



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 Staff of Nevada State Board of Osteopathic Medicine

2275 Corporate Circle, Suite 210

Henderson, NV 89074

Phone: 702-732-2147 ext. 222

Fax: 702-32-2079

Email: nmontano@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,
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 BY THE 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 POSSESSION 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 LICENSE:** 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	<input type="checkbox"/>
State Licensure Verification form sent to the Board from all states in which you have ever held any healthcare license(s)	<input type="checkbox"/>
Enclose and have notarized the completed "Affidavit and Authorization for Release of Information" form with this application when submitting it to the Board	<input type="checkbox"/>
Check in the amount of \$200.00	<input type="checkbox"/>
Child Support Information Form (per NRS 633.326)	<input type="checkbox"/>
Letter from the Locum Tenens facility	<input type="checkbox"/>
Completed Medical Malpractice and or Professional Liability Reporting form or any and all malpractice claims, settlements, and or judgments.	<input type="checkbox"/>

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:

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

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				
<input type="checkbox"/> Public Access	Street			
<input type="checkbox"/> Mailing				
	City	State	Zip Code	
	Telephone	Fax	E-mail address	Alternate Phone
 Home Address				
<input type="checkbox"/> Public Access	Street			
<input type="checkbox"/> Mailing				
	City	State	Zip Code	
	Telephone	Fax	E-mail address	Alternate Phone
Medical Specialty: _____				
Are you Board Certified in the above specialty? <input type="checkbox"/> Yes <input type="checkbox"/> 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? 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

_____/_____/_____ Date of Birth (mm/dd/yyyy)	_____ Birth City	_____ Birth State	_____ Birth Country
_____ Gender	_____ Social Security Number (if none, see below)		
	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. 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.

<u>Examination</u>	<u>Most Recent Date taken (Month/Year)</u>	<u>Passed (P) or Failed (F)</u>	<u>Number of attempts</u>
<input type="checkbox"/> State Board Exam _____ State _____	_____	<input type="checkbox"/> P <input type="checkbox"/> F	_____
<input type="checkbox"/> NBOME Part I	_____	<input type="checkbox"/> P <input type="checkbox"/> F	_____
<input type="checkbox"/> NBOME Part II	_____	<input type="checkbox"/> P <input type="checkbox"/> F	_____
<input type="checkbox"/> NBOME Part III	_____	<input type="checkbox"/> P <input type="checkbox"/> F	_____
<input type="checkbox"/> COMVEX	_____	<input type="checkbox"/> P <input type="checkbox"/> F	_____
<input type="checkbox"/> COMLEX Part I	_____	<input type="checkbox"/> P <input type="checkbox"/> F	_____
<input type="checkbox"/> COMLEX Part II CE	_____	<input type="checkbox"/> P <input type="checkbox"/> F	_____
<input type="checkbox"/> COMLEX Part II PE	_____	<input type="checkbox"/> P <input type="checkbox"/> F	_____
<input type="checkbox"/> COMLEX Part III	_____	<input type="checkbox"/> P <input type="checkbox"/> F	_____
<input type="checkbox"/> SPEX	_____	<input type="checkbox"/> P <input type="checkbox"/> F	_____
<input type="checkbox"/> FLEX Pre-1985	_____	<input type="checkbox"/> P <input type="checkbox"/> F	_____
<input type="checkbox"/> FLEX Component 1	_____	<input type="checkbox"/> P <input type="checkbox"/> F	_____
<input type="checkbox"/> FLEX Component 2	_____	<input type="checkbox"/> P <input type="checkbox"/> F	_____
<input type="checkbox"/> NBME Part I	_____	<input type="checkbox"/> P <input type="checkbox"/> F	_____
<input type="checkbox"/> NBME Part II	_____	<input type="checkbox"/> P <input type="checkbox"/> F	_____
<input type="checkbox"/> NBME Part III	_____	<input type="checkbox"/> P <input type="checkbox"/> F	_____
<input type="checkbox"/> USMLE Step I	_____	<input type="checkbox"/> P <input type="checkbox"/> F	_____
<input type="checkbox"/> USMLE Step II	_____	<input type="checkbox"/> P <input type="checkbox"/> F	_____
<input type="checkbox"/> USMLE Step III	_____	<input type="checkbox"/> P <input type="checkbox"/> 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 _____ (Special, Training, or Full License)	License Number _____	Status _____	Issue Date _____
2. State _____	Type _____ (Special, Training, or Full License)	License Number _____	Status _____	Issue Date _____
3. State _____	Type _____ (Special, Training, or Full License)	License Number _____	Status _____	Issue Date _____
4. State _____	Type _____ (Special, Training, or Full License)	License Number _____	Status _____	Issue Date _____
5. State _____	Type _____ (Special, Training, or Full License)	License Number _____	Status _____	Issue Date _____
6. State _____	Type _____ (Special, Training, or Full License)	License Number _____	Status _____	Issue Date _____
7. State _____	Type _____ (Special, Training, or Full License)	License Number _____	Status _____	Issue Date _____
8. State _____	Type _____ (Special, Training, or Full License)	License Number _____	Status _____	Issue Date _____
9. State _____	Type _____ (Special, Training, or Full License)	License Number _____	Status _____	Issue Date _____
10. State _____	Type _____ (Special, Training, or Full License)	License Number _____	Status _____	Issue Date _____

