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 RECIPROCITY 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, 2017 – June 30, 2018**

<table>
<thead>
<tr>
<th>Category</th>
<th>Application Fee</th>
<th>Registration Fee</th>
<th>Criminal Background Investigation Fee</th>
<th>Total Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active/Unrestricted</td>
<td>$600</td>
<td>$750.00</td>
<td>$75</td>
<td>$1,425.00</td>
</tr>
<tr>
<td>Inactive Status</td>
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<td>$375.00</td>
<td>$75</td>
<td>$1,225.00</td>
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<tr>
<td>Endorsement License</td>
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<td>Authorized Facility</td>
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<tr>
<td>Locum Tenens</td>
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<td>$75</td>
<td>$515.00</td>
</tr>
<tr>
<td>Temporary</td>
<td>$400</td>
<td>$40.00</td>
<td>$75</td>
<td>$515.00</td>
</tr>
</tbody>
</table>

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.

Additional Items

- **Credentials Verification / Completing the Licensure Application.** See page 6 for more 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:**
  
  o Observerships, Externships, Research positions or Research Fellowships prior to completion of your postgraduate training in the United States or Canada.
  
  o 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. Proof of 2 hours AMA Category 1 continuing medical education (CME) in clinically-based suicide prevention and awareness.

- **Examination Regarding Nevada Law Governing Your Medical Practice.** A jurisprudence examination familiarizing you with the Medical Practice Act (Nevada Revised Statutes, Chapters 630 and 629 and Nevada Administrative Code, Chapter 630) will be mailed to you upon acknowledgement of receipt of your application and appropriate fees. You must correctly answer at least 75% of the questions.

- **National Practitioner Data Bank Self-Query.** Visit [http://www.npdb.hrsa.gov/](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.

(Added to NRS by 1983, 301; A 1985, 2236; 1987, 198)

NRS 630.305 Accepting compensation to influence evaluation or treatment; inappropriate division of fees; inappropriate referral to health facility, laboratory or commercial establishment; charging for services not rendered; aiding practice by unlicensed person; delegating responsibility to an unqualified person; failing to disclose conflict of interest; failing to initiate performance of community service; exception. The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure:

1. 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.

2. 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.

3. 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.

4. 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.

5. 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.

6. 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.

7. Failing to disclose to a patient any financial or other conflict of interest.

8. 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.

9. 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 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;
      (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.
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.
   (Added to NRS by 1985, 2223; A 1987, 199; 2001, 767; 2002 Special Session, 19; 2003, 3433; 2009, 2963; 2015, 493, 1170)

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.
   (Added to NRS by 1983, 302; A 1985, 2238; 1987, 200; 1989, 1663; 1993, 2302; 2015, 494)
UNIFORM APPLICATION INSTRUCTIONS

Credentials Verification and the Uniform Application

Credentials verification is an important part of the licensure process. The Board accepts the use of the FCVS for credentials verification as part of the licensure process, but FCVS is not required for licensure. FCVS staff verifies primary source documents related to your identity, education, training, and more, creating a personalized profile that eliminates the re-verification of items that never change. Your profile can be updated and sent to additional boards as needed.

If you do not use FCVS, you must provide your credentials directly to the board for verification. If you use FCVS, you will still need to complete the Uniform Application for Physician State Licensure (UA), but you will not need to complete several of the UA verification forms.

To work on the initial FCVS application for creating a profile or the subsequent FCVS application for updating an existing profile, visit http://www.fsmb.org/ and select FCVS in the Licensure or Sign In menu, then sign in as directed. For assistance, use the messaging tool within FCVS or call 888-275-3287 with your FCVS ID number between 8am and 5pm CT Monday through Friday.

Completing the Licensure Application

The UA was developed to streamline and simplify the licensure application process. Once the core UA has been completed, it can be modified and used to apply for licensure to additional boards without reentering the same information. Updates can be made as needed.

As part of the online UA, you will be asked to complete a chronology of activities of all working and non-working time since medical school graduation. You will also be asked to provide details of any malpractice liability claims. Having this information on hand before you begin will help you to complete the UA more efficiently.

To work on the UA, go to http://www.fsmb.org/ and select Uniform Application from the Licensure menu or Sign In menu. If you have submitted a UA, select the state board in the State Board section to open the UA for editing. Submit your UA to the board when you have finished updating your UA.

Please note the following:

- Licenses will be issued in your legal name as indicated on the submitted documented proof of such name (i.e. U.S. Birth Certificate, Certificate of Naturalization, Alien Registration card, Employment Authorization card, and/or legal documentation reflecting name change).

