Nevada State Board of Osteopathic Medicine
Application for Osteopathic Physician

Dear Applicant:

Thank you for considering obtaining an Osteopathic Physician License in the State of Nevada. Nevada remains among the fastest growing states in the country. With such population growth, the need for physicians is increasing.

The Board of Osteopathic Medicine's primary mission is to protect the public by licensing osteopathic physicians and physician assistants who demonstrate clinical competence to practice medicine as well as the professional and ethical demeanor necessary to lead the modern health care team. With this in mind, we have developed application procedures, which are very thorough so that the board can maintain confidence that the licensees will benefit the community in which they practice.

Balancing the states dramatic need for physicians with the public mandate of quality and professional excellence; the increased desire from the profession for license portability; the board has worked tirelessly to modernize the application process. The application you will be completing, although somewhat lengthy in appearance, is as concise as legally permissible.

Nevada upholds some of the highest medical licensing standards in the United States to help maintain the public's trust in the osteopathic medical profession. Additionally, the board has updated the requirements to obtain information considered important in the licensing process, please see below:

Federation Credentials Verification Service (FCVS) or Primary Source Documents to the NV State Board of Osteopathic Medicine. FCVS Is no longer required for osteopathic physicians licensure. The licensee can have primary source verification of a medical provider's core medical credentials sent directly to this Board. We will require original college transcripts, COMLEX test scores, USMLE test scores (if applicable), confirmation of residency program(s), notarized copy of your passport, or a certified copy of your birth certificate.

You may enroll in the FCVS service by going to www.fsmb.org or call 1-817-868-4000. FCVS credentialing process may be utilized and initiated as soon as possible by contacting them at www.fsmb.org/fcvs or call 817-868-4000. The gathering and verifying of core credentials takes the longest amount of time during the application process, therefore we encourage that it be initiated immediately.

Please read **NRS Chapter 633.399 and NRS Chapter 633.400** before starting the FCVS process to see if you qualify for license by endorsement. **New updated regulations** allow the licensee to have primary source verifications sent directly to this Board and forego the FCVS process.

1.) **Fingerprinting for NCIC** – National criminal Information Center (FBI)**.** Pursuant to NRS 633.309 all applicants of licensure (except a special license) must submit to the board a complete set of fingerprints for a criminal background check. Although a criminal record or history may not be absolute grounds for denial of licensure, these and all issues will be seriously considered and MUST be disclosed on your application before this report is received in our office.

Per AB275: An Applicant for a license who does not have a social security number must provide an alternative personally identifying number, including, without limitation, his or her individual taxpayer identification number, when completing an application for a license.

After we have received your completed application with the fee, the FCVS report or primary source documents, the criminal background check report, and all other required forms, the packet for licensure will be reviewed by our Executive Director and pre-approved to be sent to our Board Members for their review. All packets must be completed within 30 days of any scheduled board meeting to be considered for that particular board meeting. If the packet is accepted you will receive a letter by mail letting you know that you have been scheduled for consideration at the next board meeting.

If you are a resident who is enrolled in a postgraduate training program in this State, has completed 24 months of the program and has committed, in writing, that you will complete the program, a proof of satisfactory completion of the postgraduate training program **must** be sent to us within 120 days after the scheduled completion of the program.

An interview may be required if the Executive Director and President of the Board deems it necessary to explore your packet more thoroughly if certain information was learned during the application process. All applicants required to attend an interview with the Board are notified 21 working days prior to the meeting date via certified mail.

Again, thank you for considering licensure! If you have any questions, regarding the application process, please do not hesitate to contact the Board office and speak with the licensing specialist.

Sincerely,

The Executive Director and Licensing Staff of
Nevada State Board of Osteopathic Medicine
2275 Corporate Circle, Suite 210
Henderson, NV 89074
(702) 732-2147 ext. 222
(702) 732-2079 (Facsimile)
Toll Free: (877) 725-7828

E-Mail: tsine@bom.nv.gov
Website: www.bom.nv.gov

Nevada State Board of Osteopathic Medicine
Application for Osteopathic Physician Licensure
Requirements and Instructions

Minimum Requirements for Licensure refer to NRS 633.311.

