#8817

STATE OF NEVADA
BOARD OF MEDICAL EXAMINERS
APPLICATION FOR LICENSURE

RECEIVED
SEP 27 1990 $400-
NEVADA STATE BOARD OF MEDICAL EXAMINERS

1. Name LEVY (Last) Adam (First) Vincent (Middle) ______ (Maiden)

If you have ever used another name, please indicate no

2. Business and/or Mailing Address 554th MG/SGHSO, NELLIS AFB, NV 89191 (Street # / City / State / Zip)

3. Home Address ______ (Street # / City / State / Zip)

4. Telephone Number (702) ______ (Office) → (702) 652-3357 (office) (Home)

5. Date of Birth ______ 57 Place of Birth San Francisco, CA

6. Citizenship: US Citizen Yes Alien Registration # ______ Other ______
Submit a certified copy of birth certificate, Certificate of Naturalization and/or Alien Registration Card with this application.

7. Have you ever previously applied for medical licensure in Nevada? ☐ Yes ☒ No

If YES, give date of previous application ______

8. List name and address of all colleges or universities attended other than schools where professional medical instruction was received. Have each school submit an official transcript directly to the board.

Name	Address	Dates of Attendance From (Mo/Yr)	To (Mo/Yr)
Univ of Calif, Santa Cruz	Santa Cruz, Calif	9/75	6/76
" " "	" "	9/77	6/80

9. List name and address of all schools where professional medical instruction was received. Have each school submit an official transcript directly to the board.

Name	Address	Place Where Instruction Received	Dates of Attendance From (Mo/Yr)	To (Mo/Yr)
Univ. of Southern Calif	2025 Zonal Ave L.A., CA 90033	School of Med.	8/80	5/84

10. Doctor of Medicine Degree granted by:

Name of Medical School	Address of Medical School	Exact Date of Issuance
Univer. of Southern Cal.	see above	8 May 1984

11. Have you taken any part of the National Boards? ☒ Yes ☐ No If YES, list location, parts taken, date and score(s). Have certificate of scores submitted from National Boards to the board.

Location	Part Taken	Date	Result (Score(s))
Los Angeles, CA	I	6/82	PASS 555
" " "	II	4/84	PASS 425
" " "	III	3/85	PASS 450

MAR 28 1989

12. Have you taken any part of the FLEX? ☐ Yes ☒ No If YES, list location, parts taken, date and score(s). Have certificate of scores submitted from FLEX directly to the board.

Location	Part Taken	Date	Result (Score(s))

13. Have you taken any part of ECFMG or FMGEMS? ☐ Yes ☒ No If YES, list part(s) taken, location, date and result(s) of examination. Have certification of examination(s) submitted from the ECFMG directly to the board.

Location	Part Taken	Date	Result (Score(s))

14. Have you received ACGME* approved postgraduate training in the United States or Canada? ☒ Yes ☐ No If YES, fill in the information requested below.
*Accreditation Council on Graduate Medical Education

Hospital/ Institution	Mailing Address	Type of Service or Specialty	Dates of Attendance	
			From (Mo/Yr)	To (Mo/Yr)
Univ. of Southern CAL LA Co. Med Ctr	2025 Zonal Ave Los Angeles, CA 90033	Intern OB/Gyn	6/84	6/85
Valley Med Ctr (UCSF)	445 S. Cedar Ave Fresno CA 93702	OB/Gyn Resid.	6/85	6/89

15. Have you completed any ACGME*approved Fellowship programs? ☐ Yes ☒ No If YES, fill in the information requested below.

Institution	Mailing Address	Type of Fellowship	Dates of Attendance	
			From (Mo/Yr)	To (Mo/Yr)

16. List any other postgraduate medical education not accounted for in questions 14 and 15 above. Ø

Institution	Mailing Address	Type of Service or Specialty	Dates of Attendance	
			From (Mo/Yr)	To (Mo/Yr)

17. Area of Specialty: OBSTETRICS / GYNECOLOGY

18. Are you Board Certified by a Board recognized by the American Board of Medical Specialties? ☐ Yes ☒ No If YES, complete the following:

Specialty Board	Certification #	Dates of:	
		Certification	Recertification

19. Location of medical practice since graduation (include Military Service)

City/State	From (Mo/Yr)	To (Mo/Yr)
NELLIS AFB LOSVEGAS NV 89191	8/89	Present

20. List below the requested information for all hospitals of which you are, or have ever been a Staff Member at any level. If none, please indicate.

Hospital	Complete Mailing Address	Date of Appointment	
		From (Mo/Yr)	To (Mo/Yr)
554th MG. Support Hospital	554 OSW Hospital Nellis AFB NV 89191	8/89	Present

21. Have you been licensed to practice medicine in any state or country? ☒ Yes ☐ No If YES, complete the following information:

State or Country	License #	Date of Issuance	Dates of Practice in Agency's Jurisdiction	
			From (Mo/Yr)	To (Mo/Yr)
CALIFORNIA	G60065	25 June 85	6/84	6/89

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

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

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

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

26. Have you ever failed a state licensure examination, any part of FLEX, any part of National Boards, or any part of ECFMG or FMGEMS, even if subsequently passed? ☐ Yes ☒ No

27. Have you ever had staff privileges in a hospital denied, suspended, limited, revoked or not renewed, or have you ever resigned from a medical staff in lieu of disciplinary or administrative action? ☐ Yes ☒ No (PLEASE NOTE: THIS REQUIREMENT DOES NOT INCLUDE SUSPENSIONS OR RESTRICTIONS FOR FAILURE TO COMPLETE HOSPITAL MEDICAL RECORDS)

28. Have you ever been investigated for, charged with, or convicted of unprofessional conduct, professional incompetence, gross or repeated malpractice, or any other violation of a statute, rule or regulation governing the practice of medicine by any medical licensing board or other agency, hospital or medical society? ☐ Yes ☒ No

29. Have you ever been denied membership or expelled from a medical society or other professional medical organization? ☐ Yes ☒ No

30. Have you ever received psychiatric or psychologic treatment? ☐ Yes ☒ No

31. Have you ever undergone treatment for a mental illness, drug addiction, or acute or chronic substance, drug or alcohol abuse? ☐ Yes ☒ No

32. Do you regularly take any prescription drugs for therapeutic purposes? ☐ Yes ☒ No

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

34. Are you now or were you in the past, addicted to controlled substances, including, but not limited to narcotics or alcohol? ☐ Yes ☒ No

35. Have you ever been investigated for, charged 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? ☐ Yes ☒ No

36. Have you ever been arrested, investigated for, charged 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 or less.) ☐ Yes ☒ No

NOTE: You are required to list any conviction that has been set aside and dismissed under any other provision of law.

If you answered YES to any of questions 22 through 35 please explain the circumstances and disposition on a separate sheet(s) and attach to this application.

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

If YES: Location LAS VEGAS Date ASAP

38. Personal Information

Age ____ Height ____ Weight 175 Color of Eyes BRN

Color of Hair BLD Social Security Number ____

39. I, Adam Vincent Levy, being duly sworn, depose and say: That the answers to the foregoing questions and statements made in the above application are true and correct; that I am the person named in the credentials to be submitted; and that the same were procured in the regular course of instruction and examination without fraud or misrepresentation. It is understood by me, that if any part of this application is found to be false or fraudulent, that I forfeit the right to a medical license in the State of Nevada.

40. Please check one of the following:

☒ At the time of oral examination, I wish to be examined in the area of my specialty as indicated in Number 17 of this application.

☐ At the time of oral examination, I wish to be examined in the area of general medicine.

