



NEVADA STATE BOARD OF MEDICAL EXAMINERS APPLICATION FOR PHYSICIAN MEDICAL LICENSURE

This packet contains Uniform Application forms as well as Board-specific materials. Applications which appear to have been altered in any form will not be accepted. Where applicable, application information must be typed or legibly handwritten in ink (illegible or incomplete applications will be returned). Forms and other documents submitted 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).

License Descriptions

- **Active/Unrestricted License.** This license gives full and unrestricted privileges to practice clinical medicine in the state of Nevada.
- **Inactive Status Unrestricted License.** This license is an unrestricted license but with an inactive status rather than an active status. The licensee would not be able to practice medicine in the state of Nevada and cannot prescribe. In order to change the status of this license to active, the licensee would have to apply for a status change (an additional application and fee).
- **Endorsement License.** An Endorsement license is NOT RECIPROCAL in the state of Nevada. This license may be granted to applicants who do not otherwise meet all of the requirements for licensure. The applicant must have an active license to practice medicine in the District of Columbia or any state or territory of the United States. The applicant may be required to meet with the full Board for consideration and approval of licensure by Endorsement. If granted, the license would give full and unrestricted privileges to practice clinical medicine.
- **Administrative License.** With an Administrative license, the licensee may not engage in the practice of clinical medicine, cannot prescribe, and is allowed to practice medicine in an administrative capacity only as an: 1) Officer or employee of a state agency; 2) Independent contractor pursuant to a contract with the State; or 3) Officer, employee, or independent contractor of a private insurance company, medical facility or medical care organization and who does not examine or treat patients in a clinical setting.
- **Restricted License.** There are three different restricted license types. They are granted:
 - To practice medicine in certain medical specialties for which there are critically unmet needs determined by the Governor;
 - To practice medicine in a medically underserved area of a county determined by a Board of County Commissioners;
 - For a graduate of a foreign medical school to teach, research, or practice medicine at a medical research facility or medical school – this license expires automatically once the licensee ceases to teach, research or practice clinical medicine in this State at the sponsoring medical research facility or medical school.
- **Authorized Facility License.** There are two different authorized facility licenses. They are granted:
 - To practice as a Psychiatrist in a Mental Health Center of the Division under the direct supervision of a licensed Psychiatrist;
 - To practice in an institution of the Department of Corrections under the direct supervision of a physician who holds an unrestricted license.

- **Locum Tenens License.** A locum tenens license will be effective not more than 3 months after issuance, and is granted to any physician who is licensed and in good standing in the District of Columbia or any state or territory of the United States, who meets the requirements for licensure in this State and who is of good moral character and reputation. The purpose of this license is to enable an eligible physician to serve as a substitute for another physician who is licensed to practice medicine in this State and who is absent from his practice for reasons deemed sufficient by the Board. A locum tenens license is not renewable.
- **Temporary License.** A temporary license is granted only if the Board determines that it is necessary in order to provide medical services for a community without adequate medical care. The physician must meet all of the requirements for licensure in this State and must hold an active license in good standing in the District of Columbia or any state or territory of the United States. A temporary license is granted for a specified period. The license is not renewable and is utilized for atypical circumstances.

License Fees

Fees applicable if licensed between July 1, 2019 – June 30, 2020

Active/Unrestricted	\$600 Application Fee	\$750.00 Registration Fee	\$75 Criminal Background Investigation Fee	= \$ 1,425.00
Inactive Status	\$600 Application Fee	\$375.00 Registration Fee	\$75 Criminal Background Investigation Fee	= \$ 1,050.00
Endorsement License	\$600 Application Fee	\$750.00 Registration Fee	\$75 Criminal Background Investigation Fee	= \$ 1,425.00
Administrative License	\$600 Application Fee	\$750.00 Registration Fee	\$75 Criminal Background Investigation Fee	= \$ 1,425.00
Restricted License	\$400 Application Fee	\$375.00 Registration Fee	\$75 Criminal Background Investigation Fee	= \$ 850.00
Authorized Facility	\$400 Application Fee	\$375.00 Registration Fee	\$75 Criminal Background Investigation Fee	= \$ 850.00
Locum Tenens	\$400 Application Fee	\$ 40.00 Registration Fee	\$75 Criminal Background Investigation Fee	= \$ 515.00
Temporary	\$400 Application Fee	\$ 40.00 Registration Fee	\$75 Criminal Background Investigation Fee	= \$ 515.00

Fees applicable if licensed between July 1, 2020 – June 30, 2021

Active/Unrestricted	\$600 Application Fee	\$375.00 Registration Fee	\$75 Criminal Background Investigation Fee	= \$ 1,050.00
Inactive Status	\$600 Application Fee	\$187.50 Registration Fee	\$75 Criminal Background Investigation Fee	= \$ 862.50
Endorsement License	\$600 Application Fee	\$375.00 Registration Fee	\$75 Criminal Background Investigation Fee	= \$ 1,050.00
Administrative License	\$600 Application Fee	\$375.00 Registration Fee	\$75 Criminal Background Investigation Fee	= \$ 1,050.00
Restricted License	\$400 Application Fee	\$187.50 Registration Fee	\$75 Criminal Background Investigation Fee	= \$ 662.50
Authorized Facility	\$400 Application Fee	\$187.50 Registration Fee	\$75 Criminal Background Investigation Fee	= \$ 662.50
Locum Tenens	\$400 Application Fee	\$ 40.00 Registration Fee	\$75 Criminal Background Investigation Fee	= \$ 515.00
Temporary	\$400 Application Fee	\$ 40.00 Registration Fee	\$75 Criminal Background Investigation Fee	= \$ 515.00

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.

Background Investigation

Per Nevada Revised Statute 630.161, "The Board shall not issue a license to practice medicine to an applicant who has been licensed to practice any type of medicine in another jurisdiction and whose license was revoked for gross medical negligence by that jurisdiction."

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.

** You **may** be required to personally appear before the Board for acceptance of your application for licensure:

- if you are applying for a license by Endorsement or for a restricted license,
- if you have in any way ever been involved in any malpractice awards, judgments, or settlements in any amount, or
- if you have answered in the affirmative ("Yes") to certain questions of Addendum 4 of the UA.