1. 21 YEARS OF AGE and,
2. GRADUATION FROM A SCHOOL OF OSTEOPATHIC MEDICINE BEFORE 1995, and
   a. COMPLETION OF A HOSPITAL INTERNSHIP
   b. ONE YEAR OF POSTGRADUATE TRAINING THAT COMPLIES WITH THE STANDARDS OF INTERN TRAINING ESTABLISHED BY THE AOA, or
3. GRADUATED FROM A SCHOOL OF OSTEOPATHIC MEDICINE AFTER 1995 and
   a. COMPLETED 3 YEARS OF PROGRESSIVE POSTGRADUATE MEDICAL EDUCATION AS A RESIDENT IN THE UNITED STATES OR CANADA IN A PROGRAM APPROVED BY THE BOARD, AOA, OR THE ACCME, or
   b. IS A RESIDENT WHO IS ENROLLED IN A POSTGRADUATE TRAINING PROGRAM IN THIS STATE, HAS COMPLETED 24 MONTHS OF THE PROGRAM, AND HAS COMMITTED IN WRITING TO COMPLETE THE PROGRAM, and
4. PASSES ALL PARTS OF THE LICENSING EXAM OF THE NBOME, or the FEDERATION OF STATE MEDICAL BOARDS OF THE UNITED STATES, INC., or ALL PARTS OF THE LICENSING EXAM OF THE BOARD, A STATE TERRITORY OR POSSESSION OF THE UNITED STATES OR THE DISTRICT OF COLUMBIA AND IS ELIGIBLE FOR CERTIFICATION BY A SPECIALTY BOARD OF THE AOA OR AMERICAN BOARD OF MEDICAL SPECIALTIES; or.
5. PASSAGE OF A COMBINATION OF THE PARTS OF THE LICENSING EXAMS SPECIFIED IN ITEM 6 THAT IS APPROVED BY THE BOARD.
6. COMPLETION OF THE APPLICATION AND ALL REQUESTED DOCUMENTATION; and.
7. SUBMISSION OF 1 (ONE) FINGERPRINT CARD.
8. PAYMENT OF FEES: Non-refundable application and initial licensure fee $550.00 for DO's (Includes Fingerprinting Fee). Please remit payment of **$300.00 with this application**. If additional payment is needed, you will be contacted.
   a) **Licenses issued between January 1 and June 30 will have to pay the full fee of $550.00.**
   b) **Licenses issued between July 1 and November 30 will pay $300.00.**
   c) **Please include a payment of $300.00 with this application; if additional payment is required, you will be contacted.**

   THIS MUST BE RECEIVED BEFORE YOUR LICENSE IS APPROVED.

INSTRUCTIONS

Application (pages 1-9); Are to be completed by the applicant, notarized as indicated, and returned to the Nevada State Board of Osteopathic Medicine with the application fee.

FEES ARE NON-REFUNDABLE AND ONLY APPLY TO THE YEAR THAT YOUR LICENSE IS APPROVED. THIS BOARD HAS A YEARLY RENEWAL.

FCVS You must enroll in this service immediately by going to www.fsmb.org or call 1-817-868-4000. Unless you qualify for license by endorsement; please see NRS 633.399 and NRS 633.400 on our website. **In lieu of the FCVS packet**, you may have primary source verification of medical school, testing such as COMLEX, NBOME, and USMLE, residency confirmation, and a certified birth certificate or notarized passport.

FBI Fingerprint Card and instructions will be sent to you upon receipt of this APPLICATION, the online application, **or** you can call to get them mailed to you.