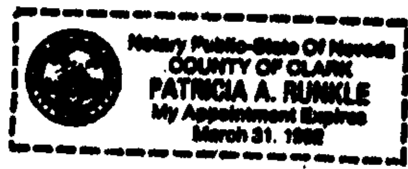
[signature]
Signature of Applicant

Subscribed and sworn to before me this 24TH

day of SEPTEMBER, 1990

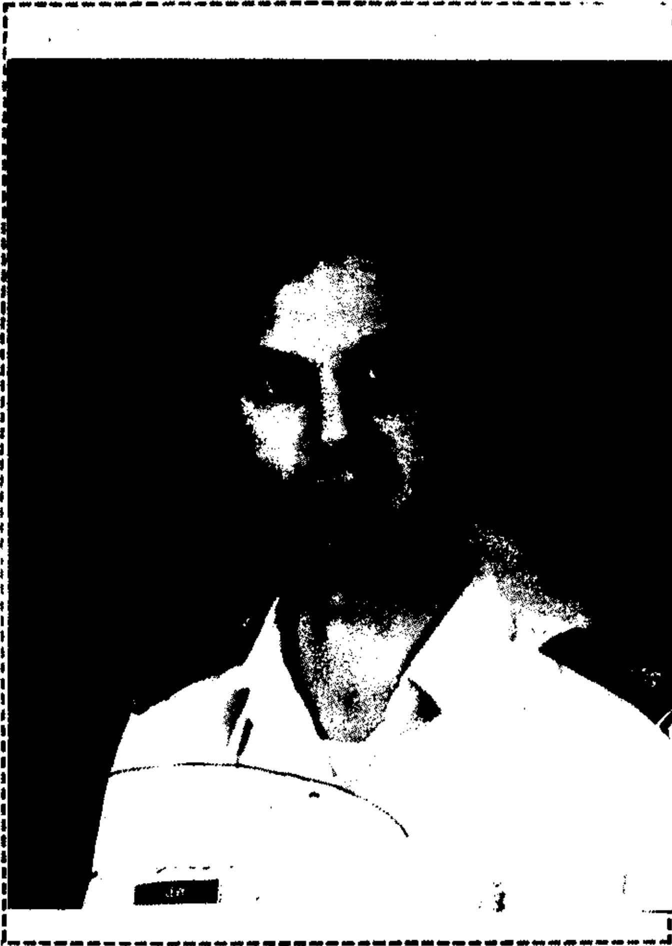
[signature]
Notary Public for State of NEVADA

(Notary Seal)



My Commission Expires 31 MARCH 1992

Residing at 4535 W. SAHARA AVE.
LAS VEGAS, NV



I hereby certify that the attached photograph is a true likeness of myself taken within the last 60 days.

Signature of Applicant

30 July 90

Date

NOTE: All items in this application are mandatory; none are voluntary. Failure to provide any of the requested information will result in the application not being processed or being rejected as incomplete. The information provided will be used for identification and to determine qualification for licensure per Nevada Revised Statute 630 which authorizes the collection of this information.

INSTRUCTIONS

The Application, and Form A, are to be completed by the applicant, notarized as indicated, and returned to the Nevada State Board of Medical Examiners.

Forms 1 thru 6, are to be completed by the agencies or individuals indicated. It is the responsibility of the applicant to see that these are promptly returned. The completed application must be received 45 days before any examination will be administered. The forms should be seperated and mailed individually, then must be returned directly to the Nevada State Board of Medical Examiners by the agencies or individuals responsible for their completion. If additional copies of any forms are needed, please photocopy.

If additional space is required for answers, separate sheets may be attached to application.

No application will be processed prior to receipt of all required fees. See fee schedule on enclosed sheet.

Application fees are non-refundable.

Please submit the application and Form A along with all required fees to:

Nevada State Board of Medical Examiners
P. O. Box 7238
Reno, NV 89510
(702) 329-2559

APPLICANT
Do Not Write In This Box
For Use At Time Of Interview

I verify that all statements made on my application for licensure in the State of Nevada received on 09-27-90, are still true and valid on 12-01-90, the date of my oral examination

Signed: [signature]

Witness: [signature] (Board Member)

System Automation

Reports Home Page

Renewal Questions for License Number 6135

Licensee	Question	Answer	Date
LEVY, Adam Vincent	Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? **If you do not have a medical condition, select No.**	N	4/7/2011
LEVY, Adam Vincent	**Explanation 1: For the above question if your answer is "Yes" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box.**		
LEVY, Adam Vincent	If you have a medical condition which in any way impairs or limits your ability to practice medicine, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? **If you do not have a medical condition, select No.**	N	4/7/2011
LEVY, Adam Vincent	**Explanation 2: For the above question if your answer is "Yes" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box.**		
LEVY, Adam Vincent	If you use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety? **If you do not use chemical substances, select No.**	N	4/7/2011
LEVY, Adam Vincent	**Explanation 3: For the above question if your answer is "Yes" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box.**		
LEVY, Adam Vincent	Have you been named as a defendant, or been requested to respond as a defendant, to a legal action involving professional liability, malpractice, including any military tort claims if applicable? Please include: who, what, where (provide state), and when in the textbox directly below this question.	Y	4/7/2011
	Explanation 4: For the above question if your		

LEVY, Adam Vincent	**answer is "Yes" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box.**		4/7/2011
LEVY, Adam Vincent	Have you had a professional liability, malpractice, claim paid on your behalf or paid such a claim yourself including any military tort claims if applicable? If "Yes" during the time period July 1, 2009 - June 30, 2011 type an explanation in the textbox directly below this question.	Y	4/7/2011
LEVY, Adam Vincent	**Explanation 5: For the above question if your answer is "Yes" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box.** Please fax a copy of the complaint, civil or otherwise to 775-688-2551.		4/7/2011
LEVY, Adam Vincent	Have you been arrested, investigated for, charged with, convicted of, or pled guilty or nolo contendere to any offense or violation of any federal (including the Uniform Code of Military Justice), state or local law, or the laws of any foreign country, which is a misdemeanor, gross misdemeanor, felony, violation of the Uniform Code of Military Justice, or synonymous thereto in a foreign jurisdiction, excluding any minor traffic offense (driving or being in control of a motor vehicle while under the influence of a chemical substance, including alcohol, is not considered a minor traffic offense), or for any offense which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? **Please note that you MUST disclose ANY investigation or arrest, including those where the final disposition was dismissal, or expungement.**	N	4/7/2011
LEVY, Adam Vincent	**Explanation 6: For the above question if your answer is "Yes" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box.**		
LEVY, Adam Vincent	Have you 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?	N	4/7/2011
LEVY, Adam Vincent	**Explanation 7: For the above question if your answer is "Yes" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box.**		

LEVY, Adam Vincent	Have you had a medical license or license to practice any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory?	N	4/7/2011
LEVY, Adam Vincent	**Explanation 8: For the above question if your answer is "Yes" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box.**		
LEVY, Adam Vincent	Have you voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory in lieu of any disciplinary action?	N	4/7/2011
LEVY, Adam Vincent	**Explanation 9: For the above question if your answer is "Yes" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box.**		
LEVY, Adam Vincent	Have you been denied membership, been asked to resign or expelled from a medical society or other professional medical organization (including the ABMS)?	N	4/7/2011
LEVY, Adam Vincent	**Explanation 10: For the above question if your answer is "Yes" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box.**		
LEVY, Adam Vincent	Have you been: a) asked to respond to an investigation; b) notified that you were under investigation for; c) investigated for; d) charged with; or e) convicted of any violation of a statute, rule or regulation governing your practice as a physician by any medical licensing board, hospital, medical society, governmental entity or agency other than the Nevada State Board of Medical Examiners?	N	4/7/2011
LEVY, Adam Vincent	**Explanation 11: For the above question if your answer is "Yes" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box.**		
LEVY, Adam Vincent	Have you surrendered your state or federal controlled substance registration or had it revoked or restricted in any way?	N	4/7/2011
LEVY, Adam Vincent	**Explanation 12: For the above question if your answer is "Yes" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box.**		
	Have you had hospital staff privileges denied, suspended, limited, revoked or not renewed by the hospital, including any and all resignations from any		

LEVY, Adam Vincent	medical staff in lieu of disciplinary or administrative action? If the answer is " Yes," type the name of the hospital, the hospital's mailing address, the type of action taken, and the date or dates of the actions taken in the textbox directly below this question. **(<u>Please Note</u>:) Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance.)**	N	4/7/2011
LEVY, Adam Vincent	**Explanation 13: For the above question if your answer is "Yes" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box.**		
LEVY, Adam Vincent	Are you out of compliance with court ordered child support? **If this does not apply to you, please answer "no".** If "Yes" during the time period July 1, 2009 - June 30, 2011 type an explanation in the textbox directly below this question.	N	4/7/2011
LEVY, Adam Vincent	**Explanation 14: For the above question if your answer is "YES" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box.**		
LEVY, Adam Vincent	I hereby request my license to be placed on Inactive status, which means I will <u>not</u> physically practice in the state of Nevada. If you choose to place your license on Inactive status, make certain to select "Yes" to this question **<u>AND</u>** choose the Inactive status in the dropdown box located at the end of the questions.	N	4/7/2011
LEVY, Adam Vincent	**Explanation 15: For the above question, if your answer is "Yes" and you want to change to Inactive status for the next biennial July 1, 2011 - June 30, 2013, please provide a brief explanation in this text box.**		
LEVY, Adam Vincent	Is your license contingent upon maintaining certification with the American Board of Medical Specialties (ABMS) in the specialty of Family Practice, Emergency Medicine, or Preventative Medicine?	N	4/7/2011
LEVY, Adam	**Explanation 16: For the above question if your answer is "YES" , please type your new scope of**		

