Nevada State Board of Osteopathic Medicine
Application for Temporary Osteopathic Medical Physician Licensure

Dear Applicant:

Thank you for considering obtaining a temporary Osteopathic Medicine License in the State of Nevada. The temporary license is good for six months only. You may reapply for a temporary license.

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

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

Sincerely,

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

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

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

Minimum Requirements for Licensure

1. 21 YEARS OF AGE and CITIZEN OF THE UNITED STATES OR IS LAWFULLY ENTITLED TO REMAIN AND WORK IN THE UNITED STATES, and,
2. GRADUATION FROM A SCHOOL OF OSTEOPATHIC MEDICINE BEFORE 1995, and
   a. COMPLETION OF A HOSPITAL INTERNSHIP
   b. ONE YEAR OF POSTGRADUATE TRAINING THAT COMPLIES WITH THE STANDARDS OF INTERN TRAINING ESTABLISHED BYTHE AOA, or
3. GRADUATED FROM A SCHOOL OF OSTEOPATHIC MEDICINE AFTER 1995 and
   a. COMPLETED 3 YEARS OF PROGRESSIVE POSTGRADUATE MEDICAL EDUCATION AS A RESIDENT IN THE UNITED STATES OR CANADA IN A PROGRAM APPROVED BY THE BOARD, AOA, OR THE ACGME, or
   b. IS A RESIDENT WHO IS ENROLLED IN A POSTGRADUATE TRAINING PROGRAM IN THIS STATE, HAS COMPLETED 24 MONTHS OF THE PROGRAM, AND HAS COMMITTED IN WRITING TO COMPLETE THE PROGRAM, and
4. PASSES ALL PARTS OF THE LICENSING EXAM OF THE NBOME, or the FEDERATION OF STATE MEDICAL BOARDS OF THE UNITED STATES, INC., or ALL PARTS OF THE LICENSING EXAM OF THE BOARD, A STATE TERRITORY OR POSESSION OF THE UNITED STATES OR THE DISTRICT OF COLUMBIA AND IS ELIGIBLE FOR CERTIFICATION BY A SPECIALTY BOARD OF THE AOA OR AMERICAN BOARD OF MEDICAL SPECIALTIES; or.
5. PASSAGE OF A COMBINATION OF THE PARTS OF THE LICENSING EXAMS SPECIFIED IN ITEM 6 THAT IS APPROVED BY THE BOARD.
6. COMPLETION OF THE APPLICATION AND ALL REQUESTED DOCUMENTATION; and.
7. PAYMENT OF FEES: Non-refundable application and temporary licensure fee $200.00.

INSTRUCTIONS

Application is to be completed by the applicant, notarized as indicated, and returned to the Nevada State Board of Osteopathic Medicine with the application fee.

FEES ARE NON-REFUNDABLE. The temporary license expires six months from the date of issuance. You may reapply for a temporary license.

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

A **LETTER** is required from the facility that the locum tenens position will be taking place including the time span.

If additional space is required for answers, separate sheets may be attached to the application. All additional sheets must be 8 and ½ x 11 inches in size. No Application will be processed prior to receipt of all required fees.

Checklist

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

Completed Application	☐
State Licensure Verification form sent to the Board from **all** states in which you have ever held **any** healthcare license(s)	☐
Enclose and have notarized the completed "Affidavit and Authorization for Release of Information" form with this application when submitting it to the Board	☐
Check in the amount of $200.00	☐
Child Support Information Form (per NRS 633.326)	☐
Letter from the Locum Tenens facility	☐
Proof of Citizenship such as birth certificate or passport	☐
Completed Medical Malpractice and or Professional Liability Reporting form or **any and all** malpractice claims, settlements, and or judgments.	☐

It is your responsibility to immediately notify the board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license being granted to you by the board.

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

State of Nevada - Board of Osteopathic Medicine
2275 Corporate Circle, Suite 210
Henderson, NV 89074
(702) 732-2147
(702) 732-2079 (fax)
tsine@bom.nv.gov

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

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

1. Full Name (use no initials)

Last Name	First Name	Middle Name	Suffix	Maiden Name

All other names used

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

2. Address/Phone

Practice Address
☐ Public Access
☐ Mailing

Street

City State Zip Code

Telephone Fax E-mail address Alternate Phone

Home Address
☐ Public Access
☐ Mailing

Street

City State Zip Code

Telephone Fax E-mail address Alternate Phone

Medical Specialty: _____

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

Specialty Board	Certification Number	Date of Certification	Date of Re-Certification

Active Military: ☐ **Yes** ☐ **No**
Have you ever served in the United States Military?
If yes, in which branch did you serve? _____
When? _____