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
<p>1.</p> <p>From:</p> <p>To:</p>	<p>Practice/Employment Name _____</p> <p>Practice/Employment Address _____ City _____ State _____ Zip Code _____ Country _____</p> <p>Position & Department: _____ % Clinical _____ % Administrative _____</p> <p><input type="checkbox"/> Employment <input type="checkbox"/> Staff Privileges <input type="checkbox"/> Affiliation <input type="checkbox"/> Other _____</p>
<p>2.</p> <p>From:</p> <p>To:</p>	<p>Practice/Employment Name _____</p> <p>Practice/Employment Address _____ City _____ State _____ Zip Code _____ Country _____</p> <p>Position & Department: _____ % Clinical _____ % Administrative _____</p> <p><input type="checkbox"/> Employment <input type="checkbox"/> Staff Privileges <input type="checkbox"/> Affiliation <input type="checkbox"/> Other _____</p>
<p>3.</p> <p>From:</p> <p>To:</p>	<p>Practice/Employment Name _____</p> <p>Practice/Employment Address _____ City _____ State _____ Zip Code _____ Country _____</p> <p>Position & Department: _____ % Clinical _____ % Administrative _____</p> <p><input type="checkbox"/> Employment <input type="checkbox"/> Staff Privileges <input type="checkbox"/> Affiliation <input type="checkbox"/> Other _____</p>
<p>4.</p> <p>From:</p> <p>To:</p>	<p>Practice/Employment Name _____</p> <p>Practice/Employment Address _____ City _____ State _____ Zip Code _____ Country _____</p> <p>Position & Department: _____ % Clinical _____ % Administrative _____</p> <p><input type="checkbox"/> Employment <input type="checkbox"/> Staff Privileges <input type="checkbox"/> Affiliation <input type="checkbox"/> Other _____</p>
<p>5.</p> <p>From:</p> <p>To:</p>	<p>Practice/Employment Name _____</p> <p>Practice/Employment Address _____ City _____ State _____ Zip Code _____ Country _____</p> <p>Position & Department: _____ % Clinical _____ % Administrative _____</p> <p><input type="checkbox"/> Employment <input type="checkbox"/> Staff Privileges <input type="checkbox"/> Affiliation <input type="checkbox"/> Other _____</p>

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 8 1/2 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 minor traffic violations). 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



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 **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 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: _____

Board Authorized Signature: _____

Affix Board Seal Here

Title: _____

Date: _____

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

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