NEVADA STATE BOARD OF OSTEOPATHIC MEDICINE
FIRST AND FINAL 2022 ANNUAL LICENSE RENEWAL NOTICE AND APPLICATION

REQUIREMENTS FOR RENEWAL OF LICENSURE

The list of requirements below are non-negotiable and must be filled out completely, signed and either mailed or hand delivered to the Board office prior to the expiration date of your DO Special License.
If your renewal application is late, you will be automatically assessed a late fee of $200 and your renewal application will not be accepted without it and we will make absolutely NO EXCEPTIONS!!

• **2022 ANNUAL RENEWAL FEE –** The **$200** renewal fee for DO Special license types.
• **PUBLIC ADDRESS** – This is for the public, usually also a Practice Address - Must fill out completely.
• **MAILING ADDRESS –** This is for the Board staff to utilize for notices such as this; this is not for the public to use.
• **MEDICAL SPECIALTY –** Must fill this out, along with any certifications.
• **CHILD SUPPORT DISCLOSURE –** Must check one of the options.
• **BUSINESS LICENSE –** Must check one of the options.
• **RENEWAL QUESTIONNAIRE** – If you answer "yes" to #4 or #5, please download and fill out the additional form.
• **CME COMPLETION AFFIDAVIT** – Must read and sign below.
• **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 REGARDING THE REPORTING OF THE ABUSE OR NEGLECT OF A CHILD**– Must read and sign below.

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 ADDRESS: (Not Public)

Name of Practice, if applicable: _____
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.220for 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**
trauma or training in long-term trauma? ☐ **Yes** ☐ **No** If **yes, please describe above training** _____

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 #4 (regarding medical malpractice claims) and/or #5 (regarding Office Based Procedures) the appropriate form on the website 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 complete the "MEDICAL MALPRACTICE FORM" for EACH claim, settlement, or judgment, listing the plaintiff, defendant, insurer, and disposition of each matter and provide in writing an explanation.
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. If YES, please complete the "OFFICE BASED PROCEDURE SURVEY" form.
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. _____Since your last renewal, or in the past year, do you 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. If "Yes" how are you managing the impairment? (respond below or on separate sheet)

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, 2021 and December 31, 2021.**

• D.O. license – must have a total of 35 CME credits (these are 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 ACCME.**

As of 2018, all physicians must complete at least 2 hours on clinically-based suicide prevention and awareness within two years of being licensed and then complete every 4 years thereafter.
All licensees must complete biennially (in the even-numbered years) at least 2 hours in ethics, pain management, or addiction care.

CME Audit Acknowledgment
I understand that I may be asked to produce proof of receipt of CME credits I declare for purposes of renewal of my Nevada Osteopathic Medical License upon written request by the Board at any time (NRS 633.471). Should I fail to provide proof of receipt of CME credits satisfactory to the Board that I will be subject to disciplinary action.

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).

_____ _____
Licensee Signature (NO STAMPS) Date

_____
Print Licensee Name License Number

Mail or hand-deliver your 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: nmontano@bom.nv.gov www.bom.nv.gov