



NEVADA STATE BOARD OF OSTEOPATHIC MEDICINE 2019-2020 ANNUAL SPECIAL LICENSE RENEWAL

REQUIREMENTS FOR RENEWAL OF LICENSURE

LICENSEE NAME: _____ LICENSE NUMBER: _____

ADDRESS INFORMATION

Please note that per NAC 633.260, we must have available to the public, at least one address from each licensee. Please complete the information below, indicating both Public and Mailing addresses. The Public address is available to the public via the Board's website. The Mailing address is for internal use only and is not available to the public without prior approval by the licensee.

PUBLIC ADDRESS (typically a Practice Address)

Name of Practice, if applicable: _____

Public Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

MAILING ADDRESS:

Name of Practice, if applicable: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

E-MAIL ADDRESS: _____

MEDICAL SPECIALTY

Please indicate your specialty: _____

CHILD SUPPORT DISCLOSURE (Required per NRS 633.326)

Please mark the appropriate response:

- **I am not** subject to a court order for the support of a child.
- **I am** subject to a court order for the support of one or more children and am in compliance with the order, or I am in compliance with 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;
- **I am** subject to a court order for the support of one or more children and I 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.

MILITARY SERVICE ATTESTATION

Active Military: Yes No Spouse Active Military: Yes No

Have you ever served in the Armed Forces of the United States? Yes No

If yes, in which branch and When?

Are you the surviving spouse of a veteran? Yes No

Have you ever been assigned to duty for a minimum of 6 continuous years in the National Guard or a reserve component of the Armed Forces of the United States and separated from such service under conditions other than dishonorable? Yes No

Have you ever served the Commissioned Corps of the United States Public Health Service or the Commissioned Corps of the National Oceanic and Atmospheric Administration of the United States in the capacity of a commissioned officer while on active duty in defense of the United States and separated from such service under conditions other than dishonorable? Yes No

QUESTIONS REQUIRED FOR RENEWAL

Please answer the questions, below. Note: all, "Yes" responses must be explained on an attached separate sheet of paper.

(Mark "Y" for yes and "N" for no)

1. _____ Since your last renewal have you been investigated for, charged with, convicted of, or plead guilty or nolo contendere to, any offense or violation of any federal, state or local law, including any foreign country, which is a misdemeanor, gross misdemeanor or felony (including violations from any federal, state or local law related to the manufacture, distribution, prescribing or dispensing of controlled substances)?
2. _____ Since your last renewal have you been investigated for, charged with, or convicted of any violation of a statute, rule or regulation governing the practice of medicine by any medical licensing board, hospital, medical society, governmental entity or other agency?
3. _____ Since your last renewal have you surrendered your state or federal controlled substance registration or was it revoked or restricted?
4. _____ Since your last renewal were there claims, medical malpractice lawsuits, dismissals of claims or lawsuits, settlements, verdicts, judgments, or any disposition related to a claim or lawsuit, involving professional liability (malpractice)? If "YES," please attach a separate sheet listing EACH claim, settlement, or judgment, listing the plaintiff, defendant, insurer, and disposition of the claim.
 - In addition, responding "YES" to question 4, please complete the "MEDICAL MALPRACTICE FORM."
5. _____ Since your last renewal have you been denied any of the following: 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?
6. _____ Since your last renewal was your medical license revoked, suspended, or limited in any state, or U.S. territory?
7. _____ Since your last renewal did you voluntarily surrender a license to practice in the healing arts in any state, country or U.S. territory?
8. _____ Since your last renewal were staff privileges in a hospital denied, suspended, limited, revoked or non-renewed; or, have you resigned from a medical staff in lieu of disciplinary or administrative action? (NOT including suspensions or restrictions for failure to complete medical records).
9. _____ Since your last renewal have you been investigated for, charged with, or convicted of unprofessional conduct, professional incompetence, gross or repeated malpractice, or any other violation or statute, rule or regulation governing the practice of medicine by any medical licensing board or other agency (including Federal), hospital or medical society?
10. _____ Are you currently in treatment for a mental illness, drug addiction, or acute substance, drug or alcohol abuse?
11. _____ Are you now or were you in the recent past, addicted to controlled substances, including, but not limited to narcotics or alcohol?

Truth in Application

By acknowledging this statement, answering the above renewal questions, I am stating under penalties of perjury that all information and answers provided in this renewal application are true and correct and that such responses are willfully provided. I am further stating that I have completed all appropriate sections completely and understand that if I have not completed all sections that my renewal application will be returned along with my renewal fee and my renewal application will not be processed until all sections are completed. I understand that it is considered unprofessional conduct to provide false information to the Board pursuant to NRS 633.131(1)(a).

Signature (NO STAMPS)

Date Signed

Print Licensee Name

License Number

E-mail or fax your completed renewal application to the following address:

NEVADA STATE BOARD OF OSTEOPATHIC MEDICINE
2275 Corporate Circle, Suite 210
Henderson, NV 89074
702-732-2147 Fax: 702-732-2079
E-mail: tsine@bom.nv.gov www.bom.nv.gov