Form #1, **VERIFICATION OF LICENSE**: Applicant is to fill out top portion and then forward to each State Board in which a license is/was held. Each state board will complete the bottom portion and return to the *Nevada State Board of Osteopathic Medicine*. Many States charge a fee for verification, which is the responsibility of the applicant. This form will only be accepted if received ***FROM*** that states professional licensing authority or board. We **do** accept verification through VeriDoc.

Form #2, **MEDICAL MALPRACTICE:** Applicant is to complete this form if there is an open, closed, or dismissed medical malpractice claim.

Form #3, **AFFIDAVIT OF MORAL AND PROFESSIONAL CHARACTER**: Must be delivered by the applicant to three licensed physicians, (DO or MD) and **returned directly to the Board from the physician completing the affidavit** after being completed and notarized. Additional copies may be obtained by photocopying Form 4.

If additional space is required for answers, separate sheets may be attached to the application. All additional sheets must be 8 and ½ x 11 inches in size. Any "Yes" question other than #15 and #16 on the survey section **MUST** be explained on a separate sheet of paper.
No Application will be processed prior to receipt of all required fees.

Checklist

After completing the enclosed application, you are responsible for submitting the application along with certain documents. This checklist is intended to help you ensure that all proper documents accompany your application.

Completed Application	☐
State Licensure Verification form sent to the Board from **all** states in which you have ever held **any** healthcare license(s)	☐
Enclose and have notarized the completed "Affidavit and Authorization for Release of Information" form with this application when submitting it to the Board	☐
Federation Credentials Verification Service (FCVS) completed report or Primary Source Documents (See above)	☐
Initial check in the amount of $300.00 (partial application and FBI Fingerprint fee). Licenses approved prior to July 1 will require an additional payment of $250.00 and will be contacted for payment.	☐
Child Support Information Form (per NRS 633.307)	☐
Proof of residency program	☐
Completed Medical Malpractice and or Professional Liability Reporting form or **any and all** malpractice claims, settlements, and or judgments.	☐
1 (one) Completed FBI Applicant Fingerprint Card, authorization form, and identification form.	☐ ☐
Copy of Board Specialty Certification if applying for **license by endorsement**. See **NRS 633.399 and NRS 633.400**.	☐
3 (three) Affidavits of Moral and Professional Character from licensed DO, MD, or PA.	☐ ☐ ☐

It is your responsibility to 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 being granted to you by the board.

All forms should be sent directly to the board unless otherwise indicated:

State of Nevada - Board of Osteopathic Medicine
2275 Corporate Circle, Suite 210
Henderson, NV 89074
(702) 732-2147

(702) 732-2079 (fax)
Toll Free: (877) 325-7828 tsine@bom.nv.gov

State of Nevada - Board of Osteopathic Medicine
Application for Osteopathic Physician Licensure

1. Name: Indicate your full legal name. If your name has changed at any time during your life, you must submit a copy of the legal document (marriage certificate, divorce decree, etc.) supporting your name change.

1. Full Name (use no initials)

Last Name | First Name | Middle Name | Suffix | Maiden Name

All other names used

2. Address/Phone: Please complete all sections and indicate which address you wish to be used for public access and which is to be used for mailings from the medical board. Each state's law determines whether each addresses or phone number is a public record in the state in which you are applying. You may wish to contact the licensing authority for that state for further information. Many boards publish the "Public Access" address on their website; therefore you should consider what your preferred address is for these purposes.

2. Address/Phone

Practice Address
☐ Public Access
☐ Mailing

Street

City | State | Zip Code

Telephone | Fax | E-mail address | Alternate Phone

Home Address
☐ Public Access
☐ Mailing

Street

City | State | Zip Code

Telephone | Fax | E-mail address | Alternate Phone

Medical Specialty: _____

Are you Board Certified in the above specialty? ☐ **Yes** ☐ **No**
If yes, please complete the following:

Specialty Board | Certification Number | Date of Certification | Expiration Date

Active Military: ☐ **Yes** ☐ **No** **Spouse Active Military:** ☐ **Yes** ☐ **No**