- The Public Access Address will be available to the public on the Board’s website, and will also be your contact address once licensed. It can be changed if you complete the Notification of Address Change form on the Board’s website. The Mailing Address will be used for communication only during the application process. It can be the same as the Public Access Address.

- Provide both your current home address and current business practice/training address, otherwise an error will occur.

- Be sure that your Social Security Number is listed correctly. NRS 630:197(1)(a) – An applicant for the issuance of a license to practice medicine shall include the social security number of the applicant in the application submitted to the board. NRS 630.165(5) – The applicant bears the burden of proving and documenting his or her qualifications for licensure. NRS 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.

- In the state of Nevada, a person must pass Step 1, Step 2, and Step 3 of the United States Medical Licensing Examination (USMLE) within 7 years after the date on which the person first passes any step of the USMLE, and a person is limited to a combined maximum of 9 attempts to pass Step 1, Step 2, and Step 3, and no more than three attempts at Step 3 of the USMLE.
• 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 postgraduate training program, you should answer affirmatively to question #8 of Addendum 2. 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.

• MD and DO licenses cannot be added or edited in the UA as all MD and DO license information comes directly into the system from the state boards. Email ua@fsmb.org with the correct information if changes are needed.

• Enter all other professional licenses you have held (active or inactive) in the U.S. or Canada. Request verification from these boards by using UA Licensure Verification Form #1.

• If you are applying for a special or temporary license and hold licenses in countries outside the U.S. or Canada, please provide that information on a separate sheet of paper.

• Activities that need to be listed in the Chronology of Activities include hospitals, teaching institutions, HMOs, private practice, corporations, military assignments, government agencies, and Locum Tenens assignments. Include all periods of unemployment, non-medical activities, military assignments, etc.

• Check the box for Staff Privileges if you were a staff member at the given hospital or surgery center.

• Clinical time indicates time spent with patients. Administrative indicates time spent on paperwork.

• If you have ever been named in a legal action involving professional liability (malpractice), whether or not you have ever had a professional liability, settlement, claim paid on your behalf, or paid such a claim yourself, provide explanations for all malpractice cases throughout your career. Be descriptive (include who, what, where, when, why).
  
  o Also provide copies of legal documentation for cases that occurred within the past 10 years (Complaint, Settlement, and/or Dismissal).
  
  o Complete Addendum 5 listing all malpractice insurance carriers since completion of postgraduate training.
  
  o Complete Addendum 6 requesting malpractice carrier verifications from all malpractice insurance carriers within the past 10 years only if you answered yes to have had a claim paid.
  
  o For pending case(s), request a status letter to be sent directly to the Board from your attorney.

• To open an already submitted UA for editing, select the Board from the State Board section. Update your UA as needed, then submit your UA to the Board.

In addition to completing the core UA online, all applicants must:

• Complete the state addendum in this packet as directed.

• Submit a UA Affidavit and Authorization for Release of Information form to the Board. The UA Affidavit is separate from the FCVS Affidavit and must be sent directly to the Board. Attach a recent (fewer than 90 days old) two inch by two inch (2” x 2”) passport quality, color photograph of yourself in the space provided.

• Have each full, and temporary medical license or certification you have ever held in the U.S. or Canada verified by the granting board, whether the license or certification is active or inactive. Determine the fees and verification method for each board using the licensure verification resource at http://www.fsmb.org/licensure/uniform-application/. Use the UA Licensure Verification Form for boards that need a written request. If the verifying board uses VeriDoc or another method, use that method instead.
If you are using FCVS for credentials verification,

- Do not complete the UA Medical Education Verification, Postgraduate Training Verification, or Fifth Pathway Verification forms. Do not send any identity documents, transcripts, certificates, or examination scores to the Board. FCVS handles all of this for you.

If you are not using FCVS for credentials verification,

- **U.S. born citizens** must submit an original or certified Birth Certificate that bears an original seal of the issuing agency (notarized copies are not acceptable). This will be returned to you via secured mail.

- **Foreign-born citizens** must submit an original "Certificate of Naturalization" or current U.S. Passport. This document will be returned to you via secured mail.

- **Non U.S. citizens** must submit a copy of both sides of their Alien Registration card or Employment Authorization card or Visa, as well as a copy of your foreign passport.

- Contact each appropriate exam entity to have a certified transcript of your scores sent directly to the Board. If you have taken any component of the NBME in conjunction with another exam (USMLE/FLEX), request your transcript from the NBME. For contact information, see the UA FAQ at [http://www.fsmb.org/licensure/uniform-application/faq](http://www.fsmb.org/licensure/uniform-application/faq).