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.

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.

Each applicant will be required to submit their fingerprints for a FBI criminal history background report. 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 and the signed Civil Applicant Waiver (included in this packet) must be returned to the Board prior to licensure. Note: Receipt of the criminal history background results will not delay licensure.

Credentials Verification Information

- **ABMS Certification.** A copy of your American Board of Medical Specialties (ABMS) Board certification or recertification certificate(s) must be sent to the Board. If you hold “lifetime or historical” ABMS Board certification, include a notarized statement agreeing to maintain your specific Board certification for the duration of your licensure in the state of Nevada.
- **Confirmation may be required from you if the following circumstances apply:**
 - Observerships, Externships, Research positions or Research Fellowships prior to completion of your postgraduate training in the United States or Canada.
 - Employment in a medical setting between medical school and postgraduate training or in between postgraduate training years and prior to completion of your postgraduate training in the United States or Canada.
- **Continuing Education:**
- Each applicant must provide proof of 4 hours of 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 under “AMA Category 1 bioterrorism continuing medical education” or take a classroom course.
- Each applicant must provide proof of 2 hours AMA Category 1 continuing medical education (CME) in clinically-based suicide prevention and awareness.
- **National Practitioner Data Bank Self-Query.** Visit <http://www.npdb.hrsa.gov/> and begin the process to receive a Self-Query. Follow the instructions provided. Once you have received the final report or self-query response from the NPDB, forward a copy of this report to the Board office by mail, fax, or email. For assistance, contact the NPDB at 800-767-6732 or help@npdb.hrsa.gov.
- **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.

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.

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.

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](#).

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 or willfully procuring or administering certain controlled substances or dangerous drugs; failure to supervise medical assistant adequately; allowing person not enrolled in accredited medical school to perform certain activities; failure to obtain required training regarding controlled substances.

1. The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure:

- (a) 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.
- (b) Engaging in any conduct:

- (1) Which is intended to deceive;
 - (2) Which the Board has determined is a violation of the standards of practice established by regulation of the Board; or
 - (3) Which is in violation of a regulation adopted by the State Board of Pharmacy.
 - (c) 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.
 - (d) 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.
 - (e) 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.
 - (f) 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.
 - (g) 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.
 - (h) Habitual intoxication from alcohol or dependency on controlled substances.
 - (i) 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.
 - (j) Failing to comply with the requirements of NRS 630.254.
 - (k) 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.
 - (l) 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.
 - (m) Failure to be found competent to practice medicine as a result of an examination to determine medical competency pursuant to NRS 630.318.
 - (n) Operation of a medical facility at any time during which:
 - (1) The license of the facility is suspended or revoked; or
 - (2) An act or omission occurs which results in the suspension or revocation of the license pursuant to NRS 449.160.
 - ➔ This paragraph applies to an owner or other principal responsible for the operation of the facility.
 - (o) Failure to comply with the requirements of NRS 630.373.
 - (p) Engaging in any act that is unsafe or unprofessional conduct in accordance with regulations adopted by the Board.
 - (q) Knowingly or willfully 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:
 - (1) Was procured through a retail pharmacy licensed pursuant to chapter 639 of NRS;
 - (2) 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;
 - (3) Is marijuana being used for medical purposes in accordance with chapter 453A of NRS; or
 - (4) Is an investigational drug or biological product prescribed to a patient pursuant to NRS 630.3735 or 633.6945.
 - (r) Failure to supervise adequately a medical assistant pursuant to the regulations of the Board.
 - (s) Failure to comply with the provisions of NRS 630.3745.
 - (t) Failure to obtain any training required by the Board pursuant to NRS 630.2535.
2. As used in this section, "investigational drug or biological product" has the meaning ascribed to it in NRS 454.351.

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; failure to comply with certain requirements relating to controlled substances. 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 knowingly 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.
- 7. Failure to comply with the requirements of NRS 453.163 or 453.164.

NRS 630.3065 Knowing or willful disclosure of privileged communication; knowing or willful failure to comply with law, subpoena or order; knowing or willful failure to perform legal obligation. The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure:

- 1. Knowingly or willfully disclosing a communication privileged pursuant to a statute or court order.
- 2. Knowingly or willfully failing 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. Knowingly or willfully failing to perform a statutory or other legal obligation imposed upon a licensed physician, including a violation of the provisions of NRS 439B.410.

Uniform Application Checklists

After completing the online application, you are responsible for submitting certain documents. There are two checklists below; one is for items that you need to send directly to the Board office, and one is for items to be solicited for direct return to the Board by a verifying institution.

Both checklists have columns for your use, whether or not you are, or are not using FCVS. Please be aware, the addendum(s) and verification items are required.

To be completed and returned directly to the Board office by you, unless the checklist otherwise indicates direct source verification.	APPLICATION CHECKLIST	APPLICANT NOTES
	<input type="checkbox"/>	
Notarized Affidavit and Authorization for Release of Information form (found in online UA)	<input type="checkbox"/>	
Application, Registration, and Criminal Background Investigation Fees. (Cashier's Check or Money Order must be made payable to Nevada State Board of Medical Examiners. Credit cards will only be accepted by receipt of Addendum 10.)	<input type="checkbox"/>	
Addendum 1: Responsibility Statement	<input type="checkbox"/>	
Addendum 2: Civil Applicant Waiver	<input type="checkbox"/>	
Addendum 3: Additional Physician Information	<input type="checkbox"/>	
Addendum 4: Attestation Questions (including explanations and copies of all pertinent documentation for affirmative responses)	<input type="checkbox"/>	
Addendum 5: List of Malpractice Insurance Carriers (<u>if needed</u> per affirmative answers in Addendum 4)	<input type="checkbox"/>	
Addendum 6: Malpractice Insurance Carrier Verification (if needed per affirmative answer to claim(s) paid in Addendum 4) sent to the Board (Direct Source)	<input type="checkbox"/>	
Addendum 7: Verification of Hospital or Surgery Center Privileges (if needed per affirmative answers in Addendum 4) sent to the Board (Direct Source)	<input type="checkbox"/>	
Addendum 8: Request for Licensure by Endorsement (<u>if needed</u>)	<input type="checkbox"/>	
Addendum 9: Request for Licensure by a Resident (<u>if needed</u>)	<input type="checkbox"/>	
Addendum 10: Credit Card Authorization Form (<u>if needed</u>)	<input type="checkbox"/>	
Copy of your ABMS Board certification/re-certification certificate(s). If you hold "lifetime or historical" ABMS Board certification, include a notarized statement stating your agreement to maintain Board certification for the duration of your licensure in the state of Nevada	<input type="checkbox"/>	
National Practitioner Data Bank's "Practitioner Request" For Information Disclosure (Self Query Verification)	<input type="checkbox"/>	
Nevada and FBI Criminal History Background Report (once application fees have been received, fingerprint cards and instructions will be mailed to you)	<input type="checkbox"/>	
Verification of ABMS Board certification, if applying via state written exam/board certification; Verification of ABMS Board certification (direct source) if lifetime/historically board certified (Direct Source)	<input type="checkbox"/>	
State Licensure Verification form (Form #1) sent to the Board from all states in which you have ever held any medical doctor license (Direct Source)	<input type="checkbox"/>	