Have you ever served in the Armed Forces of the United States? ☐ **Yes** ☐ **No**
If yes, in which branch and When? _____

Are you the surviving spouse of a veteran? ☐ **Yes** ☐ **No**

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 and separated from such service under conditions other than dishonorable? ☐ **Yes** ☐ **No**

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 and separated from such service under conditions other than dishonorable? ☐ **Yes** ☐ **No**

3. Identification

__/__/__

Date of Birth (mm/dd/yyyy) | Birth City | Birth State | Birth Country

_____ _____

Gender | Social Security Number (if none, see below)

Or, If none,

_____

Alternative Personal Identification Number (such as Taxpayer ID)

_____ _____ _____ _____

Height | Weight | Color of Hair | Color of Eyes

Your social security number is required to facilitate reporting to the federal Healthcare Integrity & Protection Data Bank (42 U.S.C. Sections 1320a-7e(b), 5 U.S.C. Section 552a, and 45 C.F.R. pt. 61) and for accurate identification under the federal and state child support enforcement law (42 U.S.C. Section 666 and applicable state law). It may also be used for reporting to the National Practitioner Data Bank (42 U.S.C. Section 11101 and 45 C.F.R. pt. 60) and for other investigative/enforcement purposes in compliance with state laws governing physician discipline or as otherwise required by state or federal law (NRS 633.326).

4. List name and address for any and all colleges or universities attended other than schools where professional medical education was received.

4. Colleges or Universities (attach additional pages if necessary)

1. _____
School Name | Address

_____
City | State | Zip Code | Country | Attendance Dates From – To | Graduation Date | Degree

2. _____
School Name | Address

_____
City | State | Zip Code | Country | Attendance Dates From – To | Graduation Date | Degree

5. Medical School: List **all** medical schools you have attended, even those from which you did not graduate in chronological order. Attach an additional sheet if necessary.

5. Medical School (attach additional pages if necessary)

1. _____
School Name Address

_____
City State Zip Code Country Attendance Dates From – To Graduation Date Degree

2. _____
School Name Address

_____
City State Zip Code Country Attendance Dates From – To Graduation Date Degree

6. Child Support Information (per NRS 633.326)

Please mark the appropriate response:

_____ I am NOT subject to a court order for the support of a child.

_____ 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 controlling public agency enforcing the order for the repayment of the amount owed pursuant to the order; or

_____ 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.

_____
Signature of Applicant

7. Examination History:

7. Examination History

List each licensure examination, U.S. or international, you have taken (USMLE, NBME, NBOME, Etc.). If additional space is necessary, please enclose a separate sheet with your application and include all the information below.

Examination	Most Recent Date taken (Month/Year)	Passed (P) or Failed (F)	Number of attempts
☐ State Board Exam _____ State	_____	☐ P ☐ F	_____
☐ NBOME Part I	_____	☐ P ☐ F	_____
☐ NBOME Part II	_____	☐ P ☐ F	_____
☐ NBOME Part III	_____	☐ P ☐ F	_____
☐ COMVEX	_____	☐ P ☐ F	_____
☐ COMLEX Part I	_____	☐ P ☐ F	_____
☐ COMLEX Part II CE	_____	☐ P ☐ F	_____
☐ COMLEX Part II PE	_____	☐ P ☐ F	_____
☐ COMLEX Part III	_____	☐ P ☐ F	_____
☐ SPEX	_____	☐ P ☐ F	_____
☐ FLEX Pre-1985	_____	☐ P ☐ F	_____
☐ FLEX Component 1	_____	☐ P ☐ F	_____
☐ FLEX Component 2	_____	☐ P ☐ F	_____
☐ USMLE Step I	_____	☐ P ☐ F	_____
☐ USMLE Step II	_____	☐ P ☐ F	_____
☐ USMLE Step III	_____	☐ P ☐ F	_____

8. Postgraduate Training: List **all** postgraduate programs you have attended, even those you did not complete. Attach an additional sheet if necessary.