Vincent	**practice or specialty in this text box.**		
LEVY, Adam Vincent	Do you want to change your scope of practice or specialty? If you answer "Yes" type your current scope of practice or specialty in the textbox directly below this question.	N	4/7/2011
LEVY, Adam Vincent	**Explanation 17: For the above question if your answer is "Yes" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box.**		
LEVY, Adam Vincent	I have completed the required amount of AMA Category 1 CME within the current biennial. (Review CME information online at www.medboard.nv.gov) I understand that I may be included in a random audit following the July 1st, 2011 renewal. I agree to retain CME's taken between July 1, 2009 and June 30, 2011. If renewing to an Inactive status, CME is not required and "No" can be selected.	Y	4/7/2011
LEVY, Adam Vincent	I SWEAR OR AFFIRM UNDER THE PENALTY OF PERJURY THAT I PERSONALLY ANSWERED ALL OF THE QUESTIONS IN THIS APPLICATION AND THAT THE ANSWERS I HAVE PROVIDED ARE TRUE AND CORRECT.	Y	4/7/2011

6135	LEVY, Adam Vincent	Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety?	N	5/7/2009
6135	LEVY, Adam Vincent	If you have a medical condition which in any way impairs or limits your ability to practice medicine, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice?	N	5/7/2009
6135	LEVY, Adam Vincent	If you use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety?	N	5/7/2009
6135	LEVY, Adam Vincent	Have you been named as a defendant, or been requested to respond as a defendant or potential defendant, to a legal action involving professional liability (malpractice)? Please include: who, what, where (provide state), and when in the textbox directly below this question.	Y	5/7/2009

6135	LEVY, Adam Vincent	For the above question if your answer is "Yes" for the time period July 1, 2007 - June 30, 2009, please type your explanation in this text box.	5/7/2009

6135	LEVY, Adam Vincent	Have you had a professional liability (malpractice) claim paid on your behalf or paid such a claim yourself (including any military tort claims if applicable)? Please include: who, what, where (provide state), when and case number in the textbox directly below this question. Please fax a copy of the complaint, civil or otherwise to 775-688-2551.	N	5/7/2009
6135	LEVY, Adam Vincent	Have you been arrested, investigated for, charged with, convicted of, or pled guilty or nolo contendere to any criminal offense related to the manufacture, distribution, prescribing, or dispensing of controlled substances? Please note that you MUST disclose ANY investigation or arrest, including those where the final disposition was dismissal, sealing of a record, or expungement.	N	5/7/2009
6135	LEVY, Adam Vincent	Have you been arrested, investigated for, charged with, convicted of, or pled guilty or nolo contendere to any criminal offense other than a criminal offense listed in Question #6? Please note that you MUST disclose ANY investigation or arrest, including those where the final disposition was dismissal, sealing of a record, or expungement.	N	5/7/2009
6135	LEVY, Adam Vincent	Have you 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?	N	5/7/2009
6135	LEVY, Adam Vincent	Have you had a medical license or license to practice any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory?	N	5/7/2009

6135	LEVY, Adam Vincent	Have you voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory in lieu of any disciplinary action?	N	5/7/2009
6135	LEVY, Adam Vincent	Have you been denied membership, been asked to resign or expelled from a medical society or other professional medical organization (including the ABMS)?	N	5/7/2009
6135	LEVY, Adam Vincent	Regarding any medical licensing board, hospital medical society, or other governmental entity or agency (other than the Nevada State Board of Medical Examiners), have you been: (a) Asked to respond to an investigation; (b) Notified that you were under investigation for; (c) Investigated for; (d) Charged with; or (e) Convicted of any violation of a statute, rule or regulation governing your practice as a physician?	N	5/7/2009
6135	LEVY, Adam Vincent	Have you surrendered your state or federal controlled substance registration or had it revoked or restricted in any way?	N	5/7/2009
6135	LEVY, Adam Vincent	Have you had hospital staff privileges denied, suspended, limited, revoked or not renewed by the hospital, including any and all resignations from any medical staff in lieu of disciplinary or administrative action? If the answer is " Yes," type the name of the hospital, the hospital's mailing address, the type of action taken, and the date or dates of the actions taken in the textbox directly below this question. (Please Note: Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance.)	N	5/7/2009

6135	LEVY, Adam Vincent	Are you out of compliance with court ordered child support? If this does not apply to you, please answer "no". If "Yes" during the time period July 1, 2007- June 30, 2009 type an explanation in the textbox directly below this question.	N	5/7/2009
6135	LEVY, Adam Vincent	I hereby request my license to be placed on Inactive status, which means I will not physically practice in the state of Nevada.	N	5/7/2009
6135	LEVY, Adam Vincent	Do you want to change your scope of practice or specialty? If you answer "Yes" type your current scope of practice or specialty in the textbox directly below this question.	N	5/7/2009
6135	LEVY, Adam Vincent	I have completed the required amount of AMA Category 1 CME within the current biennial. (Review CME information online at www.medboard.nv.gov) I understand that I may be included in a random audit following the July 1st, 2009 renewal. I agree to retain CME's taken between July 1, 2007 and June 30, 2009.	Y	5/7/2009
6135	LEVY, Adam Vincent	I SWEAR OR AFFIRM UNDER THE PENALTY OF PERJURY THAT I PERSONALLY ANSWERED ALL OF THE QUESTIONS IN THIS APPLICATION AND THAT THE ANSWERS I HAVE PROVIDED ARE TRUE AND CORRECT.	Y	5/7/2009

License Number	Licensee Name	Question Text	Answer	Date Answered
6135	LEVY, Adam Vincent	Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety?	N	3/29/2007
6135	LEVY, Adam Vincent	If you have a medical condition which in any way impairs or limits your ability to practice medicine, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice?	N	3/29/2007
6135	LEVY, Adam Vincent	If you use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety?	N	3/29/2007
6135	LEVY, Adam Vincent	Have you failed to initiate the performance of public service within one year after the date the public service is required to begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local government for your medical education?	N	3/29/2007
6135	LEVY, Adam Vincent	Have you been named as a defendant, or been requested to respond as a defendant, to a legal action involving professional liability (malpractice), or had a professional liability claim paid on your behalf, or paid such a claim yourself?	N	3/29/2007

6135	LEVY, Adam Vincent	Have you been investigated for, arrested for, charged with, convicted of, or plead guilty or nolo contendere to any offense or violation of any federal (including the U.S. Military), state or local law, including any foreign country, which is in a foreign jurisdiction equivalent to, a misdemeanor, gross misdemeanor, court martial, or felony, excluding any minor traffic offense (driving or being in control of a motor vehicle while under the influence of any chemical substance and/or including alcohol, is not considered a minor traffic offense), or for any offense which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? Please note that you MUST disclose ANY investigation or arrest, even if the ultimate disposition was dismissal or expungement.	N	3/29/2007
6135	LEVY, Adam Vincent	Have you 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?	N	3/29/2007
6135	LEVY, Adam Vincent	Have you had a medical license or license to practice any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory?	N	3/29/2007
6135	LEVY, Adam Vincent	Have you voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory by the direct request of a medical board?	N	3/29/2007
6135	LEVY, Adam Vincent	Have you been denied membership or expelled from a medical society or other professional medical organization?	N	3/29/2007

6135	LEVY, Adam Vincent	Have you been: a) notified that you were under investigation for; b) investigated for; c) charged with; or d) convicted of any violation of a statute, rule or regulation governing your practice as a physician by any medical licensing board, hospital, medical society, governmental entity or agency other than the Nevada State Board of Medical Examiners?	N	3/29/2007
6135	LEVY, Adam Vincent	Have you surrendered your state or federal controlled substance registration or had it revoked or restricted in any way ?	N	3/29/2007
6135	LEVY, Adam Vincent	Have you had hospital staff privileges denied, suspended, limited, revoked or not renewed by the hospital? If you have answered "Yes" you will be required to submit a list of any and all resignations from any medical staff in lieu of disciplinary or administrative action via email to elicensensbme@medboard.nv.gov (Please Note: Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance.)	N	3/29/2007
6135	LEVY, Adam Vincent	Is your license currently contingent upon compliance with the Diversion program also known as the Nevada Health Professionals Assistance Foundation?	N	3/29/2007
6135	LEVY, Adam Vincent	Is your license currently contingent upon maintaining certification by the American Board of Medical Specialties in the specialty of Family Practice, Emergency Medicine or Preventative medicine?	N	3/29/2007

