changes necessary in accordance with the information supplied by that agency.

3. Based on 28 CFR § 50.12 (b), officials making such determinations should not deny the license or employment based on information in the record until the applicant has been afforded a reasonable time to correct or complete the record or has declined to do so.

4. You have the right to expect that officials receiving the results of the fingerprint-based criminal history record check will use it only for authorized purposes and will not retain or disseminate it in violation of federal or state statute, regulation or executive order, or rule, procedure or standard established by the National Crime Prevention and Privacy Compact Council.

5. I hereby authorize the Nevada State Board of Medical Examiners, to submit a set of my fingerprints to the Nevada Department of Public Safety, Records Bureau for the purpose of accessing and reviewing State of Nevada and FBI criminal history records that may pertain to me.

In giving this authorization, I expressly understand that the records may include information pertaining to notations of arrest, detainments, indictments, information or other charges for which the final court disposition is pending or is unknown to the above referenced agency. For records containing final court disposition information, I understand that the release may include information pertaining to dismissals, acquittals, convictions, sentences, correctional supervision information and information concerning the status of my parole or probation when applicable.

6. I hereby release from liability and promise to hold harmless under any and all causes of legal action, the State of Nevada, its officer(s), agent(s) and/or employee(s) who conducted my criminal history records search and provided information to the submitting agency for any statement(s), omission(s), or infringement(s) upon my current legal rights. I further release and promise to hold harmless and covenant not to sue any persons, firms, institutions or agencies providing such information to the State of Nevada on the basis of their disclosures. I have signed this release voluntarily and of my own free will.

A reproduction of this authorization for release of information by photocopy, facsimile or similar process, shall for all purposes be as valid as the original.

In consideration for processing my application I, the undersigned, whose name and signature voluntarily appears below; do hereby and irrevocably agree to the above.

Applicant's Name: _____
(PLEASE PRINT LAST, FIRST, MIDDLE)

Address: _____

Applicant's Signature: _____

Date: _____

Submitting Agency: Nevada State Board of Medical Examiners

Address: 1105 Terminal Way, Ste. 301, Reno, NV 89502

Agency Representative: Daniels, L. L.
(PLEASE PRINT LAST, FIRST, MIDDLE)

Agency Representative's Signature: *Daniels, L. L.*

Date: 3/1/2013

PHYSICIAN ASSISTANT
APPLICATION FOR LICENSURE
NEVADA STATE BOARD OF
MEDICAL EXAMINERS

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

Date Received by Board

License No._____

File No._____

For Board Use Only

Identity:

1. Present Legal Name _____
   Last First Middle Maiden

   List any other name ever used _____

Address:

The **Public Access Address** will be available to the public on the Board's website, and will also be your contact address once licensed. It can be changed if the Licensee completes the Notification of Address Change form available on the Board's website: www.medboard.nv.gov.
The **Mailing Address** that you choose will be used for communication only during the application process. It can be one and the same.

2. Public Address _____
   Street City County State Zip

   ☐ Please check if you choose to have your Mailing Address the same as the Public Address you have entered above.

3. Mailing Address _____
   Street City County State Zip

4. Telephone Numbers (_____)_____ (_____)_____ (_____)_____ (_____)_____
   Office Fax Home Cellular (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 # _____ Visa_____

   Submit a Certified 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 card 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 630.197(1)(a) An applicant for the issuance of a license to practice as a physician assistant shall include the social security number of the applicant in the application submitted to the Board.
   NAC 290(2)(c) An applicant must submit to the Board such further evidence and other documents or proof of qualifications as required by the Board.

Questions:

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 SIGNED 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?
   (If "Yes," attach explanation on separate sheet.) _____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, the manner in which you have chosen to practice, or by any other reasonable accommodation?
   (If "Yes," attach explanation on separate sheet.) _____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?
    (If "Yes," attach explanation on separate sheet.) _____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?
    (If "Yes," attach explanation on separate sheet.) _____Yes _____No

Malpractice Questions:

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 ANSWER IS "YES", YOU MUST COMPLETE FORM B AND FORM 4 – 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

Malpractice Explanation(s):

List of all claims or suits for medical malpractice made against you. A claim is any formal or informal demand for payment to any person or organization. If have not answered "yes" to questions #12 and/or #12a and do not have any such claims or suits, this section will be left blank. If you have more than 1 claim, make a copy or copies of this page and submit all explanations with your application for licensure.