8. Postgraduate Training (copy and attach additional pages if necessary)

Complete name and address of hospital where training was conducted (Do Not Abbreviate)

1. _____
Hospital Name

_____
Hospital Address **City** **State** **Zip Code** **Country**

PGY: ___ (e.g., 1, 2, 3, etc.) ☐ **Internship** ☐**Residency** ☐**Fellowship** ☐**Research** ☐**Other**_____

Department/Specialty: _____

From: ____/____ **To:** ____/____ **Successfully Completed?** ☐ **Yes** ☐ **No** ☐ **In Progress**
Month **Year** **Month** **Year**

2. _____
Hospital Name

_____
Hospital Address **City** **State** **Zip Code** **Country**

PGY: ___ (e.g., 1, 2, 3, etc.) ☐ **Internship** ☐**Residency** ☐**Fellowship** ☐**Research** ☐**Other**_____

Department/Specialty: _____

From: ____/____ **To:** ____/____ **Successfully Completed?** ☐ **Yes** ☐ **No** ☐ **In Progress**
Month **Year** **Month** **Year**

3. _____
Hospital Name

_____
Hospital Address **City** **State** **Zip Code** **Country**

PGY: ___ (e.g., 1, 2, 3, etc.) ☐ **Internship** ☐**Residency** ☐**Fellowship** ☐**Research** ☐**Other**_____

Department/Specialty: _____

From: ____/____ **To:** ____/____ **Successfully Completed?** ☐ **Yes** ☐ **No** ☐ **In Progress**
Month **Year** **Month** **Year**

4. _____
Hospital Name

_____
Hospital Address **City** **State** **Zip Code** **Country**

PGY: ___ (e.g., 1, 2, 3, etc.) ☐ **Internship** ☐**Residency** ☐**Fellowship** ☐**Research** ☐**Other**_____

Department/Specialty: _____

From: ____/____ **To:** ____/____ **Successfully Completed?** ☐ **Yes** ☐ **No** ☐ **In Progress**
Month **Year** **Month** **Year**

9. State or Professional Licensure: You must complete the attached "Licensure Verification" form and forward it to **all** states in which you have held **any** healthcare license or certification. The verifying entity must forward all documentation directly to this board. Some state boards charge a fee for this information. Contact the state board where you hold or held a license to determine their requirements.

9. State Licensure –DO only – all others complete the section below; attach additional pages if necessary

1. State_____Type _____License Number_____Status_____Issue Date_____
(Special, Training, or Full License)
2. State_____Type_____License Number_____Status_____Issue Date_____
(Special, Training, or Full License)
3. State_____Type_____License Number_____Status_____Issue Date_____
(Special, Training, or Full License)
4. State_____Type_____License Number_____Status_____Issue Date_____
(Special, Training, or Full License)
5. State_____Type_____License Number_____Status_____Issue Date_____
(Special, Training, or Full License)
6. State_____Type_____License Number_____Status_____Issue Date_____
(Special, Training, or Full License)
7. State_____Type_____License Number_____Status_____Issue Date_____
(Special, Training, or Full License)
8. State_____Type_____License Number_____Status_____Issue Date_____
(Special, Training, or Full License)
9. State_____Type_____License Number_____Status_____Issue Date_____
(Special, Training, or Full License)
10. State_____Type_____License Number_____Status_____Issue Date_____
(Special, Training, or Full License)

All Other Healthcare Licensure/Certification (e.g., RN, PA, etc.) - attach additional pages if necessary.

1. State_____Type_____License Number_____Status_____Issue Date_____
2. State_____Type_____License Number_____Status_____Issue Date_____
3. State_____Type_____License Number_____Status_____Issue Date_____
4. State_____Type_____License Number_____Status_____Issue Date_____
5. State_____Type_____License Number_____Status_____Issue Date_____

Applicant Name: _____ Date: _____

10. Chronology of Activities: Please provide a chronological listing of **all medical and non-medical employment** for the past ten (10) years. Use an additional page to account for non-professional activities and any other gaps in time between professional experiences, including military duty.