6135	LEVY, Adam Vincent	Are you a foreign medical doctor, who holds a Conditional Resident Alien Card, Employment Authorization Card, or Visa with the Department of Homeland Security, Immigration and Naturalization Services?	N	3/29/2007
6135	LEVY, Adam Vincent	Are you out of compliance with court ordered child support? If this does not apply to you please answer "no".	N	3/29/2007
6135	LEVY, Adam Vincent	Do you want to change your scope of practice or specialty? If you answer "Yes" please email your request to elicensensbme@medboard.nv.gov	N	3/29/2007
6135	LEVY, Adam Vincent	Are you currently supervising a Physician Assistant or an Advanced Practitioner of Nursing? If you answer "Yes" please email a list of names of those you are supervising to elicensensbme@medboard.nv.gov	Y	3/29/2007
6135	LEVY, Adam Vincent	I have completed the required amount of AMA Category 1 CME within the current biennial. (Review CME information online at www.medboard.nv.gov) I understand that I may be included in a random audit following July 1st 2007 renewal. I agree to retain CME's taken between July 1, 2005 and June 30, 2007.	Y	3/29/2007
6135	LEVY, Adam Vincent	I have actively practiced medicine in Nevada within the past 12 months.	Y	3/29/2007
6135	LEVY, Adam Vincent	I hereby request my license to be placed on Inactive status. I will not physically practice in the state of Nevada.	N	3/29/2007
6135	LEVY, Adam Vincent	I HEREBY SWEAR OR AFFIRM UNDER THE PENALTIES OF PERJURY THAT I AM IN FULL COMPLIANCE WITH ANY AND ALL OBLIGATIONS, TERMS OR CONDITIONS OF MY NEVADA MEDICAL LICENSE SPECIFIED BY THE BOARD.	Y	3/29/2007

PHYSICIAN
APPLICATION FOR REGISTRATION RENEWAL
FOR THE BIENNIAL REGISTRATION PERIOD 2005 - 2007
NEVADA STATE BOARD OF MEDICAL EXAMINERS

Post Office Box 7238 Reno, Nevada 89510 Phone (775) 688-2559
Physical Address: 1105 Terminal Way, Suite 301 Reno, Nevada 89502

Date Received by Board
MAR 2 8 2005
APR 1 5 2005
(For Board Use Only)

License No. 6135

File No.

12/1/90

I hereby apply for renewal of biennial registration and enclose the appropriate fee(s) as indicated below:

✓ ACTIVE STATUS $600.00
_____ INACTIVE STATUS $300.00......***(INACTIVE STATUS DOES NOT PERMIT THE PRACTICE OF MEDICINE INCLUDING THE WRITING OF PRESCRIPTIONS IN NEVADA)***
_____ I REQUEST NON-RENEWAL OF MY LICENSE*
(*IF YOU ARE REQUESTING NON-RENEWAL, SEE BELOW)

File No: License No: 6135

Adam Vincent LEVY M.D.
1670 E Flamingo Rd # C
Las Vegas NV 89119-

Make checks payable to:
NEVADA STATE BOARD OF MEDICAL EXAMINERS
(Foreign checks must indicate "U.S. FUNDS")

Request for NON-RENEWAL of License to Practice Medicine in Nevada

I hereby represent that I am the person named in this *APPLICATION FOR REGISTRATION RENEWAL* of license to practice medicine in the state of Nevada.

By signing on the signature line below, I am requesting that my license to practice medicine in Nevada NOT be renewed by the Nevada State Board of Medical Examiners. I will return this signed form to the Board office.

Date __________ Signature **(SIGNATURE STAMP UNACCEPTABLE)**

PLEASE NOTE:

- **YOUR CURRENT M.D. LICENSE EXPIRES ON JUNE 30, 2005. COMPLETED *APPLICATION FOR REGISTRATION RENEWAL* FORMS NOT RECEIVED AT THE BOARD OFFICE BY JULY 1, 2005 AT 5:00 P.M. ARE AUTOMATICALLY SUSPENDED FOR NON-PAYMENT. EXTENSIONS OF TIME ARE NOT ALLOWED FOR ANY REASON, AS NEVADA HAS NO GRACE PERIOD. (USE THE ENCLOSED ENVELOPE TO MAIL YOUR COMPLETED *APPLICATION FOR REGISTRATION RENEWAL* FORM.)**
- **YOUR LICENSE WILL NOT BE RENEWED UNLESS YOU ANSWER ALL QUESTIONS ON THIS *APPLICATION FOR REGISTRATION RENEWAL* FORM. YOU MUST PROVIDE WRITTEN EXPLANATIONS FOR ALL QUESTIONS ANSWERED "YES."**
- **ALL INFORMATION YOU PROVIDE ON THIS *APPLICATION FOR REGISTRATION RENEWAL* FORM IS PUBLIC INFORMATION.**

PLEASE TYPE OR PRINT LEGIBLY

1. Active status registration renewal requires the submission of proof of completion of 44 hours of AMA Category 1 continuing medical education (CME), which includes 2 hours of CME in medical ethics and 20 hours of CME in your scope of practice or specialty **completed during the period July 1, 2003 through June 30, 2005.** Additionally, pursuant to Nevada Revised Statutes (NRS) 630.253(2)(b), an applicant must complete a course of instruction relating to the medical consequences of an act of terrorism that involves the use of a weapon of mass destruction. "The course must provide at least 4 hours of instruction that includes instruction in the following subjects: (1) An overview of acts of terrorism and weapons of mass destruction; (2) Personal protective equipment required for acts of terrorism; (3) Common symptoms and methods of treatment associated with exposure to, or injuries caused by, chemical, biological, radioactive and nuclear agents; (4) Syndromic surveillance and reporting procedures for acts of terrorism that involve biological agents; and (5) An overview of the information available on, and the use of, the Health Alert Network." Submit your proof of completion of CME with your completed *Application for Registration Renewal* form. (See last page of this form for CME statement.)

2. If your name and/or address has changed from that printed on the label on this form, clearly indicate the change in the space provided below. Also, please indicate your current telephone and fax numbers. [Please note: a notarized or certified copy of the document authorizing your name change (marriage license, divorce decree, etc.) must be included.]

Name __________

Street __________

City __________ County __________ State _____ Zip _____

Phone Number __________ Fax Number __________

3. **IF YOU HAVE RETIRED OR MOVED YOUR PRACTICE,** indicate the location of patient records below:

Name ____________________

Street ____________________

City ____________ County ____________ State ____________ Zip ____________

Phone Number ____________________

4. **Indicate below your primary and secondary scopes of practice using the following codes:**