- Complete the UA Medical Education Verification, Postgraduate Training Verification, and Fifth Pathway Verification (if applicable) forms as directed on each form. The UA Medical School Verification form should be accompanied by a copy of your diploma if you graduated from that school.

- If you are an International Medical Graduate, request from ECFMG that your ECFMG certificate, Fifth Pathway Program Certificate, and/or FMGEMS certificate be sent to the Board, as applicable. See the UA FAQ at the link on the previous page for contact information.

For UA assistance, see the UA FAQ at [http://www.fsmb.org/licensure/uniform-application/faq](http://www.fsmb.org/licensure/uniform-application/faq). If your issue is not listed, contact UA customer service at 800-793-7939 or ua@fsmb.org with a description of the problem and your username or Federation ID number. Please email a screenshot if you see an error.

Use the checklists on the next two pages to ensure you send all needed information to the Board.
Uniform Application Checklists

After completing the online application, you are responsible for submitting certain documents. There are two different 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 if you are or are not using FCVS. Please use the column that applies to you.

<table>
<thead>
<tr>
<th>To be completed &amp; returned directly to the Board office by you</th>
<th>NOT using FCVS to verify credentials</th>
<th>Using FCVS to verify credentials</th>
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</thead>
<tbody>
<tr>
<td>Completed online Uniform Application</td>
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<tr>
<td>Notarized Affidavit and Authorization for Release of Information form (found in online UA)</td>
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<tr>
<td>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.)</td>
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<td>Addendum 1: Responsibility Statement</td>
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<td>Addendum 2: Civil Applicant Waiver</td>
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<td>Addendum 3: Additional Physician Information</td>
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<td>[ ]</td>
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<td>Addendum 4: Attestation Questions (including explanations and copies of all pertinent documentation for affirmative responses)</td>
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<td>[ ]</td>
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<tr>
<td>Addendum 5: List of Malpractice Insurance Carriers (if needed per affirmative answers in Addendum 4)</td>
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<td>Addendum 8: Request for Licensure by Endorsement (if needed)</td>
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<tr>
<td>Addendum 9: Request for Licensure by a Resident (if needed)</td>
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<tr>
<td>Addendum 10: Credit Card Authorization Form (if needed)</td>
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<td>[ ]</td>
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<tr>
<td>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</td>
<td>[ ]</td>
<td>[ ]</td>
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<tr>
<td>National Practitioner Data Bank’s “Practitioner Request” For Information Disclosure (Self Query Verification)</td>
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<td>Proof of 4 hours of Bio-Terrorism CME (AMA Category 1 bioterrorism continuing medical education).</td>
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<tr>
<td>Proof of 2 hours AMA Category 1 continuing medical education (CME) in clinically-based suicide prevention and awareness.</td>
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<tr>
<td>Jurisprudence Exam (will be mailed to you upon acknowledgement of your application)</td>
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<tr>
<td>FBI Criminal History Background Report (once application fees have been received, fingerprint cards and instructions will be mailed to you)</td>
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<tr>
<td>Identity document: US born citizens – Original or Certified Birth Certificate (notarized copies are not acceptable), Foreign-born citizens - Original Certificate of Naturalization or Current U.S. passport, Non US citizens – Copy of both sides of Alien Registration card, Employment Authorization card, or Visa; Copy of foreign passport</td>
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<tr>
<td>Supporting documentation of any legal name change</td>
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<tr>
<td>Addendum 6: Malpractice Insurance Carrier Verification (if needed per affirmative answer to claim(s) paid in Addendum 4) sent to the Board</td>
<td>NOT using FCVS to verify credentials</td>
<td>Using FCVS to verify credentials</td>
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<tr>
<td>Addendum 7: Verification of Hospital or Surgery Center Privileges (If needed per affirmative answers in Addendum 4) sent to the Board</td>
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<td></td>
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<tr>
<td>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</td>
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<tr>
<td>State Licensure Verification form (Form #1) sent to the Board from all states in which you have ever held any medical doctor license</td>
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<tr>
<td>Medical Education Verification form (Form #2) sent to the Board from all medical schools attended – include a copy of your diploma (must be sealed by your school)</td>
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<td>N/A</td>
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<tr>
<td>Medical School Transcripts sent to the Board by your medical school(s)</td>
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<td>N/A</td>
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<tr>
<td>Postgraduate Training Verification form (Form #3) sent to the Board from all programs you attended</td>
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<td>N/A</td>
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<tr>
<td>A copy of your postgraduate training certificate(s) sent to the Board</td>
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<td>N/A</td>
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<tr>
<td>Fifth Pathway form (Form #4) (if applicable) sent to the Board from the medical school and institution - include a copy of your diploma (must be sealed by your school)</td>
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<td>N/A</td>
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<tr>
<td>Examination Transcripts sent to the Board</td>
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<tr>
<td>ECFMG Status Report (if applicable) sent to the Board</td>
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<td>N/A</td>
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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 the case is pending, provide a letter from your attorney giving the status of the case.