10. Chronology of Activities (copy and attach additional pages if necessary)

Dates: From/To	Practice/Employment
1. From: To:	_____ Practice/Employment Name _____ Practice/Employment Address City State Zip Code Country Position & Department: _____ % Clinical ____ % Administrative ____ ☐Employment ☐Staff Privileges ☐Affiliation ☐Other _____
2. From: To:	_____ Practice/Employment Name _____ Practice/Employment Address City State Zip Code Country Position & Department: _____ % Clinical ____ % Administrative ____ ☐Employment ☐Staff Privileges ☐Affiliation ☐Other _____
3. From: To:	_____ Practice/Employment Name _____ Practice/Employment Address City State Zip Code Country Position & Department: _____ % Clinical ____ % Administrative ____ ☐Employment ☐Staff Privileges ☐Affiliation ☐Other _____
4. From: To:	_____ Practice/Employment Name _____ Practice/Employment Address City State Zip Code Country Position & Department: _____ % Clinical ____ % Administrative ____ ☐Employment ☐Staff Privileges ☐Affiliation ☐Other _____
5. From: To:	_____ Practice/Employment Name _____ Practice/Employment Address City State Zip Code Country Position & Department: _____ % Clinical ____ % Administrative ____ ☐Employment ☐Staff Privileges ☐Affiliation ☐Other _____

11. Questions: Please answer yes or no to the following questions. All, **'yes'**, answers in questions **1 through 14 must be explained** on a **separate sheet of 81/2 x 11 piece of paper**. Each numbered question corresponds to a numbered, 'yes', or, 'no', check box on the right side of this page.

1. Have any disciplinary or administrative actions ever been taken against any healing art license which you now hold or have held by the U.S. Military, U.S. Public Health Service, or other U.S. federal government entity? 1. ☐Yes ☐No

2. 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? 2. ☐Yes ☐No

3. Have you ever had a medical license revoked, suspended, or limited in any state, or U.S. territory? 3. ☐Yes ☐No

4. Have you ever voluntarily surrendered a license to practice in the healing arts in any state, country or U.S. territory? 4. ☐Yes ☐No

5. Have you ever failed a state licensure examination, any part of FLEX, COMLEX, USMLE, or NBOME even if subsequently passed? 5. ☐Yes ☐No

6. Have you ever had staff privileges in a hospital denied, suspended, limited, revoked or non-renewed, or have you ever resigned from a medical staff in lieu of disciplinary or administrative action? (This does not include suspensions or restrictions for failure to complete medical records). 6. ☐Yes ☐No

7. Have you ever been investigated for, charged with, or convicted of unprofessional conduct, professional incompetence, gross malpractice or malpractice, or any other violation or statute, rule or regulation governing the practice of medicine by any medical licensing board or other agency (including Federal), hospital or medical society or **sued in a court of law for alleged malpractice**? 7 ☐Yes ☐No

8. Have you ever been denied membership or expelled from a medical society or other professional medical organization including the AOA, AMA, any member specialty board of the AOA or ABMS? 8. ☐Yes ☐No

9. Are you currently in treatment for a mental illness, drug addiction, or acute substance, drug or alcohol abuse? 9. ☐Yes ☐No

10. Do you regularly take any prescription drug for therapeutic purposes? 10. ☐Yes ☐No

11. Have you ever surrendered your state or federal controlled substance registration or had it restricted in any way? 11. ☐Yes ☐No

12. Are you now or within the past year, addicted to controlled substances, including, but not limited to narcotics or alcohol? 12. ☐Yes ☐No

13. Are you now or have been within the past year investigated for, charged with or convicted of, or pled nolo contendere to a violation of any federal, state or local law relating to the manufacture, distribution, or dispensing of controlled substances, or to drug addiction? 13. ☐Yes ☐No