Identity Information: To be completed and returned directly to the Board office by you, unless the checklist otherwise indicates direct source verification.

APPLICATION CHECKLIST

<p>IDENTITY (Identity documents will be returned to you via secured mail.):</p> <ol style="list-style-type: none"> 1. 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). 2. Foreign-born citizens: Original Certificate of Naturalization or current U.S. Passport. 3a. Non-U.S. citizens (with legal status): Copy of both sides of Alien Registration or Employment Authorization card, or Visa; <u>and</u> current foreign passport. 3b. Non-U.S. citizens (otherwise): Individual Taxpayer Identification Number (ITIN) and original ITIN assignment letter from the IRS. Supporting documentation of identity also required, e.g., Passport, or USCIS, US Military, or US State I.D. <p><i>Note: FCVS verification packet may provide appropriate "Seal verified" Identity documentation.</i></p>	<input type="checkbox"/>	<p>*</p>
<p>Supporting documentation of any legal name change (Photocopy)</p>	<input type="checkbox"/>	<p>*</p>
<p>Verification Information Below: To be completed and returned directly from the verifying institutions to the Board.</p>		
<p>Medical Education Verification form (Form #2) sent to the Board from all medical schools attended – (must be sealed by your school) (Direct Source)</p>	<input type="checkbox"/>	<p>*</p>
<p>Medical School Transcripts sent to the Board by your medical school(s) (Direct Source)</p>	<input type="checkbox"/>	<p>*</p>
<p>Postgraduate Training Verification form (Form #3) sent to the Board from all programs you attended (Direct Source)</p>	<input type="checkbox"/>	<p>*</p>
<p>Fifth Pathway form (Form #4) (if applicable) sent to the Board from the medical school and institution - (must be sealed by your school) (Direct Source)</p>	<input type="checkbox"/>	<p>*</p>
<p>Examination: National Boards, FLEX, LMCC, USMLE certification of scores sent to the Board (Direct Source)</p>	<input type="checkbox"/>	<p>*</p>
<p>ECFMG Status Report (if applicable) sent to the Board (Direct Source)</p>	<input type="checkbox"/>	<p>*</p>

* Denotes if you hold a completed Federation Credential Verification Service (FCVS) verification packet, and it is submitted to the Board, it may fulfill this item.

Nevada State Board of Medical Examiners

Instructions for Addenda

Complete the addenda as instructed below. Please type or print your responses. Return the completed addenda along with any and all supporting documentation to the Nevada State Board of Medical Examiners.

- Addendum 1: Responsibility Statement.** Please read this form carefully. The signed and dated form must be returned to the Board.
- Addendum 2: Civil Applicant Waiver.** Please read this form carefully. The signed and dated form must be returned to the Board.
- Addendum 3: Additional Physician Information.** You must complete each question.
- Addendum 4: Attestation Questions.** You must complete each question. For all “yes” responses, you must submit appropriate explanations on a separate sheet and attach copies of all pertinent documentation. This form must be notarized and returned to the Board.
 - If you have ever been a defendant in a legal action involving professional liability (malpractice), whether or not you have ever had a settlement paid on your behalf, you should answer affirmatively to questions #5a and/or #5b and submit the appropriate documentation, including copies of the Complaint, Settlement and Dismissal. If your case is pending, have your attorney provide the Board a direct source letter indicating the status of the pending case(s).

Provide signed explanations for all malpractice cases. Provide copies of legal documentation for malpractice cases that occurred within the past 10 years unless otherwise instructed.

- If you have ever been arrested, read question #6 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) or copy of expungement.
- If you have ever had any actions, restrictions or limitations imposed on you, or have been placed on probation while participating in any type of training program, you should answer affirmatively to question #8. Submit a signed and dated explanation addressed to the Board for any postgraduate training issues and include copies of documentation you received from your program.
- 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 #13 and submit the appropriate documentation. Provide signed and dated explanations and copies of any related documentation you received regarding any investigation unless otherwise instructed.

Provide signed explanations for all hospital disciplinary history and copies of any related hospital privilege/disciplinary history that occurred within the past 10 years unless otherwise instructed.

- Addendum 5: List of Malpractice Insurance Carriers.** If you answered affirmatively to Addendum 4, questions #5a and/or #5b, list all malpractice carriers since completion of your postgraduate training.
- Addendum 6: Malpractice Claim Verification Request.** If you answered affirmatively to Addendum 4, questions #5a and #5b, submit this form to all malpractice carriers verifying all coverage, to include claims history, within the past 10 years. If more than one malpractice carrier, photocopies of the blank form may be made and used. (See Disclaimer on the next page.)
- Addendum 7: Verification of Hospital or Surgery Center Privileges.** If you answered affirmatively to questions #13 and/or #15 in Addendum 4, submit this form to all hospitals where you have had privileges within the past 10 years. If more than one hospital or surgery center, photocopies of the blank form may be made and used.

