



NEVADA STATE BOARD OF OSTEOPATHIC MEDICINE FIRST AND FINAL 2021 ANNUAL LICENSE RENEWAL NOTICE AND APPLICATION

REQUIREMENTS FOR RENEWAL OF LICENSURE

The list of requirements below are non-negotiable (except voluntary reporting of disaster/emergency training). The questions listed in the renewal application **MUST** be completed, signed and submitted via the following: 1) US mail; 2) Hand delivered to the Board office prior to or by 5.00 pm, December 31, 2020; or, 3) Completed on line via the web site, by 11.59 PM, December 31, 2020.

PLEASE THOROUGHLY REVIEW THE BELOW REQUIREMENTS.

Renewal applications submitted after December 31, 2020, **WILL** be assessed a \$200 late fee. Payment **MUST** be made before renewal applications are accepted. **NO EXCEPTIONS!**

- **2019 ANNUAL RENEWAL FEE** – Osteopathic Physicians (DOs) - \$350; and, Physician Assistants (PAs) - \$150.
- **PUBLIC ADDRESS** – Visible to the public, typically a Practice Address - Must complete.
- **MAILING ADDRESS** – Visible **only** to Board staff for communications, such as this notice.
- **MEDICAL SPECIALTY** – Must be completed, along with any certifications.
- **CHILD SUPPORT DISCLOSURE** – One option must be marked.
- **BUSINESS LICENSE** – One option must be marked.
- **RENEWAL QUESTIONNAIRE** – If you answer “YES” to #4 or #5, please download and complete the additional form.
- **CME COMPLETION ATTESTATION/AFFIDAVIT (SEE BELOW)** – Must read and sign.
- **MILITARY SERVICE ATTESTATION** – Must complete questions.
- **VOLUNTARY REPORTING OF DISASTER AND EMERGENCY TRAINING** – Please indicate on page below, if any of the following apply: 1) Training in mental/emotional trauma due to an emergency or a disaster; 2) Training in short-term treatment of said trauma or training in long-term trauma; and, 3) Indicate if you would agree to be contacted to respond immediately to an emergency or disaster in any location in the state.
- **ATTESTATION TO REPORT THE ABUSE OR NEGLECT OF A CHILD**– Must read and sign below.
- **IF YOU HAVE A D.O. LICENSE:**
 - If you chose **NOT** to renew your license, you must notify the board in **writing** before December 31, 2020. Failure to do so will result in automatic revocation due to Non-Payment, a reportable action per NRS 633.481.
 - If you place your license on **INACTIVE** status the annual fee is \$200.00. Complete the appropriate form by December 31, 2020, which is located on the Board website.
- **IF YOU HAVE A P.A. LICENSE:**
 - You **MUST** have a supervising agreement with an osteopathic physician (D.O.) to be considered **ACTIVE**. Without such an agreement, you may only renew as **ACTIVE-NOT WORKING** until you have engaged in collaboration with a supervising D.O. You may opt for an **INACTIVE** status, for an annual fee of \$200.00, accompanied by an affidavit. Note that The Board does **NOT** issue refunds; therefore, be sure of your intended license status!
 - If you choose to **NOT** to renew your license, you must notify the board in **writing** before December 31, 2019. Failure to do so will result in automatic revocation due to Non-Payment, a reportable action per NRS 633.481.
 - You are required to show **proof of your current NCCPA certification**.

LICENSEE NAME: _____ LICENSE NUMBER: _____

ADDRESS INFORMATION

Public Address: Per NAC 633.260, the Board must have available to the public at least ONE public address from each licensee. Please complete the two address types, below. NOTE: The Public address will be made available to the public via the Board website; and, the Mailing address is ONLY available to the Board and will not be made public, unless requested.

PUBLIC ADDRESS (typically a Practice Address)

Name of Practice or Private Corporation: _____

PUBLIC Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

MAILING/HOME ADDRESS: (Not Public)

Mailing Address (must be either a home address or PO Box): _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

E-MAIL ADDRESS: _____

MEDICAL SPECIALTY

Medical Specialty: _____

BOARD CERTIFICATIONS

Please list below and circle either AOA or ABMS accordingly.

AOA or ABMS _____ Cert Date: _____ Exp. Date: _____

AOA or ABMS _____ Cert Date: _____ Exp. Date: _____

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 per the order.

ATTESTATION REGARDING THE REPORTING OF THE ABUSE OR NEGLECT OF A CHILD

I attest and affirm that I am aware of and understand the reporting requirements per NRS 432B.220 for the abuse or neglect of a child.