14. Have you ever been arrested, investigated for, charged with or convicted of, or pled nolo contendere to any offense, misdemeanor or felony in any state, the United States, or a foreign country? (Except minor traffic violations). 14. ☐Yes ☐No

15. Do you attest to knowledge of safe injection practices and CDC Guidelines? 15. ☐Yes ☐No

16. If granted a license, do you intend to practice in Nevada? 16. ☐Yes ☐No

If yes, LOCATION _____
When: _____

Affidavit and Authorization for Release of Information: You must attach a recent (less than 6 months old) passport quality, color photograph of yourself to this form. Take the form to a notary public and sign the form in the presence of the notary public. The notarized form then must be sent directly to this Board.

Affidavit
And
Authorization For Release of Information

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have or shall make with respect thereto are true, that I am the original and lawful possessor 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 Application for Physician 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 furnishing information, 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 licensure or permit to practice medicine.

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

_____

Applicant's **Printed** Last Name

_____

Applicant's **Printed** First Name, Middle Initial, and Suffix (e.g., Jr.)

_____

Date of Signature

Applicant Photograph

Securely tape or glue in this square a current, front-view, 2-inch by 2-inch passport-type color photograph of yourself

NOTARY

Dated _____ Signed _____

State of _____ County of _____

SUBSCRIBED AND SWORN TO before me this _____ day of _____, 20___.

My commission expires: _____ (NOTARY PUBLIC SIGNATURE & SEAL)

Licensure Verification Form

(Copy this form for multiple licenses)

I am applying for a license to practice medicine with the **State of Nevada - Board of Osteopathic Medicine**. The Board requires that this form be completed by each state or Canadian province in which I hold or have held licenses, whether now current or not. Please complete the form and return it directly to the following Board:

To be completed by applicant

Applicant Name: _____
Last First Middle Suffix

Date of Birth: _____ SS or TIN Number: _____ License Number: _____
(From State/Province you are sending this form to)

The applicant's social security number is to be used for purposes of identification and may not be used for any other reason.

I hereby authorize the licensing agency of the State/Province of _____ to furnish the information to the Board indicated below.

Signature of Applicant _____ Date _____

Board Name: NEVADA STATE BOARD OF OSTEOPATHIC MEDICINE

Address: 2275 Corporate Circle, Suite 210 Henderson NV 89074
Street City State Zip Code

TO BE COMPLETED BY STATE LICENSING BOARD OR CANADIAN PROVINCE

Name of Licensee: _____
Last First Middle Suffix

License Type: _____ License Number: _____ Issue Date: _____

Is this license current? ☐Yes ☐No Expiration Date: _____

1) Have formal disciplinary proceedings been initiated against applicant's license by a disciplinary authority in your state?
☐Yes ☐No ☐Cannot answer under state law
If Yes, please explain: _____

2) Has the applicant ever been warned, censured, placed on probation, formal consent, reprimand or in any other manner disciplined or has applicant's license been revoked, suspended, or in any other manner limited by a licensing or disciplinary authority in your state?
☐Yes ☐No ☐Cannot answer under state law
If Yes, please explain: _____

Affix Board Seal Here

Board Authorized Signature: _____

Title: _____

Date: _____

Return to:
State of Nevada - Board of Osteopathic Medicine
2275 Corporate Circle, Suite 210
Henderson, NV 89074

Form #2

Medical Malpractice/Professional Liability Claims Information

(Copy this form to report multiple claims)

Date of Claim/Suit:_____ Date You Received Notice:_____

State/County of Event: _____ Date of Event:_____

Court Case Number _____ Court Filing Date: _____
Court Where Filed In: _____

Insurance Company (or specify if self-insured):_____

Insurance Claim No. (or if self-insured write n/a):_____

Claimant:_____

Respondent:_____

Brief Description of Allegations:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