SCOPES OF PRACTICE CODES

1 ADDICTION MEDICINE
2 ADOLESCENT MEDICINE
3 AEROSPACE MEDICINE
4 ALLERGY
5 ALLERGY/IMMUNOLOGY
6 AMBULATORY MEDICINE
7 ANESTHESIOLOGY
8 BLOODBANKING
9 BRONCO-ESOPHAGOLOGY
10 CARDIOVASCULAR DISEASES
11 CATSCAN/ULTRASOUND
12 CHILD NEUROLOGY
13 CHILD PSYCHIATRY
14 CLINICAL PHARMACOLOGY
15 CRITICAL CARE
16 DERMATOLOGY
17 DERMATOPATHOLOGY
18 EMERGENCY MEDICINE
19 ENDOCRINOLOGY
20 FAMILY PRACTICE
21 FORENSIC MEDICINE
22 GASTROENTEROLOGY
23 GENERAL PRACTICE
24 GERIATRIC PSYCHIATRY
25 GERIATRICS
26 GYNECOLOGY
27 HAIR TRANSPLANTATION
28 HEMATOLOGY
29 HOMEOPATHY
30 HYPNOSIS
31 IMMUNOLOGY
32 INFECTIOUS DISEASES
33 INFERTILITY
34 INTERNAL MEDICINE
35 LARYNGOLOGY
36 LEGAL MEDICINE
37 MATERNAL/FETAL MEDICINE
38 MEDICAL ACUPUNCTURE
39 MEDICAL ETHICS
40 MEDICAL GENETICS
41 NEO/PERINATAL MEDICINE
42 NEOPLASTIC DISEASES
43 NEPHROLOGY
44 NEUROLOGY
45 NEURO-OPHTHALMOLOGY
46 NEUROPATHOLOGY
47 NEURORADIOLOGY
48 NEUROTOLOGY
49 NON-CONVENTIONAL MEDICINE
50 NUCLEAR MEDICINE
51 NUTRITION
52 OBSTETRICS
53 OBSTETRICS/GYNECOLOGY
54 OCCUPATIONAL MEDICINE
55 ONCOLOGY
56 ONCOLOGY, GYNECOLOGICAL
57 ONCOLOGY, HEMATOLOGY
58 ONCOLOGY, RADIATION
59 ONCOLOGY, SURGICAL
60 OPHTHALMOLOGY
61 OTOLARYNGOLOGY
62 OTOLOGY
63 PAIN MANAGEMENT
64 PATHOLOGY
65 PATHOLOGY, ANATOMIC
66 PATHOLOGY, CLINICAL
67 PATHOLOGY, FORENSIC
68 PEDIATRIC, ALLERGY
69 PEDIATRIC, ANESTHESIOLOGY
70 PEDIATRIC, CARDIOLOGY
71 PEDIATRIC, CRITICAL CARE
72 PEDIATRIC, EMERGENCY MEDICINE
73 PEDIATRIC, ENDOCRINOLOGY
74 PEDIATRIC, GASTROENTEROLOGY
75 PEDIATRIC, HEMATOLOGY/ONCOLOGY
76 PEDIATRIC, INFECTIOUS DISEASES
77 PEDIATRIC, INTENSIVIST
78 PEDIATRIC, NEPHROLOGY
79 PEDIATRIC, NEUROLOGY
80 PEDIATRIC, OPHTHALMOLOGY
81 PEDIATRIC, PHYSIATRY
82 PEDIATRIC, PULMONARY
83 PEDIATRIC, RADIOLOGY
84 PEDIATRIC, RHEUMATOLOGY
85 PEDIATRIC, SURGERY
86 PEDIATRIC, UROLOGY
87 PEDIATRICS
88 PHYSICAL MEDICINE/REHABILITATION
89 PREVENTIVE MEDICINE
90 PSYCHIATRY
91 PSYCHOANALYSIS
92 PSYCHOMATIC MEDICINE
93 PUBLIC HEALTH
94 PULMONARY DISEASES
95 OCCUPATIONAL MEDICINE
96 RADIOLOGY
97 RADIOLOGY, DIAGNOSTIC
98 RADIOLOGY, INTERVENTIONAL
99 RADIOLOGY, NUCLEAR
100 RADIOLOGY, THERAPEUTIC
101 RADIOLOGY, VASCULAR
102 RHEUMATOLOGY
103 RHINOLOGY
104 SLEEP DISORDERS
105 SPORTS MEDICINE
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107 SURGERY, CARDIOTHORACIC
108 SURGERY, CARDIOVASCULAR
109 SURGERY, COLON/RECTAL
110 SURGERY, CRANIOFACIAL
111 SURGERY, GENERAL
112 SURGERY, HAND
113 SURGERY, HEAD/NECK
114 SURGERY, MAXILLOFACIAL
115 SURGERY, NEUROLOGICAL
116 SURGERY, ORTHOPEDIC
117 SURGERY, PLASTIC
118 SURGERY, THORACIC
119 SURGERT, TRANSPLANT
120 SURGERY, TRAUMATIC
121 SURGERY, UROLOGIC
122 SURGERY, VASCULAR
123 TOXICOLOGY
124 TRANSPLANTATION
125 URGENT CARE
126 UROLOGY

Primary Scope of Practice **Code** 26 **Secondary Scope of Practice** **Code** ________

PLEASE INDICATE AMERICAN BOARD OF MEDICAL SPECIALTIES BOARD CERTIFICATION & RECERTIFICATION

Board OB/Gyn **Date of Initial Certification** 12/31/91 (Mo./Yr.) **Date of Last Recertification** 9/30/05 (Mo./Yr.)

Subboard ____________________ (Mo./Yr.) (Mo./Yr.)

All of the following questions refer to the time period July 1, 2003, through the present date only.

For the purposes of the following questions, these phrases or words have these meanings:

"Ability to practice medicine" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments;
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and

3. The physical capability to perform medical tasks such as physician examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to, orthopedic, vision, speech, hearing, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, emotional or mental illness, HIV disease, tuberculosis, drug addiction, and alcoholism.

"Chemical substances" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction.

FOR ALL "YES" RESPONSES TO THE FOLLOWING QUESTIONS, YOU MUST SUBMIT YOUR WRITTEN EXPLANATION(S) ON A SEPARATE SHEET ATTACHED TO YOUR COMPLETED *APPLICATION FOR REGISTRATION RENEWAL* FORM.

1. Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? ______Yes __X__No

2. If you have a medical condition which in any way impairs or limits your ability to practice medicine, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? ______Yes __X__No __X__N/A

3. If you use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety? ______Yes __X__No ______N/A

4. Have you failed to initiate the performance of public service within one year after the date the public service is required to begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local government for your medical education? ______Yes __X__No ______N/A

5. Have you been a defendant in a legal action involving professional liability (malpractice) or had a professional liability claim paid in your behalf or paid such a claim yourself? ______Yes __X__No

6. Have you ever 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, excluding any minor traffic offense (driving or in control of a motor vehicle while under the influence of any chemical substance is **not considered a minor traffic offense**) or which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? ______Yes __X__No

7. 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? ______Yes __X__No

8. Have you ever had a medical license or license to practice any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory? ______Yes __X__No

9. Have you ever voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory? ______Yes __X__No

10. Have you ever been denied membership or expelled from a medical society or other professional medical organization? ______Yes __X__No

11. Have you ever been: a) notified that you were under investigation for; b) investigated for; c) charged with; or d) convicted of any violation of a statute, rule or regulation governing your practice as a physician by any medical licensing board, hospital, medical society, governmental entity or other agency other than the Nevada State Board of Medical Examiners? ______Yes __X__No

12. Have you ever surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? ______Yes __X__No

13. List all hospitals where you have had staff privileges denied, suspended, limited, revoked or not renewed by the hospital. List any and all resignations from any medical staff in lieu of disciplinary or administrative action. (Please Note: Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance.) (If more space is needed, attach a separate sheet)

Hospital	Mailing Address	Type of Action	Dates of Action From (Mo./Yr.)	To (Mo./Yr.)
None				

CHILD SUPPORT STATEMENT

Please place a check mark next to one of the following statements:

_______ (a) I am not subject to a court order for the support of a child;

___✓___ (b) 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 public agency enforcing the order for the repayment of the amount owed pursuant to the order; **OR**

_______ (c) 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.

CONTINUING MEDICAL EDUCATION (CME) STATEMENT

Please place a check mark next to one of the following statements:

___✓___ (a) I completed a minimum of 44 hours of AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics and 20 hours of which were in my scope of practice or specialty, and an additional 4 hours of AMA Category 1 continuing medical education in acts of terrorism, during the past biennial period of July 1, 2003 through June 30, 2005;

_______ (b) I was initially licensed in Nevada during the time period January 1, 2004 through June 30, 2004, the second six months of the past biennial period, and completed a minimum of 34 hours of AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics and 20 hours of which were in my scope of practice or specialty, and an additional 4 hours of AMA Category 1 continuing medical education in acts of terrorism;

_______ (c) I was initially licensed in Nevada during the time period July 1, 2004 through December 31, 2004, the third six months of the past biennial period, and completed a minimum of 24 hours of AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics and 18 hours of which were in my scope of practice or specialty, and an additional 4 hours of AMA Category 1 continuing medical education in acts of terrorism;

_______ (d) I was initially licensed in Nevada during the time period January 1, 2005 through June 30, 2005, the fourth six months of the past biennial period, and completed a minimum of 14 hours of AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics and 8 hours of which were in my scope of practice or specialty, and an additional 4 hours of AMA Category 1 continuing medical education in acts of terrorism; OR

_______ (e) I am exempt from submitting proof of completion of continuing medical education (CME) because I have completed a full year of residency or fellowship training during the biennial period July 1, 2003 through June 30, 2005.

- **ATTACH COPIES OF PROOF OF YOUR COMPLETION OF CONTINUING MEDICAL EDUCATION (CME) HOURS.**
- **IF YOU COMPLETED A FULL YEAR OF RESIDENCY OR FELLOWSHIP TRAINING DURING THE BIENNIAL PERIOD JULY 1, 2003 THROUGH JUNE 30, 2005, ATTACH A COPY OF PROOF OF COMPLETION OF YOUR TRAINING.**
- **YOUR COPIES OF PROOF OF CME OR TRAINING COMPLETION WILL NOT BE RETURNED TO YOU.**

I HAVE ___✓___ HAVE NOT _____ *(CHECK ONE)* ACTIVELY PRACTICED MEDICINE IN NEVADA WITHIN THE PAST 12 MONTHS.