Yes: _____ No: _____

BUSINESS LICENSE (Required by SB21) MARK ALL THAT APPLY

- I do NOT have a Nevada business license number.
- I do have a Nevada business license **IN MY NAME ONLY**, assigned by the Nevada Secretary of State, and comply with NRS Chapter 76.
- Nevada business license number: _____
- Business name: _____
- TIN number: _____

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

VOLUNTARY REPORTING OF DISASTER AND EMERGENCY TRAINING

Have you received training in mental/emotional trauma due to emergency or disaster; training in short-term treatment of said trauma or training in long-term trauma? Yes No If yes, please describe above training _____

Would you be willing to respond immediately to an emergency or disaster in any location in the state? Yes No

QUESTIONS REQUIRED FOR RENEWAL

Please answer the following questions below: **NOTE: ALL “YES” responses MUST be explained on a separate sheet of paper. However, responding YES for question #5 - regarding Office Based Procedures – the form on the web site must be downloaded and completed under the “Licensee Services” section at www.bom.nv.gov.**

(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? (This includes any violation 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 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?
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, did you have any claims, medical malpractice lawsuits, dismissals of claims or lawsuits, settlements, verdicts, judgments, or dispositions of a claim or lawsuit, involving professional liability (malpractice)? If YES, please provide in writing, an explanation for EACH claim, settlement, or judgment, listing the plaintiff, defendant, insurer, and disposition of each matter.
 - A “Yes” response to question #4 requires completion of the **“MEDICAL MALPRACTICE FORM.”**
5. _____ Do you perform ANY procedure or surgery in your office using conscious sedation, deep sedation, or general anesthesia? This includes ANY surgical procedures performed in-office or any surgical facility, EXCEPT the following: medical facility; surgical center for ambulatory patients; hospital; or, surgeries performed outside the State of Nevada.
 - A “Yes” response to question #5 requires completion of the **“OFFICE BASED PROCEDURE SURVEY.”**
6. _____ Since your last renewal, were you denied any of the following: license; permission to practice medicine or other healing art; permission to take an examination to practice medicine; or, any healing art in any state, country, or U.S. territory?
7. _____ Since your last renewal, was your medical license revoked, suspended, or limited in any state, or U.S. territory?
8. _____ Since your last renewal, have you voluntarily surrendered a license to practice in the healing arts in any state, country or U.S. territory?
9. _____ Since your last renewal, were you denied hospital privileges, suspended, limited, revoked or non-renewed; or, have you 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).
10. _____ Are you currently in treatment for a mental illness, drug addiction, or acute substance, drug or alcohol abuse?
11. _____ Are you currently or in the past, addicted to controlled substances, including, but not limited to narcotics or alcohol?

ATTESTATION OF EARNED REQUIRED CONTINUING MEDICAL EDUCATION (CME) CREDITS

By signing the application below, you attest to receiving the CME credits that you have either already received or will receive **between January 1, 2020 and December 31, 2020.**

• **D.O. License** – must have a total of **35 CME credits** (non-transferable). **A minimum of 10 of the 35 required CME credits MUST be Category 1 or 1A as accredited by the AOA or the ACGME/AMA.**

As of July 1, 2017, all physician licensees (DOs) must complete biennially (even years only) at least two (2) credits on clinically-based suicide prevention and awareness within first two years of licensing. Afterward, obtaining two (2) credits in suicide prevention must be repeated only every four (4) years.

As of October 1, 2013, all physicians licensees must complete biennially (in the even years) at least 2 hours in ethics, pain management or addiction care.

As of October 1, 2011, all physician licensees must 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.

As of 2017, Per AB474, ALL Licensees must complete two (2) credits in opioid prescribing and substance abuse.

- **P.A. License** – must have **20 CME credits** with two (2) credits in opioid subscribing (see above).
- Only CME credits received in the calendar year (**January-December 2020**) will be accepted for renewal.

CME Audit Acknowledgment

I understand that I may be requested by the Board at any time (NRS 633.471) to produce proof of receipt of CME credits for purposes of renewal of my Nevada Osteopathic Medical License. Should I fail to provide proof of receipt of CME credits satisfactory to the Board; I may be subject to disciplinary action.

Physician Assistants ONLY:

Supervising Physicians Name: _____
Address: _____
City, State, Zip Code: _____
Effective Date: _____

Please attach separate sheet listing multiple supervising physicians.

ALL LICENSEES MUST SIGN BELOW

Truth in Application

By acknowledging this statement, answering the above renewal questions, and affirming that I have met the continuing education requirement for license renewal, 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 also understand that I was offered to utilize the online renewal system that has a built in error checker and is 99% error free but I chose to fill out the hard copy – paper format renewal application even while knowing that the chosen form of completion will possibly take longer to complete and has more room for error which might delay my processing time, but I am willing to take this chance. I understand that it is considered unprofessional conduct to provide false information to the Board pursuant to NRS 633.131(1)(a).

Signature Licensee (NO STAMPS) Date

Print Licensee Name License Number

Mail/hand-deliver the completed renewal application and renewal fee (check or money order) 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