(See Disclaimer below)

- Addendum 8: Request for Licensure by Endorsement.** Complete this form only if you are applying for a license by Endorsement (Endorsement is NOT reciprocity). Please refer to the License Descriptions section of the Instructions for clarification. This form must be notarized and returned to the Board.
- Addendum 9: Request for Licensure by a Resident.** Complete this form only if you are currently enrolled in a postgraduate training program, have completed at least 24 months of progressive postgraduate training and meet all requirements for an unlimited license in the state of Nevada including having passed all 3 steps of USMLE with the time period allowed by NAC 630.080.
- Addendum 10: Credit Card Authorization Form.** Complete this form only if paying the required fees by credit card. The Nevada State Board of Medical Examiners does not accept credit card payment via phone. The Board must have the signed credit card authorization form before payment can be processed. This form must be sent by U.S. mail, overnight carrier, or facsimile only.

*** 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.**

NOTE: APPLICATIONS WILL NOT BE PROCESSED WITHOUT RECEIPT OF THE APPLICATION FEE, CRIMINAL BACKGROUND INVESTIGATION FEE, AND REGISTRATION FEE IN THE FORM OF EITHER A CASHIER'S CHECK OR MONEY ORDER PAYABLE TO "NEVADA STATE BOARD OF MEDICAL EXAMINERS," OR SIGNED CREDIT CARD AUTHORIZATION FORM.

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

IMPORTANT: Your application is not considered complete and cannot be processed by Board Staff until all of the following are received:

- Online submission of the Uniform Application,
- All applicable addenda and reports (according to the checklists provided in this packet), and full payment.

Please be sure that you receive an email confirmation that your Online Uniform Application has been submitted. This email will be sent to you from the Federation of State Medical Boards.

Please return completed addenda and payment/credit card authorization form to the:

**Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521**

ADDENDUM 1 – RESPONSIBILITY STATEMENT

ATTENTION APPLICANT!

Please sign and return this statement with your application for licensure to:

**The Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521**

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 medical school or your postgraduate 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.

○ ○ ○ ○ ○

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.

ADDENDUM 2 – 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, detentions, 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 if 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.

(continued on next page)

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: 9600 Gateway Drive, Reno, NV 89521

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

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

Date: April 18, 2018

ADDENDUM 3 – ADDITIONAL PHYSICIAN INFORMATION

CITIZENSHIP AND IDENTIFICATION

U.S. Citizen: Yes No Social Security Number: _____

Non U.S. Citizen: Yes No Social Security Number: _____ or

Individual Taxpayer Identification Number (ITIN): _____

Visa Indicate Visa Type: _____ Applying for Visa: Yes No

For the items below, please provide your USCIS number.

Conditional Resident _____ Permanent Resident _____

Employment Authorization _____ Asylee _____

Color of Eyes: _____ Color of Hair: _____ Height: _____ Weight: _____

EXAMINATION SCORES

List all licensure examinations you have taken, whether U.S. or International, on the Examination History tab of the online Uniform Application. Also list below the score you received on each exam taken. **INCLUDE ALL INFORMATION PERTAINING TO ANY AND ALL FAILED ATTEMPTS.**

Examination Name	Date Taken	Score Received	Examination Name	Date Taken	Score Received
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

SPECIALTY CERTIFICATION

Scope of Practice/Specialty(ies): _____

List any and all certifications and re-certifications by a Board or Sub-Board recognized by the **American Board of Medical Specialties**. **INCLUDE ALL INFORMATION PERTAINING TO ANY AND ALL FAILED ATTEMPTS.**

Board / Specialty Board	If you are Lifetime Board Certified, indicate "Lifetime"	Certification #	Dates of Certification/ Recertification (MM/YY)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If you hold "lifetime or historical" ABMS Board Certification, please provide a notarized statement agreeing to maintain Board Certification for the duration of your licensure in the state of Nevada.

ADDENDUM 4 – ATTESTATION QUESTIONS

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 THIS ADDENDUM.

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? If “Yes,” attach an explanation on a separate sheet. Yes No N/A
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? If “Yes,” attach an explanation on a separate sheet. 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? If “Yes,” attach an explanation on a separate sheet. Yes No
4. Have you failed to initiate the performance of public service within one year after the date the public service is required to begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local government for your medical education? If “Yes,” attach an explanation on a separate sheet. Yes No
- 5a. Have you EVER been named as a defendant, or been requested to respond as a defendant, to a legal action involving professional liability, or malpractice, including any military tort claims if applicable? If “Yes,” please describe in the space provided on the Malpractice Liability Claims Information page within the online Uniform Application. Also complete addendum 5. Yes No
- 5b. Have you EVER had a professional liability, malpractice, claim paid on your behalf, or paid such a claim yourself including any military tort claims if applicable? If “Yes,” please describe in the space provided on the Malpractice Liability Claims Information page within the online Uniform Application. Also complete addenda 5 and 6. Yes No
6. Have you EVER been arrested, investigated for, charged with, convicted of, or pled guilty or nolo contendere to any offense or violation of any federal (including the Uniform Code of Military Justice), state or local law, or the laws of any foreign country, which is a misdemeanor, gross misdemeanor, felony, violation of the Uniform Code of Military Justice, or synonymous thereto in a foreign jurisdiction, excluding any minor traffic offense (driving or being in control of a motor vehicle while under the influence of a chemical substance, including alcohol, is not considered a minor traffic offense), or for any offense which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? *Please note that you MUST disclose ANY investigation or arrest, including those where the final disposition was dismissal, or expungement. If “Yes,” attach an explanation on a separate sheet. Yes No
7. Have you previously applied for medical licensure in Nevada (including in a Residency program)? If “Yes,” attach an explanation on a separate sheet. Yes No
8. Have you EVER been the subject of an investigation (including matters that resulted in no adverse action or outcome to you), have you resigned, been dismissed, or have any actions, restrictions, limitations, probations, terminations or any other disciplinary actions ever been imposed on you while participating in any type of training program? If “Yes,” attach an explanation on a separate sheet. Yes No