BY SIGNING ON THE SIGNATURE LINE BELOW:

1) **I HEREBY REPRESENT THAT I AM THE PERSON NAMED IN THIS *APPLICATION FOR REGISTRATION RENEWAL* OF LICENSE TO PRACTICE MEDICINE IN THE STATE OF NEVADA AND THAT ALL STATEMENTS I HAVE MADE HEREIN ARE TRUE;**

2) **I UNDERSTAND THAT THIS *APPLICATION FOR REGISTRATION RENEWAL* WILL BE DENIED IF I HAVE NOT PLACED A CHECK MARK NEXT TO (a), (b), OR (c) UNDER THE CHILD SUPPORT STATEMENT SECTION; AND**

3) **I UNDERSTAND THAT THIS *APPLICATION FOR REGISTRATION RENEWAL* WILL BE DENIED IF I HAVE NOT ANSWERED ALL QUESTIONS THEREON AND/OR ATTACHED THERETO: (a) THE APPROPRIATE COPIES OF PROOF OF CONTINUING MEDICAL EDUCATION (CME), OR RESIDENCY OR FELLOWSHIP TRAINING COMPLETION; (b) PAYMENT OF THE APPROPRIATE REGISTRATION RENEWAL FEE; AND (c) WRITTEN EXPLANATION(S) TO ANY "YES" ANSWER(S).**

2/3/05

Date

Signature (SIGNATURE STAMP UNACCEPTABLE)

PHYSICIAN
APPLICATION FOR REGISTRATION RENEWAL
FOR THE BIENNIAL REGISTRATION PERIOD 2003- 2005
NEVADA STATE BOARD OF MEDICAL EXAMINERS

Post Office Box 7238 Reno, Nevada 89510 Phone (775) 688-2559
Physical Address: 1105 Terminal Way, Suite 301 Reno, Nevada 89502

Date Received by Board
FEB 21 2003
MAR 10 2003
(For Board Use Only)

License No. 6135
File No. ______

I hereby apply for renewal of biennial registration and enclose the appropriate fee(s) as indicated below:

✓ ACTIVE STATUS $400.00
_____ INACTIVE STATUS $200.00.....(*INACTIVE STATUS DOES NOT PERMIT THE PRACTICE OF MEDICINE INCLUDING THE WRITING OF PRESCRIPTIONS IN NEVADA*)
_____ I REQUEST NON-RENEWAL OF MY LICENSE*
(*IF YOU ARE REQUESTING NON-RENEWAL, SEE BELOW)

Adam V LEVY M.D.
1670 E Flamingo Rd # C
Las Vegas NV 89119

Make checks payable to:
NEVADA STATE BOARD OF MEDICAL EXAMINERS
(Foreign checks must indicate "U.S. FUNDS")

Request for NON-RENEWAL of License to Practice Medicine In Nevada

I hereby represent that I am the person named in this *APPLICATION FOR REGISTRATION RENEWAL* of license to practice medicine in the state of Nevada.

By signing on the signature line below, I am requesting that my license to practice medicine in Nevada NOT be renewed by the Nevada State Board of Medical Examiners. I will return this signed form to the board office.

Date ______ Signature **(SIGNATURE STAMP UNACCEPTABLE)** ______

PLEASE NOTE:

- **YOUR CURRENT M.D. LICENSE EXPIRES ON JUNE 30, 2003. COMPLETED *APPLICATION FOR REGISTRATION RENEWAL* FORMS NOT RECEIVED AT THE BOARD OFFICE BY JULY 1, 2003 AT 5:00 P.M. ARE AUTOMATICALLY SUSPENDED FOR NON-PAYMENT. EXTENSIONS OF TIME ARE NOT ALLOWED FOR ANY REASON, AS NEVADA HAS NO GRACE PERIOD. (USE THE ENCLOSED ENVELOPE TO MAIL YOUR COMPLETED *APPLICATION FOR REGISTRATION RENEWAL* FORM.)**
- **YOUR LICENSE WILL NOT BE RENEWED UNLESS YOU ANSWER ALL QUESTIONS ON THIS *APPLICATION FOR REGISTRATION RENEWAL* FORM. YOU MUST PROVIDE WRITTEN EXPLANATIONS FOR ALL QUESTIONS ANSWERED "YES."**
- **ALL INFORMATION YOU PROVIDE ON THIS *APPLICATION FOR REGISTRATION RENEWAL* FORM IS PUBLIC INFORMATION.**

PLEASE TYPE OR PRINT LEGIBLY

1. Active status registration renewal requires the submission of proof of completion of 40 hours of AMA Category 1 continuing medical education (CME), which includes 2 hours of CME in medical ethics and 20 hours of CME in your scope of practice or specialty **completed during the period July 1, 2001 through June 30, 2003.** Submit your proof of completion of CME with your completed *Application for Registration Renewal* form. (See last page of this form for CME statement.)

2. If your name and/or address has changed from that printed on the label on this form, clearly indicate the change in the space provided below. Also, please indicate your current telephone and fax numbers. [Please note: a notarized or certified copy of the document authorizing your name change (marriage license, divorce decree, etc.) must be included.]

Name ______
Street ______
City ______ County ______ State ______ Zip ______
Phone Number ______ Fax Number ______

3. **IF YOU HAVE RETIRED OR MOVED YOUR PRACTICE,** indicate the location of patient records below:

Name ______
Street ______
City ______ County ______ State ______ Zip ______
Phone Number ______

4. Indicate below your primary and secondary scopes of practice using the following codes:

SCOPES OF PRACTICE CODES

1 ADDICTION MEDICINE
2 ADOLESCENT MEDICINE
3 AEROSPACE MEDICINE
4 ALLERGY
5 ALLERGY/IMMUNOLOGY
6 AMBULATORY MEDICINE
7 ANESTHESIOLOGY
8 BLOODBANKING
9 BRONCO-ESOPHAGOLOGY
10 CARDIOVASCULAR DISEASES
11 CATSCAN/ULTRASOUND
12 CHILD NEUROLOGY
13 CHILD PSYCHIATRY
14 CLINICAL PHARMACOLOGY
15 CRITICAL CARE
16 DERMATOLOGY
17 DERMATOPATHOLOGY
18 EMERGENCY MEDICINE
19 ENDOCRINOLOGY
20 FAMILY PRACTICE
21 GASTROENTEROLOGY
22 GENERAL PRACTICE
23 GERIATRIC PSYCHIATRY
24 GERIATRICS
25 GYNECOLOGY
26 HAIR TRANSPLANTATION
27 HEMATOLOGY
28 HOMEOPATHY
29 HYPNOSIS
30 IMMUNOLOGY
31 INFECTIOUS DISEASES
32 INFERTILITY
33 INTERNAL MEDICINE
34 LARYNGOLOGY
35 LEGAL MEDICINE
36 MATERNAL/FETAL MEDICINE
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64 PATHOLOGY, CLINICAL
65 PATHOLOGY, FORENSIC
66 PEDIATRIC, ALLERGY
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78 PEDIATRIC, PHYSIATRY
79 PEDIATRIC, PULMONARY
80 PEDIATRIC, RADIOLOGY
81 PEDIATRIC, RHEUMATOLOGY
82 PEDIATRIC, SURGERY
83 PEDIATRIC, UROLOGY
84 PEDIATRICS
85 PHYSICAL MEDICINE/REHABILITATION
86 PREVENTIVE MEDICINE
87 PSYCHIATRY
88 PSYCHOANALYSIS
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91 PULMONARY DISEASES
92 RADIOLOGY
93 RADIOLOGY, DIAGNOSTIC
94 RADIOLOGY, INTERVENTIONAL
95 RADIOLOGY, NUCLEAR
96 RADIOLOGY, THERAPEUTIC
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98 RHEUMATOLOGY
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102 SURGERY, ABDOMINAL
103 SURGERY, CARDIOTHORACIC
104 SURGERY, CARDIOVASCULAR
105 SURGERY, COLON/RECTAL
106 SURGERY, GENERAL
107 SURGERY, HAND
108 SURGERY, HEAD/NECK
109 SURGERY, MAXILLOFACIAL
110 SURGERY, NEUROLOGICAL
111 SURGERY, ORTHOPEDIC
112 SURGERY, PLASTIC
113 SURGERY, THORACIC
114 SURGERY, TRANSPLANT
115 SURGERY, TRAUMATIC
116 SURGERY, UROLOGIC
117 SURGERY, VASCULAR
118 TOXICOLOGY
119 URGENT CARE
120 UROLOGY

	Code		Code
Primary Scope of Practice	25	**Secondary Scope of Practice**	50

//

All of the following questions refer to the time period July 1, 2001, through the present date only.