  - 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 malpractice cases. Provide copies of legal documentation for malpractice cases that occurred within the past 10 years 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 3, questions #5a and/or #5b, list all malpractice carriers since completion of your postgraduate training. Also include a copy of the legal Complaint and a copy of the Settlement and/or filed Dismissal.

☐ **Addendum 6: Malpractice Claim Verification Request.** If you answered affirmatively to Addendum 3, questions #5a and #5b, submit this form to all malpractice carriers verifying all coverage 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 3, 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.

* 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
1105 Terminal Way #301
Reno, NV 89502
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
1105 Terminal Way, Ste 301
Reno, NV 89502

Because you are applying for the privilege of practicing medicine in Nevada, you should know that our state has some of the most stringent licensing requirements and comprehensive investigation programs in the United States.

Via FBI fingerprinting and other investigative modalities, our licensing specialists are likely to discover if data you have submitted on your application is erroneous or incomplete; therefore, you must answer all questions truthfully and completely. Specifically, this includes any sanctions or disciplinary actions you may have experienced during 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.
NOTICE OF NONCRIMINAL JUSTICE APPLICANT’S RIGHTS

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

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

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

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

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

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

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

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

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

(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: 1105 Terminal Way, Suite 301, Reno, NV 89502_____________________________________

Agency Representative: Daniels, L.L. ____________________________________________________________

(PLEASE PRINT LAST, FIRST, MIDDLE)

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

Date: 3/1/2013________________________________________________________________________
## ADDENDUM 3 – ADDITIONAL PHYSICIAN INFORMATION

### CITIZENSHIP AND IDENTIFICATION

<table>
<thead>
<tr>
<th>U.S. Citizen</th>
<th>Yes ☐ No ☐</th>
<th>Alien Registration #______________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment Authorization #______________</td>
<td>Visa #______________</td>
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</table>

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.

<table>
<thead>
<tr>
<th>Examination Name</th>
<th>Score Received</th>
<th>Examination Name</th>
<th>Score Received</th>
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### 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.

<table>
<thead>
<tr>
<th>Board / Specialty Board</th>
<th>If you are Lifetime Board Certified, indicate “Lifetime”</th>
<th>Certification #</th>
<th>Dates of Certification/Recertification (MM/YY)</th>
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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 [ ]

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 [ ]

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 department or staff meetings, or maintain required malpractice insurance.)

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Mailing Address</th>
<th>Type of Action</th>
<th>Dates of Action (From MM/YY to MM/YY)</th>
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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](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](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)?
   (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, which occurs prior to my being granted licensure to practice medicine in the state of Nevada.

_________________________________________________________   _________________
Signature of applicant                                      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

2- If yes, which branch of service did you serve?  
   Air Force  Army  Navy  Marine Corp  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:   DD MM YYYY
   To:       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?  
    _______Yes   _______No

APPLICATION AFFIRMATION

Form:   _____/ _____/ _______  To:   _____/ _____/ _______
DD       MM       YYYY        DD       MM       YYYY

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

Nevada State Board of Medical Examiners
January 2018

Uniform Application Addendum
Page 10 of 16
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:

Occurred Date:               Status:               Date Closed:               Indemnity Amount:
_______________________________________________________________________________

Description of Claim: ________________________________________________________________

____________________________________________________________________________________

Insurance Carrier Agent:

__________________________________
Print Name and Title

__________________________________
Signature of Agent

__________________________________
Telephone

__________________________________
Email address

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

Malpractice Insurance Carrier: If you have questions, you may contact the Nevada Board at (775) 688-2559.
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 3, 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
1105 Terminal Way, Suite 301
Reno, NV 89502 (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 and date

State of ________________ County of ________________

Subscribed and sworn to before me this __________ day of __________________, 20___.

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

______________________________________ (state, territory, or District of Columbia) since ____________________________ (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 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
1105 Terminal Way #301
Reno, NV 89502
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 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

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
1105 Terminal Way #301

Reno, NV 89502

or fax to:
775-688-2321

Please type or print legibly.