3. Identification

__/__/__

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

_____ | _____ | Are you a U.S. Citizen? ☐ Yes ☐ No

Gender | Social Security Number

_____ | _____ | _____ | _____

Height | Weight | Color of Hair | Color of Eyes

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

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

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

1. _____
School Name | Address

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

2. _____
School Name | Address

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

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

5. Medical School (attach additional pages if necessary)

1. _____
School Name | Address

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

2. _____
School Name | Address

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

6. Child Support Information (per NRS 633.326)

Please mark the appropriate response:

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

_____ I AM subject to a court order for the support of one or more children and am in compliance with the order or am in compliance with a plan approved by the District Attorney or other controlling public agency enforcing the order for the repayment of the amount owed pursuant to the order; or

_____ I AM subject to a court order for the support of one or more children and am not in compliance with the order or a plan approved by the District Attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

_____
Signature of Applicant

7. Examination History:

7. Examination History

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

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

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

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

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

1. _____
Hospital Name

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

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

Department/Specialty: _____

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

2. _____
Hospital Name

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

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

Department/Specialty: _____

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

3. _____
Hospital Name

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

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

Department/Specialty: _____

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

4. _____
Hospital Name

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

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

Department/Specialty: _____

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

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

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

1. State_____ Type _____ License Number_____ Status_____ Issue Date_____
   (Special, Training, or Full License)
2. State_____ Type_____ License Number_____ Status_____ Issue Date_____
   (Special, Training, or Full License)
3. State_____ Type_____ License Number_____ Status_____ Issue Date_____
   (Special, Training, or Full License)
4. State_____ Type_____ License Number_____ Status_____ Issue Date_____
   (Special, Training, or Full License)
5. State_____ Type_____ License Number_____ Status_____ Issue Date_____
   (Special, Training, or Full License)
6. State_____ Type_____ License Number_____ Status_____ Issue Date_____
   (Special, Training, or Full License)
7. State_____ Type_____ License Number_____ Status_____ Issue Date_____
   (Special, Training, or Full License)
8. State_____ Type_____ License Number_____ Status_____ Issue Date_____
   (Special, Training, or Full License)
9. State_____ Type_____ License Number_____ Status_____ Issue Date_____
   (Special, Training, or Full License)
10. State_____ Type_____ License Number_____ Status_____ Issue Date_____
    (Special, Training, or Full License)

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

1. State_____ Type_____ License Number_____ Status_____ Issue Date_____
2. State_____ Type_____ License Number_____ Status_____ Issue Date_____
3. State_____ Type_____ License Number_____ Status_____ Issue Date_____
4. State_____ Type_____ License Number_____ Status_____ Issue Date_____
5. State_____ Type_____ License Number_____ Status_____ Issue Date_____

Applicant Name: _____ Date: _____

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

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

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

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

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

2. Have you ever been denied a license, permission to practice medicine or any other healing art, or permission to take an examination to practice medicine or any other healing art in any state, country, or U.S. territory? 2. ☐Yes ☐No

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

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

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

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

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

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

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

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

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

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

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

14. Have you ever been arrested, investigated for, charged with or convicted of, or pled nolo contendere to any offense, misdemeanor or felony in any state, the United States, or a foreign country? (Except violations of traffic laws resulting in fines of $75.00 or less). 14. ☐Yes ☐No

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

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

If yes, LOCATION _____

When: _____

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

Affidavit
And
Authorization For Release of Information

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

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

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

I hereby release, discharge and exonerate the Board, its agents or representatives and any person furnishing information, of any and all liability of every nature and kind arising out of investigation made by the Board.

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

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

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

_____

Applicant's **Printed** Last Name

_____

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

_____

Date of Signature

Applicant Photograph

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

NOTARY

Dated _____ Signed _____

State of _____ County of _____

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

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

Licensure Verification Form

(Copy this form for multiple licenses)

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

To be completed by applicant

Applicant Name: _____
Last First Middle Suffix

Date of Birth: _____ Social Security Number: _____ License Number: _____
(From State/Province you are sending this form to)

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

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

Signature of Applicant _____ Date _____

Board Name: NEVADA STATE BOARD OF OSTEOPATHIC MEDICINE

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

TO BE COMPLETED BY STATE LICENSING BOARD OR CANADIAN PROVINCE

Name of Licensee: _____
Last First Middle Suffix

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

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

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

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

Affix Board Seal Here

Board Authorized Signature: _____

Title: _____

Date: _____

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

Form #2

Medical Malpractice/Professional Liability Claims Information

(Copy this form to report multiple claims)

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

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

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

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

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

Claimant:_____

Respondent:_____

Brief Description of Allegations:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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

Claim Status & Effective Date of That Status:

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

Date of Closure: _____

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

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

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