For the purposes of the following questions, these phrases or words have these meanings:

"Ability to practice medicine" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments;
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks such as physician examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to, orthopedic, vision, speech, hearing, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, emotional or mental illness, HIV disease, tuberculosis, drug addiction, and alcoholism.

"Chemical substances" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction.

FOR ALL "YES" RESPONSES TO THE FOLLOWING QUESTIONS, YOU MUST SUBMIT YOUR WRITTEN EXPLANATION(S) ON A SEPARATE SHEET ATTACHED TO YOUR COMPLETED *APPLICATION FOR REGISTRATION RENEWAL* FORM.

1. Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? ______Yes __X__No

2. If you have a medical condition which in any way impairs or limits your ability to practice medicine, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? ______Yes _____No __X__N/A

3. If you use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety? ______Yes______No __X__N/A

4. Have you failed to initiate the performance of public service within one year after the date the public service is required to begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local government for your medical education? ______Yes ______No__X__N/A

5. Have you been a defendant in a legal action involving professional liability (malpractice) or had a professional liability claim paid in your behalf or paid such a claim yourself? __X__Yes ______No

6. Have you ever 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, excluding any minor traffic offense (driving or in control of a motor vehicle while under the influence of any chemical substance is **not considered a minor traffic offense**) or which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? ______Yes __X__No

7. 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? ______Yes __X__No

8. Have you ever had a medical license or license to practice any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory? ______Yes __X__No

9. Have you ever voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory? ______Yes__X__No

10. Have you ever been denied membership or expelled from a medical society or other professional medical organization? ______Yes __X__No

11. Have you ever been: a) notified that you were under investigation for; b) investigated for; c) charged with; or d) convicted of any violation of a statute, rule or regulation governing your practice as a physician by any medical licensing board, hospital, medical society, governmental entity or other agency other than the Nevada State Board of Medical Examiners? ______Yes __X__No

12. Have you ever surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? ______Yes__X__No

13. List all hospitals where you have had staff privileges denied, suspended, limited, revoked or not renewed by the hospital. List any and all resignations from any medical staff in lieu of disciplinary or administrative action. (Please Note: Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance).

Hospital	Mailing Address	Type of Action	Dates of Action From (Mo./Yr.) To (Mo./Yr.)
(None)			

(If more space is needed, attach a separate sheet.)

CHILD SUPPORT STATEMENT

Please place a check mark next to one of the following statements:

_______ (a) I am not subject to a court order for the support of a child;

__X__ (b) 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 public agency enforcing the order for the repayment of the amount owed pursuant to the order; **OR**

_______ (c) 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.

CONTINUING MEDICAL EDUCATION (CME) STATEMENT

Please place a check mark next to one of the following statements:

__X__ (a) I completed a minimum of 40 hours of AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics and 20 hours of which were in my scope of practice or specialty, during the past biennial period of July 1, 2001 through June 30, 2003;

_______ (b) I was initially licensed in Nevada during the time period January 1, 2002 through June 30, 2002, the second six months of the past biennial period, and completed a minimum of 30 hours of AMA Category I continuing medical education (CME), 2 hours of which were in medical ethics and 20 hours of which were in my scope of practice or specialty;

_______ (c) I was initially licensed in Nevada during the time period July 1, 2002 through December 31, 2002, the third six months of the past biennial period, and completed a minimum of 20 hours of AMA Category I continuing medical education (CME), 2 hours of which were in medical ethics and 18 hours of which were in my scope of practice or specialty;

_______ (d) I was initially licensed in Nevada during the time period January 1, 2003 through June 30, 2003, the fourth six months of the past biennial period, and completed a minimum of 10 hours of AMA Category I continuing medical education (CME), 2 hours of which were in medical ethics and 8 hours of which were in my scope of practice or specialty; **OR**

_______ (e) I am exempt from submitting proof of completion of continuing medical education (CME) because I have completed a full year of residency or fellowship training during the biennial period July 1, 2001 through June 30, 2003.

ATTACH COPIES OF PROOF OF YOUR COMPLETION OF CONTINUING MEDICAL EDUCATION (CME) HOURS.
IF YOU COMPLETED A FULL YEAR OF RESIDENCY OR FELLOWSHIP TRAINING DURING THE BIENNIAL PERIOD JULY 1, 2001 THROUGH JUNE 30, 2003, ATTACH A COPY OF PROOF OF COMPLETION OF YOUR TRAINING.
YOUR COPIES OF PROOF OF CME OR TRAINING COMPLETION WILL NOT BE RETURNED TO YOU.

I HAVE __X__ HAVE NOT ____ ***(CHECK ONE)*** ACTIVELY PRACTICED MEDICINE IN NEVADA WITHIN THE PAST 12 MONTHS.

BY SIGNING ON THE SIGNATURE LINE BELOW:

1) **I HEREBY REPRESENT THAT I AM THE PERSON NAMED IN THIS *APPLICATION FOR REGISTRATION RENEWAL* OF LICENSE TO PRACTICE MEDICINE IN THE STATE OF NEVADA AND THAT ALL STATEMENTS I HAVE MADE HEREIN ARE TRUE;**
2) **I UNDERSTAND THAT THIS *APPLICATION FOR REGISTRATION RENEWAL* WILL BE DENIED IF I HAVE NOT PLACED A CHECK MARK NEXT TO (a), (b), OR (c) UNDER THE CHILD SUPPORT STATEMENT SECTION; AND**
3) **I UNDERSTAND THAT THIS *APPLICATION FOR REGISTRATION RENEWAL* WILL BE DENIED IF I HAVE NOT ANSWERED ALL QUESTIONS THEREON AND/OR ATTACHED THERETO: (a) THE APPROPRIATE COPIES OF PROOF OF CONTINUING MEDICAL EDUCATION (CME), OR RESIDENCY OR FELLOWSHIP TRAINING COMPLETION; (b) PAYMENT OF THE APPROPRIATE REGISTRATION RENEWAL FEE; AND (c) WRITTEN EXPLANATION(S) TO ANY "YES" ANSWER(S).**

2-7-03
Date

Signature (SIGNATURE STAMP UNACCEPTABLE)

PHYSICIAN
APPLICATION FOR REGISTRATION RENEWAL
FOR THE BIENNIAL REGISTRATION PERIOD 2001- 2003
NEVADA STATE BOARD OF MEDICAL EXAMINERS
Post Office Box 7238 Reno, Nevada 89510 Phone (775) 688-2559

Date Received by Board
APR 0 6 2001
(For Board Use Only)

License No. 6135
File No.

I hereby apply for renewal of biennial registration and enclose the appropriate fee(s) as indicated below:

✓ ACTIVE STATUS	$600.00	
INACTIVE STATUS	$200.00	(*RETIRED STATUS REQUIRES THAT THE*
RETIRED STATUS	$ 50.00	*APPLICANT NOT PRACTICE MEDICINE*
~~SUPERVISING/COLLABORATING PHYSICIAN~~	$200.00	*ANYWHERE*)

Adam V LEVY M.D.
2501 W Charleston Blvd
Las Vegas NV 89102

Make checks payable to:
NEVADA STATE BOARD OF MEDICAL EXAMINERS
(Foreign checks must indicate "U.S. FUNDS")

PLEASE NOTE:

- **YOUR CURRENT M.D. LICENSE EXPIRES ON JUNE 30, 2001. COMPLETED *APPLICATION FOR REGISTRATION RENEWAL* FORMS NOT RECEIVED AT THE BOARD OFFICE BY JULY 1, 2001 AT 5:00 P.M. ARE AUTOMATICALLY SUSPENDED FOR NON-PAYMENT. EXTENSIONS OF TIME ARE NOT ALLOWED FOR ANY REASON, AS NEVADA HAS NO GRACE PERIOD. (USE THE ENCLOSED ENVELOPE TO MAIL YOUR COMPLETED *APPLICATION FOR REGISTRATION RENEWAL* FORM.)**
- **YOUR LICENSE WILL NOT BE RENEWED UNLESS YOU ANSWER ALL QUESTIONS ON THIS *APPLICATION FOR REGISTRATION RENEWAL* FORM. YOU MUST PROVIDE WRITTEN EXPLANATIONS FOR ALL QUESTIONS ANSWERED "YES."**
- **ALL INFORMATION YOU PROVIDE ON THIS *APPLICATION FOR REGISTRATION RENEWAL* FORM IS PUBLIC INFORMATION.**

PLEASE TYPE OR PRINT LEGIBLY

1. To be eligible to act as a **SUPERVISING PHYSICIAN FOR A PHYSICIAN ASSISTANT**, and/or as a **COLLABORATING PHYSICIAN FOR AN ADVANCED PRACTITIONER OF NURSING** for the biennial period of July 1, 2001 through June 30, 2003, you must complete the enclosed ***Application for Approval as Supervising/Collaborating Physician*** and return it with your payment in the amount of $200.00 in the enclosed envelope.

