Nevada State Board of Osteopathic Medicine
Application for Special License for Postgraduate Medical Education as a Resident or Intern Physician

Dear Applicant:

This is the application for a special license to practice in Nevada while actively enrolled in an accredited postgraduate medical training program in the State of Nevada. **THIS IS NOT AN APPLICATION FOR FULL LICENSURE.**

Per NRS 633.401 – 633.411, a **SPECIAL LICENSE** may be issued for up to **ONE YEAR** to a person engaged in training in this state. This license **DOES NOT PERMIT** the private practice of osteopathic medicine outside the confines of the institution or its ancillary locations in which you are training. Further, **NO FEE** may be **billed or collected by you or for you** for ANY **SERVICES provided under this license**. To do so is a **FELONY** and violators **WILL** be prosecuted**.**

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

A special license is good for up to one year, depending on the length of your study, and renewable upon certification of continued appointment to the accredited program you are training in. Certification from the program and the proper fee will suffice to renew the license. A training physician may apply for full licensure upon completion of 24 months of the accredited training program and with a written commitment and appointment to complete the residency program in this state. NO CREDENTIALS FROM THIS APPLICATION WILL TRANSFER to an application for a full license. The application for a full D.O. license is substantially more complicated and should be considered independent of this or any other application.

Normally, the staff of the Director of Medical Education (DME) for the program you are training in will provide you with this application and work with you to complete it. Unless otherwise advised by them, all information in connection with this application should be sent to them. **If you have questions regarding this application your first call should be to the program office, before contacting the Board.** Upon completion of your license application, submit it to your program office or to the Board, whichever you have been advised to do.

Sincerely,

Your Licensing Specialist ~
Nevada State Board of Osteopathic Medicine

Inquiries please contact:
Nevada State Board of Osteopathic Medicine
2275 Corporate Circle, Suite 210
Henderson, NV 89074
Phone: 702-732-2147
Fax: 702-732-2079
Email: nmontano@bom.nv.gov
Website: www.bom.nv.gov

State of Nevada - Board of Osteopathic Medicine
Application for Special Licensure for
Intern or Resident Osteopathic Physician

Requirements and Instructions

REQUIREMENTS

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 AFTER 1995, and
3. BE APPOINTED TO AN ACCREDITED PROGRAM OF POSTGRADUATE MEDICAL EDUCATION AS AN INTERN OR RESIDENT PHYSICIAN BY A DULY LICENSED HOSPITAL OR ACCREDITED ANCILARY FACILITY OR CAMPUS IN THE STATE OF NEVADA.
4. PASSED AT LEAST PART 1 OF THE NBOME, USMLE, COMLEX, OR ANY OTHER NATIONAL LICENSING EXAM.
5. COMPLETION OF THE APPLICATION AND ALL REQUESTED DOCUMENTATION.
6. PAYMENT OF FEES: Non-refundable application and initial licensure fee $200.00

INSTRUCTIONS

Note: The appointing program usually provides guidance and assistance in the completion of the program. The necessary documentation should be sent to the program office, and the program will forward the completed special application to the Board.

The application is to be completed by the applicant, notarized as indicated, and returned to their program office that will then send the completed application to the *State of Nevada - Board of Osteopathic Medicine.*

Post graduate training section (#8) should include upcoming residency program.

Form #1, **VERIFICATION OF LICENSE**: If the applicant for a Special License has any type of professional license in any other state, he/she must fill out the top portion of the form 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. **License verification forms will only be accepted if sent directly from the licensing board NOT from the applicant.**

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.

Application Fee - $200:	☐
Valid Proof of Citizenship (Certified copy of Birth Certificate, or notarized copy of Passport or naturalization certificate)	☐
Application with Release of Information (both completed, signed and notarized)	☐
Official Transcript from School of Osteopathic Medicine (Must be a sealed envelope from the school)	☐
Official Transcript(s) from ALL LEVELS of NBOME, COMLEX, USMLE, or any other national testing completed upon application for a Special License.	☐
Child Support Information Form (per NRS 633.326).	☐
Certificate of Appointment to an Accredited Postgraduate Training Program (completed by the sponsoring program).	☐
State Licensure Verification form sent to the Board from **all** states in which you have ever held **any** healthcare license(s) if applicable.	☐

It is your responsibility to immediately notify the program office as well as the board in writing of any changes to 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 program office in which you have been appointed to study.