Name of patient involved:

In which state did the action take place?

Case number (if applicable):

Which court?
(If settled before initiation of civil action, state here.)

Current status of claim:

☐ Open ☐ Closed (settled or judgment) ☐ Dismissed (no money paid out) ☐ Other

Date claim was closed/settled or dismissed: _____
Month/Year

Amount of judgment or settlement $

Month and year of event precipitating claim:

Month and year of lawsuit or court filing:

Insurance carrier at time:

What is/or was your status? ☐ Primary defendant ☐ Co-defendant ☐ Other

Please provide specifics in reference to the adverse event including the allegations and your role in the event:

Arrest Question:

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. _____Yes _____No

(If "Yes," attach explanation on separate sheet.)

Nevada License History:

14. Have you previously applied for physician assistant licensure in Nevada? _____Yes _____No

(If "Yes," attach explanation on separate sheet.)

Physician Assistant Education:

All information must 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 (Month/Day/Year)

Activities:

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.)	Percent Clinical (%)

State licenses:

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. Note: You will not be required to verify your training licenses by direct source.

State/Territory/Country	License #	Date of Issuance (Mo./Yr.)	Date of Expiration (Mo./Yr.)

Examination:

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 _____ *

* Note: You must be scheduled to sit for the examination if not certified when submitting your application.

Disciplinary Questions:

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
(If "Yes," attach explanation on separate sheet.)

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? (If "Yes," attach explanation on separate sheet.) _____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? (If "Yes," attach explanation on separate sheet.) _____Yes _____No

23. Have you ever failed the NCCPA examination, or any state or other jurisdiction examination for certification as a physician assistant? (If "Yes," attach explanation on separate sheet.) _____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 <u>other than</u> the Nevada State Board of Medical Examiners? _____Yes _____No
(If "Yes," attach explanation on separate sheet.)

25. Have you ever surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? (If "Yes," attach explanation on separate sheet.) _____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. (<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).

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

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

Attestations/Affirmations:

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.

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 PHYSICIAN ASSISTANTS

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 supervision 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, in 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

APPLICANT PHOTOGRAPH

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

PHOTOGRAPH MUST HAVE BEEN TAKEN WITHIN THE LAST SIX MONTHS AND BE AT LEAST 2" x 2" IN SIZE.

CENTER AND ATTACH PHOTOGRAPH HERE.

I hereby certify that the attached photograph is a true likeness of me taken within the last six months.

_____ _____
Signature of applicant **Date**

APPLICATION AFFIRMATION

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 occurs prior to my being granted licensure to practice medicine in the state of Nevada.

_____ _____
Signature of applicant **Date**

(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

END OF APPLICATION

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
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.

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: ______________________________

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: *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 1

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.

AFFIX SEAL HERE

Name: _____
Printed name and title of President, Registrar or Dean

Title: _____

Signature: _____

Date of Signature: _____

Telephone: _____

E-mail: _____

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
1105 Terminal Way, Ste 301
Reno, NV 89502
(775) 688 – 2559

Applicant: *This form is to be mailed to the NCCPA for completion. You may prefer to contact the NCCPA to request that an electronic verification to be sent to the Nevada State Board of Medical Examiners.*

FORM 2

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
www.nccpa.net

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: ______________________________.