***** Please attach/mail a copy of the Summons/Complain/Claim notice with form*****

Claim Status & Effective Date of That Status:

☐Open (pending) ☐Arbitration/Medication ☐Closed (settled) ☐Dismissed ☐Other

Date of Closure: _____

Amount of judgment or settlement $_____ Amount paid on your behalf $ _____

*****Refer to NRS 633.527 for all requirements of reporting Malpractice Claims/Board Actions*****

Nevada State Board of Osteopathic Medicine
2275 Corporate Circle, Suite 210
Henderson, NV 89074

Form #3

State of Nevada - Board of Osteopathic Medicine
Graduate Medical Education

(Copy this form for multiple residency programs)

Applicant Instructions: Complete Section 1 and Section 2 of this form then send this form to **each and every residency program or fellowship you attended**. Request the Chief of Medical Staff or designated official to complete Section 3 of this form and return to this Board.

Section 1: Applicant Information

Last Name:_____ First Name:_____ Middle Name:_____

Name if different when diploma awarded:_____

Social Security Number:_____ Date of Birth:_____

The applicant's social security number is to be used for purposes of identification and may not be used for any other reason.

Waiver for release of information: I authorize this hospital or medical center listed below to provide any and all information pertaining to my medical staff privileges at your institution to the State of Nevada - Board of Osteopathic Medicine.

_____ _____
Applicant's Signature Date

PGY: _____ (e.g., 1, 2, 3, etc.) ☐ Internship ☐Residency ☐Fellowship ☐Research

PGY: _____ (e.g., 1, 2, 3, etc.) ☐ Internship ☐Residency ☐Fellowship ☐Research

PGY: _____ (e.g., 1, 2, 3, etc.) ☐ Internship ☐Residency ☐Fellowship ☐Research

PGY: _____ (e.g., 1, 2, 3, etc.) ☐ Internship ☐Residency ☐Fellowship ☐Research

Section 3: RESIDENCY or FELLOWSHIP VERIFICATION

Institution Name:_____

Institution Address: _____
Street City State Zip Code

Affiliated Medical School Name:_____

Type of Specialty:_____

Training Period From Date: _____/_____/_____ To Date: _____/_____/_____

Current Status of Residency: _____

(Continued on Next Page)

Form #3 continued

Unusual Circumstances:

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

Please explain any "Yes" response from above (attach additional pages if necessary):_____

_____

_____

_____

_____

_____

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:_____

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

Title:_____

Date:_____

Phone number:_____ Fax:_____

E-mail: _____

Return to:

State of Nevada - Board of Osteopathic Medicine
2275 Corporate Circle, Suite 210
Henderson, NV 89074
702-732-2147
702-732-2079 (fax)
Toll Free: (877) 325-7828

Form #4

STATE OF NEVADA – BOARD OF OSTEOPATHIC MEDICINE
Affidavit of Moral and Professional Character

(This form may be duplicated for a total of THREE from different physicians is required)

This letter of recommendation must be signed by a licensed D.O., M.D., P.A., or APRN

_____ , 20 _____

City State Date

To the Nevada State Board of Osteopathic Medicine:

I certify that I am licensed under the laws of _____ to practice either allopathic or osteopathic medicine and that I have known the applicant,

_____**,** D.O or P.A., for _____ years, that I personally knew the applicant while actively engaged in the practice of osteopathic medicine; that he/she is of good moral character and worthy of professional recognition, that he/she is free from habits liable to interfere with the provision of professional services, has good standing in the community in which he/she resides and is worthy of receiving a license to practice osteopathic medicine in the State of Nevada.

_____ _____

Signature Address

_____ _____

Print Name

_____

Subscribed and sworn to before me on the _____
day of _____, 20 _____

_____ Notary Public State of _____

Signature of Notary

My Commission expires on _____

Residing at _____

Please return completed form to the:

Nevada State Board of Osteopathic Medicine
2275 Corporate Circle, Suite 210
Henderson, NV 89074
702-732-2147