Name of Applicant: ________________________________

Method of Payment: ☐ MasterCard ☐ Visa ☐ American Express ☐ Discover

Name on Credit Card: ________________________________

Business Name (if applicable): ____________________________

Credit Card Billing Address: ____________________________

Phone Number: ________________________________

Credit Card Number: ________________________________

Expiration Date: _____ / _____ (MM) (YYYY)

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

I authorize the Nevada State Board of Medical Examiners to charge the above credit card for a one-time payment in the amount of $ ___________, and an additional 2% service fee.

Printed Name: ________________________________

Authorized Signature: ________________________________

Date: ________________________________
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/policy/contacts.

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.

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)

[Please note: The Notary Public seal should overlap the bottom of the photo to the left.]

NOTARY

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 http://www.fsmb.org/licensure/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 http://www.fsmb.org/policy/contacts 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 ____________________________

Mailing address __________________________

City/State/Zip ____________________________

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 ____________________________

AFFIX INSTITUTIONAL SEAL HERE

Title ____________________________ Date __________

(If no seal is available, this form must be notarized.) 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.
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 or 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 ___________________________
- Mailing address _______________________________________
- City/State/Zip ___________________________

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.

   - Personal or family  From __________ to __________  ☐ Approved ☐ Unapproved
   - Academic remediation From __________ to __________  ☐ Approved ☐ Unapproved
   - Health  From __________ to __________  ☐ Approved ☐ Unapproved
   - Financial  From __________ to __________  ☐ Approved ☐ Unapproved
   - Participation in a joint degree program From __________ to __________  ☐ Approved ☐ Unapproved
   - Participation in a non-research special study (e.g., fellowship, intl. experience) From __________ to __________  ☐ Approved ☐ Unapproved
   - Other ________________  From __________ to __________  ☐ Approved ☐ 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? **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.

   - [ ] Academic
   - [ ] Unprofessional conduct
   - [ ] Behavioral reasons
   - [ ] Other ________________

   From ________________ to ________________

   [ ] Documentation attached

   [ ] Documentation attached

   [ ] Documentation attached

   [ ] 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? **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? **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? **If yes**, explain below and/or attach documentation or information of each circumstance and outcome.

   - [ ] Yes
   - [ ] No

**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 __________________________

(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.
**Postgraduate Training Verification Form (Form #3)**

- **Institution Name:**
- **Institution Address:**
- **Affiliated School:**

### Section 1: To be completed by the Applicant.

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

- **Date of birth:** (mm/dd/yyy)
- **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 information pertaining to my training there to the board listed below.

- **Board Name:**

- **Mailing address:**

- **Applicant Signature:**

### Section 2: Program Participation:

- **Important:**

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

- **From:**

- **To:**

- **Successfully Completed?:** Yes No In Progress

### Training Level:

- **E.g., 1, 2, 3, etc.**

  - **Internship**
  - **Residency**
  - **Chief Residency**
  - **Fellowship**
  - **Research**

  **Accredited by:**

  - ACGME
  - AOA
  - LCGME
  - RSC
  - CFPC
  - RCPSC
  - APPAP
  - None of these

### Unusual Circumstances:

- **Check the appropriate responses and explain any “Yes” or omitted response(s) on a separate sheet of paper.**

  1. Did this individual ever take a leave of absence or break from his/her training? Yes No
  2. Was this individual ever placed on probation? Yes No
  3. Was this individual ever disciplined or placed under investigation? Yes No
  4. Were any negative reports for behavioral reasons ever filed by instructors? Yes No
  5. 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:

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). Please Note: The Nevada Board of Medical Examiners requires an authorization letter to be attached if this form is completed by someone other than an M.D. or D.O.

- **Signature:**

- **Print name:**

- **Title:**

- **Email address:**

- **Phone Number:**

- **Date:**

---

Uniform Application for Physician Licensure

October 2017
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 __________________________
Mailing address __________________________
City/State/Zip __________________________

Applicant signature __________________________ Date ___________

Section 2: Fifth Pathway Verification

Institution name __________________________ Affiliated school __________________________
Institution name if different when applicant attended __________________________
Institution address w/country __________________________

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<th>Type of Clinical Rotation</th>
<th>From</th>
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Completed? □ Yes. Attendance was from ______________ to ______________. Completion date was ______________.
□ No. Withdrawal* date was ______________. *If the applicant withdrew or was dismissed, please explain below.
□ No. 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.)

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

Uniform Application for State Licensure

October 2017