Nevada State Board of Osteopathic Medicine
Application for Special License for Intern or Resident Physician Licensure

1. Full 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.

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

Also Known As: _____

Medical Specialty: _____

Residency Coordinator:

_____

Name Email Phone

2. Address/Phone 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.

Residency/ Internship Address
☐ Public Access

_____
Street

_____
City State Zip Code E-mail address

_____
Telephone Fax Alternate Phone

Home Address
☐ Mailing

_____
Street

_____
City State Zip Code E-mail address

_____
Telephone Fax Alternate Phone

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

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

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

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

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

3. Identification Please submit either a certified copy of your birth certificate or a notarized copy of your current, valid passport or naturalization certificate.

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

_____ _____
Gender | Social Security Number, Or if none,

_____
Alternative Personal Identification Number (such as Taxpayer ID)

_____ _____ _____ _____
Height | Weight | Color of Hair | Color of Eyes

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

4. Colleges or Universities List name and address for any and all colleges or universities attended other than schools where professional medical education was received. (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 the medical school you attended and graduated from (attach additional pages if necessary)

1. _____
School Name Address

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

6. Child Support Information (per NRS 633.326) (This section continues on page 6, do not forget to sign this section)

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 - You are responsible for contacting the appropriate examination entity and having a certified transcript of your scores sent directly to this Board

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 PE	_____	☐ P ☐ F	_____
☐ NBOME Part II CE	_____	☐ 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 (copy and attach additional pages if necessary) (list in order of most recent upcoming or current program first and note the applicable PGY {Post Graduate Year} per entry) **(Do Not Abbreviate)**

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

____

Hospital Name

____

Hospital Address City State Zip Code Country

Department/Specialty: ________________________________

From: ________/____________ To: ________/____________ Successfully Completed? ☐ Yes ☐ No ☐ In Progress
Month Year Month Year

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

____

Hospital Name

____

Hospital Address City State Zip Code Country

Department/Specialty: ________________________________

From: ________/____________ To: ________/____________ Successfully Completed? ☐ Yes ☐ No ☐ In Progress
Month Year Month Year

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

____

Hospital Name

____

Hospital Address City State Zip Code Country

Department/Specialty: ________________________________

From: ________/____________ To: ________/____________ Successfully Completed? ☐ Yes ☐ No ☐ In Progress
Month Year Month Year

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

____

Hospital Name

____

Hospital Address City State Zip Code Country

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 list any Special License, D.O. or Temporary License in any other state.

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_____

All Other Healthcare Licensure/Certification list any other professions that you have been licensed in, such as R.N or P.A., H.M.D. etc…

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_____

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

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

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

11. Questions: Please answer yes or no to the following questions. All, **'yes'**, answers in questions **1 through 13 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. Do you regularly take any prescription drug for therapeutic purposes? 9. ☐Yes ☐No

10. Have you ever surrendered your state or federal controlled substance registration or had it restricted in any way? 10. ☐Yes ☐No

11. Do you currently have a condition including mental or physical illness or substance use disorder that impairs your judgment otherwise adversely affects your ability to practice medicine in a competent, ethical and professional manner? 11. ☐Yes ☐No

If "Yes" how are you managing the impairment? (respond on separate sheet)

12. 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? 12. ☐Yes ☐No

13. 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). 13. ☐Yes ☐No

14. Do you attest to knowledge of safe injection practices and CDC Guidelines? 14. ☐Yes ☐No

15. If granted a license, do you intend to practice in Nevada? 15. ☐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

SIGNED AND NOTARIZE BELOW

Notary Signature _____ Date _____

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 **Nevada State 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 address below.**

TO BE COMPLETED BY APPLICANT

Applicant Name:_____
Last First Middle Suffix

Date of Birth:_____ SS Number or TIN:_____ License Number:_____

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

Signature of Applicant _____ Date _____

This request is being sent to the following State Board or Regulatory Agency;

Board Name:_____

Address:_____
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 If No, please explain:_____

1) Have formal disciplinary proceedings ever 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

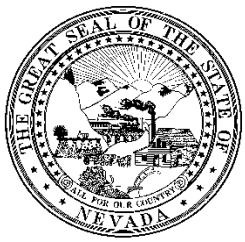
Board Authorized Signature:_____

Print Name: _____ Title:_____

Department: _____ Date: _____

Return to:

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



NEVADA STATE BOARD OF OSTEOPATHIC MEDICINE
NOTICE WAIVER FORM

I, _____, agree to waive any right that I may have to a 21 working day notice of this meeting pursuant to NRS 241.033. I further consent to allow the Board to consider a vote on my application.

Date: _____ _____

Signature