9. Have you EVER been denied a license, permission to practice medicine or any other healing art, or permission to take an examination to practice medicine or any other healing art in any state, country or U.S. territory? If "Yes," attach an explanation on a separate sheet. Yes No
10. Have you EVER had a medical license or license to practice any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory? If "Yes," attach an explanation on a separate sheet. Yes No
11. Have you EVER voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory? If "Yes," attach an explanation on a separate sheet. Yes No
12. Have you EVER been denied membership, asked to resign, or expelled from a medical society or other professional medical organization? If "Yes," attach an explanation on a separate sheet. Yes No
13. Have you EVER been: a) asked to respond to an investigation; b) notified that you were under investigation for; c) investigated for; d) charged with; or e) convicted of any violation of a statute, rule or regulation governing your practice as a physician by any medical licensing board, hospital, medical society, governmental entity or agency other than the Nevada State Board of Medical Examiners? If "Yes," attach an explanation on a separate sheet. Yes No
14. Have you EVER surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? If "Yes," attach an explanation on a separate sheet. Yes No

15. List all hospitals where you have had staff privileges denied, suspended, limited, revoked or not renewed by the hospital. List any (all resignations from any medical staff in lieu of disciplinary or administrative action.

(Please Note: Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital departmental or staff meetings, or maintain required malpractice insurance.)

Hospital	Mailing Address	Type of Action	Dates of Action

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 question 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

Yes No I attest and affirm that I am aware and understand the reporting requirements found in Nevada Revised Statute 432B.220 regarding the abuse or neglect of a child.
<http://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

Yes No I hereby attest to knowledge of and compliance with the guidelines of the Centers for Disease Control and Prevention concerning the prevention of transmission of infectious agents through safe and appropriate injection practices. I also attest that any person who is currently, or will be under my control as their supervising physician in the future, and who is not licensed pursuant to Chapter 630 of the Nevada Revised Statutes and whose duties involve injection practices, has knowledge of and is in compliance with the guidelines of the Centers for Disease Control and Prevention concerning the prevention of transmission of infectious agents through safe and appropriate injection practices.
http://www.cdc.gov/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 hereby agree that as a condition of obtaining or maintaining licensure with the Board, 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, and that the failure to do so may subject me to a fine or disciplinary action as allowed in NRS 630.244.

Printed Name of Applicant/Licensee: _____

Signature of Applicant/Licensee: _____ Email Address: _____

MILITARY SERVICE ATTESTATION

1-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.

2-If yes, which branch of service did you serve? Air Force
 Army
 Navy
 Marine Corps
 Coast Guard

3-Military occupation specialty or specialties? Administration or Personnel Logistics or Supply
 Aviation Maintenance
 Civil Engineering Medical Services
 Communications Security Forces or Military Police
 Infantry or Armor Other
 Legal or Chaplin Corps

4&5-Dates of service in the Military: 4-From: ____/____/____ 5-To: ____/____/____
DD MM YYYY DD MM YYYY

6-Are you still serving? __Yes __No

7-Have you ever served on active duty in the Armed Forces of the United States? _____Yes _____No

8-Have you ever been assigned to duty for a minimum of 6 continuous years in the National Guard or a reserve component of the Armed Forces of the United States? _____Yes _____No

9-Have you ever served the Commissioned Corps of the United States Public Health Service or the Commissioned Corps of the National Oceanic and Atmospheric Administration of the United States in the capacity of a commissioned officer while on active duty in defense of the United States? _____Yes _____No

10-If the answer to question(s) 7, 8 and/or 9 is "yes," did you separate from such service under conditions other than dishonorable? (Unless you were dishonorably discharged, your answer should be "Yes.") _____Yes _____No _____N/A

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

ADDENDUM 5 – LIST OF MALPRACTICE INSURANCE CARRIERS

If you have answered in the affirmative (“Yes”) to questions 5a and/or 5b of Addendum 4 of the UA, 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.)

ADDENDUM 6 – MALPRACTICE CLAIM VERIFICATION REQUEST

If you answered affirmatively to questions #5a and #5b in Addendum 4, complete both the top portion and release area of this form, have this form notarized, and submit this form to all malpractice carriers verifying all coverage within the past 10 years. Copies of this form may be used if you have more than one malpractice carrier or more than one occurrence with the same carrier.

Insurance Carrier Information:

Name of Insured Physician: _____

Name of Insurance Company: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

.....

(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 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
9600 Gateway Drive
Reno, NV 89521

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

RELEASE

I hereby authorize the above named institution to release any information, files, or records required by the Nevada State Board of Medical Examiners for licensure in the state of Nevada.

Medical Doctor (applicant) signature and date

State of _____ County of _____

Subscribed and sworn to before me this _____ day of _____, 2_____.

Notary Public for the State of _____

My Commission Expires: _____

Residing at: _____
City State

Signature of Notary

ADDENDUM 7 – VERIFICATION OF HOSPITAL OR SURGERY CENTER PRIVILEGES

Applicant: If you answered affirmatively to questions #13 (with regard to hospital investigations) and/or #15 in Addendum 4, submit this form to all hospitals where you have had privileges within the past 10 years. If there is more than one hospital or surgery center, photocopies of the blank form may be made and used.

Attn: Medical Staff Office

Hospital Name: _____
Address: _____

Physician Name: _____
Physician DOB: _____
Specialty: _____
Affiliation dates: _____

Hospital Chief-of-Staff or Administrator:

The above named physician submitted an application to obtain a medical license in Nevada. The applicant has indicated that he/she holds or has held staff privileges at your hospital. In order that the processing of the application may be completed, we ask that you provide us with the information requested below.

1. What privileges are/were extended to the applicant? _____

2. Dates of hospital privileges: From _____ To _____
Month / Year Month / Year

3. Have staff privileges ever been limited, restricted, suspended or revoked? No _____ Yes _____
If Yes, please explain: _____

4. Is there any derogatory information on file? No _____ Yes _____ If Yes, please explain: _____

5. Do your records indicate applicant having privileges at any other hospitals in your area?
No _____ Yes _____ If Yes, please attach list.