AFFIX BOARD SEAL HERE

Signature of certifying individual: ______________________________
Print name: ______________________________
Title: ______________________________
Date: ______________________________
Email: ______________________________

Completed form is to be returned by the verifying institution directly to:

Nevada State Board of Medical Examiners
1105 Terminal Way, Ste 301
Reno, NV 89502
(775) 688 – 2559

Applicant: *You may want to contact the state(s) where you were licensed since some states charge a fee for license verifications and some do not. The Nevada State Board of Medical Examiners also accepts VeriDoc and other secured sources of electronic verification. This is a courtesy form that provides the Board's address, however verification of your state license does not have to be met by use of this form.*

FORM 3

NEVADA STATE BOARD OF MEDICAL EXAMINERS
VERIFICATION OF STATE LICENSURE

PART 1 – TO BE COMPLETED BY APPLICANT

Printed Name Of Applicant: _____

Address: _____

_____

Date of Birth: _____

I am in the process of applying for medical 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 address below.

Signature of applicant: _____

PART 2 – TO BE COMPLETED BY LICENSING AGENCY

Name of Licensee: _____
Last First Middle

Issuing State Board: _____

License Number: _____

Issue Date: _____ Expiration Date: _____

License was issued 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 or practice

_____ Other (please attach explanation)

Note: Please attach any pertinent disciplinary documentation, if applicable.

I certify that to the best of my knowledge and belief the foregoing is a true, accurate, and complete statement of the record of the individual named on this form.

Signature of certifying individual: _____

Print name: _____

AFFIX BOARD SEAL HERE

Title: _____

Date: _____

Email: _____

Completed form or state license verification is to be mailed by the verifying institution directly to:
Nevada State Board of Medical Examiners
1105 Terminal Way, Ste 301
Reno, NV 89502

State Licensing Board: *If you have questions, you may contact the Nevada Board at (775) 688-2559.*

Applicant: *If you answered affirmatively to questions #12 and/or #12a on the Application for Licensure, complete both the top portion and release area of this form; have this form notarized, and submit this form to all malpractice carriers verifying coverage within the past 10 years. Copies of this form may be used if you have more than one malpractice carrier.*

FORM 4

MALPRACTICE CLAIM VERIFICATION REQUEST

Insurance Carrier Information:

Name of Insured Physician Assistant**:** _____

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.

Claims Experience:

Has this Physician Assistant had a settlement paid on his/her behalf? _____Yes _____No

If "yes", please provide the following information:

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

*Description of Claim:*_____

_____

Insurance Carrier Agent:

_____
Print Name and Title

_____
Signature of Agent

_____
Telephone

_____
Email address

Please mail completed form to:

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

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_____,

Notary Public for the State of _____

My Commission Expires: _____

Residing at: _____
City State

_____
Signature and Seal of Notary Public

Malpractice Insurance Carrier: *If you have questions, you may contact the Nevada Board at (775) 688-2559.*

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 and 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

Please mail completed form to:
Nevada State Board of Medical Examiners
1105 Terminal Way #301
Reno, NV 89502

NAC 630.370 Supervising physician: Duties; qualifications. (NRS 630.130, 630.275)

1. Except as otherwise provided in NAC 630.375, the supervising physician is responsible for all the medical activities of his or her physician assistant and 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 or her supervising physician;

(c) The physician assistant does not represent himself or herself 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 or her 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. Unless the physician assistant is performing medical services pursuant to NAC 630.375, the supervising physician must be available at all times that his or her physician assistant is performing medical services to consult with his or her 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. Except as otherwise provided in this subsection, if the supervising physician is unable to supervise the physician assistant as required by this section, the supervising physician shall designate a qualified substitute physician, who practices medicine in the same specialty as the supervising physician, to supervise the assistant. If the physician assistant is performing medical services pursuant to NAC 630.375, the supervising physician is not required to comply with this subsection.

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 has disciplined a physician assistant pursuant to NAC 630.410, 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.

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 the education, training, experience and level of competence of the physician assistant; and

(b) Within the scope of the practice of the supervising physician of the physician assistant.

2. The physician assistant shall wear at all times while on duty a placard, plate or insigne which identifies him or her as a physician assistant.

3. No physician assistant may represent himself or herself in any manner which would tend to mislead the general public or the patients of the supervising physician.

4. Except as otherwise provided in subsection 3 of NAC 630.340, a physician assistant shall notify the Board in writing within 72 hours after any change in the supervision of the physician assistant by a supervising physician.

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:

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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: _____