Signature:
Hospital Chief-of-Staff or Administrator

Typed Name, Title and Date

Phone # _____

Fax # _____

Email _____

Please return completed form to:
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521 (Physical Address)
Phone: (775) 688-2559

RELEASE
I hereby authorize the above named institution to release any information, files, or records required by the Nevada State Board of Medical Examiners for licensure in the state of Nevada.
_____ Medical Doctor (applicant) signature <u>and</u> date
State of _____ County of _____
Subscribed and sworn to before me this _____ day of _____, 2_____.
Notary Public for the State of _____
My Commission Expires: _____
Residing at: _____ City State
_____ Signature of Notary

Hospital Administrator: If you have questions, you may contact the Nevada Board at (775) 688-2559.

ADDENDUM 8 – REQUEST FOR LICENSURE BY ENDORSEMENT

(ENDORSEMENT IS NOT THE SAME AS RECIPROCITY)

State your Name, and fill in the state, territory, or District of Columbia in which licensed:

I, _____, being first duly sworn, do hereby swear or affirm under the penalties of perjury that the statements contained herein are true and correct to the best of my knowledge.

That I am now, and have been continuously, licensed to practice medicine by the licensing agency of

_____, since _____.
(State, territory, or District of Columbia) (month / day / year)

That I have never had a license to practice any type of medicine in any jurisdiction, country, state, territory, or District of Columbia, revoked for gross medical negligence.

That I am the person named in the license to practice medicine in _____,
(state, territory, or District of Columbia)

and that said license to practice medicine was obtained by me without fraud or misrepresentation or any mistake of which I am aware, and that all information contained in this application for licensure by Endorsement, and any accompanying materials, are complete and correct.

DATED this _____ day of _____, 2_____.

Signature: _____

Typed or Printed Name: _____

State of _____ County of _____

Subscribed and sworn to before me this _____ day of _____, 2_____.

(NOTARY SEAL)

Notary Public for the State of _____

My Commission Expires: _____

Residing at: _____
City State

Signature of Notary

Please return completed form to
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521

ADDENDUM 9 – REQUEST FOR LICENSURE BY A RESIDENT

(You must be currently enrolled in an approved postgraduate training program.)

ONLY complete this form if you are currently enrolled in a postgraduate training program, have completed at least 24 months of progressive postgraduate training and meet all requirements for an unlimited license in the state of Nevada, including having passed all 3 steps of USMLE within the time period allowed by NAC 630.080.

Acknowledgement of statutory requirements NRS 630.160

I, _____, am a Resident who is enrolled in a progressive postgraduate training
(Print your name)

program in the United States or Canada, approved by the Board, the Accreditation Council for Graduate Medical Education or the Coordinating Council of Medical Education of the Canadian Medical Association, and have completed at least 24 months of the program, and now commit in writing to the Nevada State Board of Medical Examiners (Board) that I will complete the program; and I hereby acknowledge that I will provide or cause to be provided to the Board proof of satisfactory completion of the program within sixty (60) days after the scheduled completion of the program.

If, after issuing a license to practice medicine to me, the Board obtains information from a primary or other source of information, and that information differs from the information provided by me (the applicant) or otherwise received by the Board, or if I fail to provide or cause to be provided to the Board proof of satisfactory completion of the program within sixty (60) days after the scheduled completion of the program, the Board may take action pursuant to Sections 4 and 5 of NRS 630.160, as well as any other disciplinary action deemed appropriate.

Applicant Signature

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

ADDENDUM 10 – CREDIT CARD AUTHORIZATION FORM

If mailing or faxing this page separately from the application, please mail to:

Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521
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: ____/____ Three or Four Digit Credit Card Verification Code: CVC: _____
(MM) (YYYY) (Code found on the back of the card)

***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: _____

Affidavit and Authorization for Release of Information

Applicant: In the presence of a notary public, sign this form with attached photo. If you are using FCVS for credentials verification, consider having that form notarized at the same time. Send the separate notarized FCVS form to FCVS. **Do not send this form to FCVS** as doing so will delay your licensure.

Send this form to the board you are applying to for licensure. Include all other required materials.

A directory of state medical and osteopathic boards is available at:
<http://www.fsmb.org/contact-a-state-medical-board/>.

Please send this form to: Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor of and person named in the various forms and credentials furnished or to be furnished with respect to my application, and that all documents, forms, or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the Uniform Application for Physician State Licensure and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me to furnish to the Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data, and to permit the Board or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

I hereby release, discharge, and exonerate the Board, its agents or representatives, and any person, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the Board.

I will immediately notify the Board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license to practice medicine being granted to me by the Board.

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my license or permit to practice medicine.

Applicant Photograph

Securely tape or glue a recent (per the board's instructions) front-view 2" x 2" passport-type color photo of yourself in this square taken within the last six months.

Applicant's signature (must be signed in the presence of a notary)

Applicant's printed last name, first name, middle initial, and suffix (e.g., Jr.)

Date of signature (must correspond to date of notarization)

NOTARY:

[Please note: **The Notary Public seal should overlap the bottom of the photo to the left. Do not cover the entire face with the seal.**]

State of _____, County of _____,

I certify that on the date set forth below, the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document.

The statements on this document are subscribed and sworn to before me by the applicant on this _____ day of _____, 20_____.

Notary Public Signature _____ My Notary Commission Expires _____

Licensure Verification Form (Form #1)

Applicant: Most boards require verification of each professional license ever held. Refer to the licensure verification resource at <https://www.fsmb.org/uniform-application/> to determine fees and preferred verification method(s) for each state medical and osteopathic verifying board. You may use this form for each board that requires a written request for verification. In Section 1, list the board you are applying to for licensure, using the directory at <https://www.fsmb.org/contact-a-state-medical-board/> to ensure you list the correct name and address. Mail this completed form and any required fee to the verifying board.

Verifying Board: Unless using electronic verification, complete Section 2 below and mail this form to the board at the address listed in Section 1. Use an additional sheet of paper if needed for explanation(s).

Section 1: Applicant Information

First name _____ Last name _____ Practitioner Type MD DO _____
 Middle name _____ Suffix _____ SSN* _____ Birth date (mm/dd/yyyy) _____

**The social security number is to be used for purposes of identification only and may not be used for any other reason.*

Authorization for Verifying Board: I am applying for a license to practice medicine. The board that I am applying to for licensure requires that this form or an otherwise accepted method of verification be completed by all boards through which I hold or have held licenses, whether now current or not. I authorize the licensing agency of the state/province of _____ to provide any and all information pertaining to my license number _____ to the board at the address listed below.

Board name	Nevada State Board of Medical Examiners
Mailing address	9600 Gateway Drive
City/State/Zip	Reno, NV 89521

Applicant signature _____ Date _____

Section 2: Board Verification of Licensure

Name of issuing board or license entity _____
 Name of licensee (last, first, middle, suffix) _____
 License type _____ License number _____ Issue date _____ Expiration date _____

1. Is this license current? If not current, please explain: Yes No
2. Have formal disciplinary proceedings been initiated against this applicant's license by a disciplinary authority in your state? If yes, please explain on a separate sheet of paper and attach it to this form. Yes No Cannot answer under state law
3. Has the applicant ever been warned, censured, placed on probation, formal consent, reprimand, or in any other manner disciplined, or has the applicant's license ever been revoked, suspended, or, in any other manner, limited by a licensing or disciplinary authority in your state? If yes, please explain on a separate sheet of paper and attach it to this form. Yes No Cannot answer under state law

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 _____
 Print name _____
 Title _____ Date _____
 Phone number _____ Fax number _____
 Email _____

AFFIX INSTITUTIONAL SEAL HERE

(If no seal is available, this form must be notarized.)

Please mail this completed form and any other items to the board at the address listed in Section 1. Thank you.

Medical or Osteopathic School Verification Form (Form #2)

Applicant: DO NOT COMPLETE THIS FORM IF YOU ARE USING FCVS. FCVS verifies this data for you. If you are not using FCVS, complete Section 1 below. Send this form and a copy of your medical school diploma to the current dean of your medical or osteopathic school. Copy this form for multiple schools.

Dean or Designated Official: Complete Section 2 of this two-page form and certify the enclosed copy of the diploma by placing your school seal on it. Mail the sealed diploma, an official copy of the physician's transcripts, this completed form, and any other documentation needed to the board at the address listed in Section 1. If transcripts are not in English, an original, certified, and official English translation is required.

Section 1: Applicant Information

First name _____ Last name _____ Practitioner Type MD DO _____

Middle name _____ Suffix _____ SSN* _____ Birth date (mm/dd/yyyy) _____

Name if different when diploma awarded: _____

Name of school _____

**The social security number is to be used for purposes of identification only and may not be used for any other reason.*

Waiver for Release of Information: I am applying for a license to practice medicine. I authorize the medical/osteopathic school listed above to provide any and all information pertaining to my medical/osteopathic education at that institution to the board at the address listed below. I request that the dean or a designated official complete Section 2 of this form and seal the copy of my diploma (attached) as described in the instructions above, then mail this completed form, the sealed diploma copy, and a copy of my official transcripts to the board listed below at the given address:

Board name Nevada State Board of Medical Examiners
 Mailing address 9600 Gateway Drive
 City/State/Zip Reno, NV 89521

Applicant signature _____ Date _____

Section 2: Medical or Osteopathic School Verification

School name _____

Complete address w/country _____

School name if different when applicant attended _____

Hours of undergraduate education required for admission _____ Total weeks of education applicant attended _____

Attendance (mm/yyyy) from _____ to _____ Graduation date _____ Degree awarded _____

Unusual Circumstances

The following questions apply to unusual circumstances that occurred during any part of the individual's medical or osteopathic education. Check the appropriate responses and provide dates and requested information. "Yes" responses to any of these questions require a copy of explanatory records or a written explanation attached to this form.

1. Do the official records for this individual reflect interruptions or extensions in his/her medical/osteopathic education? **If yes**, indicate the reasons for each interruption or extension, the dates of each interruption or extension, and whether each interruption or extension was approved or unapproved. Yes No

- | | | | |
|---|---------------------|-----------------------------------|-------------------------------------|
| <input type="checkbox"/> Personal or family | From _____ to _____ | <input type="checkbox"/> Approved | <input type="checkbox"/> Unapproved |
| <input type="checkbox"/> Academic remediation | From _____ to _____ | <input type="checkbox"/> Approved | <input type="checkbox"/> Unapproved |
| <input type="checkbox"/> Health | From _____ to _____ | <input type="checkbox"/> Approved | <input type="checkbox"/> Unapproved |
| <input type="checkbox"/> Financial | From _____ to _____ | <input type="checkbox"/> Approved | <input type="checkbox"/> Unapproved |
| <input type="checkbox"/> Participation in a joint degree program | From _____ to _____ | <input type="checkbox"/> Approved | <input type="checkbox"/> Unapproved |
| <input type="checkbox"/> Participation in a non-research special study (e.g., fellowship, intl. experience) | From _____ to _____ | <input type="checkbox"/> Approved | <input type="checkbox"/> Unapproved |
| <input type="checkbox"/> Other _____ | From _____ to _____ | <input type="checkbox"/> Approved | <input type="checkbox"/> Unapproved |

2. Do the official records for this individual reflect that he/she was ever placed on academic or disciplinary probation during his/her medical/osteopathic education? Yes No **If yes**, indicate below the reasons for each time of probation and the dates of placement on and removal from probation. Also attach documentation or information of each circumstance and outcome.

<input type="checkbox"/> Academic	From _____ to _____	<input type="checkbox"/> Documentation attached
<input type="checkbox"/> Unprofessional conduct	From _____ to _____	<input type="checkbox"/> Documentation attached
<input type="checkbox"/> Behavioral reasons	From _____ to _____	<input type="checkbox"/> Documentation attached
<input type="checkbox"/> Other _____	From _____ to _____	<input type="checkbox"/> Documentation attached

3. Do the official records for this individual reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical/osteopathic school or parent university? Yes No **If yes**, explain below and/or attach documentation or information of each circumstance and outcome.

4. Do the official records for this individual reflect that he/she was ever the subject of negative reports for behavioral reasons or an investigation by the medical/osteopathic school or parent university? Yes No **If yes**, explain below and/or attach documentation or information of each circumstance and outcome.

5. Do the official records for this individual reflect that there were ever any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason? Yes No **If yes**, explain below and/or attach documentation or information of each circumstance and outcome.

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.

AFFIX INSTITUTIONAL SEAL HERE
(If no seal is available, this form must be notarized.)

Signature _____
Print name _____
Title _____ Date _____
Phone number _____ Fax number _____
Email _____

Please mail this completed form and any other items to the board at the address listed in Section 1. Thank you.

Institution Name: _____
Institution Address: _____

Affiliated School: _____

Applicant: Do not complete this form for verification of accredited training if you are using FCVS. FCVS does not verify non-accredited training. When using FCVS, use this form only if your licensing board requires verification of non-accredited training.

Program Director or Designated Official: Please complete Section 2, and mail this form and any other items to the designated state medical board at the address listed in Section 1. Thank you.

Section 1:
To be completed by the Applicant.

Board Information:
 To be completed by the applicant.

Applicant Please Sign Here →

Name: _____ **Suffix** _____ **Practitioner type:** M.D. D.O.

Date of birth: _____ (mm/dd/yyyy) **SSN*** _____
 *The social security number is to be used for purposes of identification only and may not be used for any other reason.

Name if different when diploma awarded: _____

Waiver for Release of Information: I request that the program director or a designated official complete Section 2 of this form as outlined below. I authorize the postgraduate training program listed above to provide any all information pertaining to my training there to the board listed below:

Board Name: _____
Mailing address: _____
Applicant Signature _____ **Date** _____

Section 2 :
Program Participation :

Important:

Report Incomplete Training Levels (years) separate from those that were successfully completed.

If the training level (year) is currently in progress report the expected completion date in the "To" field.

Use one section per Department/Specialty. If the Department/Specialty is rotating or transitional, please provide a schedule of rotations.

Report Internships, Residencies and Fellowships separately.

Unusual Circumstances:

Check the appropriate responses and explain any "Yes" or omitted response(s) on a separate sheet of paper. Attach pages as needed.

Training Level: _____ (e.g., 1, 2, 3, etc.) <input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Chief Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Research	Specialty/Subspecialty: _____ From: ____/____/____ To: ____/____/____ Successfully Completed?: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress Accredited by: <input type="checkbox"/> ACGME <input type="checkbox"/> AOA <input type="checkbox"/> LCGME <input type="checkbox"/> RSC <input type="checkbox"/> CFPC <input type="checkbox"/> RCPSA <input type="checkbox"/> APPAP <input type="checkbox"/> None of these
Training Level: _____ (e.g., 1, 2, 3, etc.) <input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Chief Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Research	Specialty/Subspecialty: _____ From: ____/____/____ To: ____/____/____ Successfully Completed?: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress Accredited by: <input type="checkbox"/> ACGME <input type="checkbox"/> AOA <input type="checkbox"/> LCGME <input type="checkbox"/> RSC <input type="checkbox"/> CFPC <input type="checkbox"/> RCPSA <input type="checkbox"/> APPAP <input type="checkbox"/> None of these
Training Level: _____ (e.g., 1, 2, 3, etc.) <input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Chief Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Research	Specialty/Subspecialty: _____ From: ____/____/____ To: ____/____/____ Successfully Completed?: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress Accredited by: <input type="checkbox"/> ACGME <input type="checkbox"/> AOA <input type="checkbox"/> LCGME <input type="checkbox"/> RSC <input type="checkbox"/> CFPC <input type="checkbox"/> RCPSA <input type="checkbox"/> APPAP <input type="checkbox"/> None of these

- Did this individual ever take a leave of absence or break from his/her training? ----- Yes No
- Was this individual ever placed on probation? ----- Yes No
- Was this individual ever disciplined or placed under investigation? ----- Yes No
- Were any negative reports for behavioral reasons ever filed by instructors? ----- Yes No
- Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason? ----- Yes No

Certification: Affix your institutional seal in this space. If no seal is available, you must have this form notarized.

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. This section MUST be signed by the program director (M.D. or D.O. only). (Signature by personnel other than an M.D. or D.O. must attach an authorization letter. Applicable only for Nevada State Board of Medical Examiners.)

Signature: _____
Print name: _____
Title: _____
Email address: _____
Phone Number: _____ **Date:** _____

Fifth Pathway Verification Form (Form #4)

Applicant: DO NOT COMPLETE THIS FORM IF YOU ARE USING FCVS. FCVS verifies this data for you. If you are not using FCVS, complete Section 1 below. Send this form to your Fifth Pathway program director.

Program Director or Designated Official: Complete Section 2 of this form. Mail this completed form and any other documentation (if applicable) to the board at the address listed in Section 1.

Section 1: Applicant Information

First name _____ Last name _____ Practitioner Type MD DO _____

Middle name _____ Suffix _____ SSN* _____ Birth date (mm/dd/yyyy) _____

Name if different when diploma was awarded: _____

Name of medical school _____

**The social security number is to be used for purposes of identification only and may not be used for any other reason.*

Waiver for Release of Information: I request that the program director or a designated official complete Section 2 of this form as outlined above. I authorize the designated official to provide any and all information pertaining to my time there to the board listed below:

Board name Nevada State Board of Medical Examiners
 Mailing address 9600 Gateway Drive
 City/State/Zip Reno, NV 89521

Applicant signature _____ Date _____

Section 2: Fifth Pathway Verification

Institution name _____ Affiliated school _____

Institution name if different when applicant attended _____

Institution address w/country _____

Type of Clinical Rotation	From	To	Weeks	Credit
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Completed? Yes. Attendance was from _____ to _____. Completion date was _____.

No. Commencement date was: _____ Withdrawal* date was _____. **If the applicant withdrew or was dismissed, please explain below.*

No. Commencement date was: _____ Dismissal* date was: _____. **If the applicant withdrew or was dismissed, please explain below.*

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 _____
 Print name _____
 Title _____ Date _____
 Phone number _____ Fax number _____
 Email _____

AFFIX INSTITUTIONAL SEAL HERE
 (If no seal is available, this form must be notarized.)