2. Active status registration renewal requires the submission of proof of completion of 40 hours of AMA Category 1 continuing medical education (CME), which includes 2 hours of CME in medical ethics and 20 hours of CME in your scope of practice or specialty **completed during the period July 1, 1999 through June 30, 2001**. Submit your proof of completion of CME with your completed *Application for Registration Renewal* form. (See last page of this form for CME statement.)

3. If your name and/or address has changed from that printed on the label on this form, clearly indicate the change in the space provided below. Also, please indicate your current telephone and fax numbers. [Please note: a notarized or certified copy of the document authorizing your name change (marriage license, divorce decree, etc.) must be included.]

Name____
Street____
City____ County____ State____ Zip____
Phone Number____ Fax Number____

4. **IF YOU HAVE RETIRED OR MOVED YOUR PRACTICE,** indicate the location of patient records below:

Name____
Street____
City____ County____ State____ Zip____
Phone Number____

5. Indicate below the **EXACT NAME AND LOCATION** of the Medical School from which you graduated and your **EXACT DATE** of graduation:

University of Southern California — Medical School Name and Location

5-8-1984 — Date of Graduation (Month / Day / Year)

6. Indicate below your primary, secondary and tertiary practice specialties using the following codes:

SCOPE OF PRACTICE
SPECIALTY CODES

1 ADDICTION MEDICINE
2 ADOLESCENT MEDICINE
3 AEROSPACE MEDICINE
4 ALLERGY
5 ALLERGY/IMMUNOLOGY
6 ANESTHESIOLOGY
7 BLOODBANKING
8 BRONCO-ESOPHAGOLOGY
9 CARDIOVASCULAR DISEASES
10 CATSCAN/ULTRASOUND
11 CHILD NEUROLOGY
12 CHILD PSYCHIATRY
13 CLINICAL PHARMACOLOGY
14 CRITICAL CARE
15 DERMATOLOGY
16 DERMATOPATHOLOGY
17 EMERGENCY MEDICINE
18 ENDOCRINOLOGY
19 FAMILY PRACTICE
20 GASTROENTEROLOGY
21 GENERAL PRACTICE
22 GERIATRICS
23 GYNECOLOGY
24 HEMATOLOGY
25 HOMEOPATHY
26 HYPNOSIS
27 IMMUNOLOGY
28 INFECTIOUS DISEASES
29 INFERTILITY
30 INTERNAL MEDICINE
31 LARYNGOLOGY
32 LEGAL MEDICINE
33 MATERNAL/FETAL MEDICINE
34 MEDICAL ACUPUNCTURE
35 MEDICAL ETHICS
36 MEDICAL GENETICS
37 NEO/PERINATAL MEDICINE
38 NEOPLASTIC DISEASES
39 NEPHROLOGY
40 NEUROLOGY
41 NEURO-OPHTHALMOLOGY
42 NEUROPATHOLOGY
43 NEURORADIOLOGY
44 NON-CONVENTIONAL MEDICINE
45 NUCLEAR MEDICINE
46 NUTRITION
47 OBSTETRICS
48 OBSTETRICS/GYNECOLOGY
49 OCCUPATIONAL MEDICINE
50 ONCOLOGY
51 ONCOLOGY, GYNECOLOGICAL
52 ONCOLOGY, HEMATOLOGY
53 ONCOLOGY, RADIATION
54 ONCOLOGY, SURGICAL
55 OPHTHALMOLOGY
56 OTOLARYNGOLOGY
57 OTOLOGY
58 PAIN MANAGEMENT
59 PATHOLOGY
60 PATHOLOGY, ANATOMIC
61 PATHOLOGY, CLINICAL
62 PATHOLOGY, FORENSIC
63 PEDIATRIC, ALLERGY
64 PEDIATRIC, CARDIOLOGY
65 PEDIATRIC, CRITICAL CARE
66 PEDIATRIC, EMERGENCY MEDICINE
67 PEDIATRIC, ENDOCRINOLOGY
68 PEDIATRIC, GASTROENTEROLOGY
69 PEDIATRIC, HEMATOLOGY/ONCOLOGY
70 PEDIATRIC, INFECTIOUS DISEASES
71 PEDIATRIC, INTENSIVIST
72 PEDIATRIC, NEPHROLOGY
73 PEDIATRIC, NEUROLOGY
74 PEDIATRIC, OPHTHALMOLOGY
75 PEDIATRIC, PHYSIATRY
76 PEDIATRIC, PULMONARY
77 PEDIATRIC, RADIOLOGY
78 PEDIATRIC, SURGERY
79 PEDIATRIC, UROLOGY
80 PEDIATRICS
81 PHYSICAL MEDICINE/REHABILITATION
82 PREVENTIVE MEDICINE
83 PSYCHIATRY
84 PSYCHOANALYSIS
85 PSYCHOMATIC MEDICINE
86 PUBLIC HEALTH
87 PULMONARY DISEASES
88 RADIOLOGY
89 RADIOLOGY, DIAGNOSTIC
90 RADIOLOGY, INTERVENTIONAL
91 RADIOLOGY, NUCLEAR
92 RADIOLOGY, THERAPEUTIC
93 RADIOLOGY, VASCULAR
94 RHEUMATOLOGY
95 RHINOLOGY
96 SLEEP DISORDERS
97 SPORTS MEDICINE
98 SURGERY, ABDOMINAL
99 SURGERY, CARDIOTHORACIC
100 SURGERY, CARDIOVASCULAR
101 SURGERY, COLON/RECTAL
102 SURGERY, GENERAL
103 SURGERY, HAND
104 SURGERY, HEAD/NECK
105 SURGERY, MAXILLOFACIAL
106 SURGERY, NEUROLOGICAL
107 SURGERY, ORTHOPEDIC
108 SURGERY, PLASTIC
109 SURGERY, THORACIC
110 SURGERY, TRANSPLANT
111 SURGERY, TRAUMATIC
112 SURGERY, UROLOGIC
113 SURGERY, VASCULAR
114 URGENT CARE
115 UROLOGY

Primary Specialty Code: 48 **Secondary Specialty** Code: ____ **Tertiary Specialty** Code: ____

All of the following questions refer to the time period July 1, 1999, through the present date only.

For the purposes of the following questions, these phrases or words have these meanings:

"Ability to practice medicine" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments;
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks such as physician examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to, orthopedic, vision, speech, hearing, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, emotional or mental illness, HIV disease, tuberculosis, drug addiction, and alcoholism.

"Chemical substances" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction.

FOR ALL "YES" RESPONSES TO THE FOLLOWING QUESTIONS, YOU MUST SUBMIT YOUR WRITTEN EXPLANATION(S) ON A SEPARATE SHEET ATTACHED TO YOUR COMPLETED *APPLICATION FOR REGISTRATION RENEWAL* FORM.

1. Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? ______ Yes __X__ No

2. If you have a medical condition which in any way impairs or limits your ability to practice medicine, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? ______ Yes ______ No __X__ N/A

3. If you use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety? ______ Yes ______ No __X__ N/A

4. Have you failed to initiate the performance of public service within one year after the date the public service is required to begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local government for your medical education? ______ Yes ______ No __X__ N/A

5. Have you been a defendant in a legal action involving professional liability (malpractice) or had a professional liability claim paid in your behalf or paid such a claim yourself? __X__ Yes ______ No

6. Have you ever 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, excluding any minor traffic offense (driving or in control of a motor vehicle while under the influence of any chemical substance is not considered a minor traffic offense) or which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? __X__ Yes ______ No

7. 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? ______ Yes __X__ No

8. Have you ever had a medical license or license to practice any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory? ______ Yes __X__ No

9. Have you ever voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory? ______ Yes __X__ No

10. Have you ever been denied membership or expelled from a medical society or other professional medical organization? ______ Yes ______ No

11. Have you ever been: a) notified that you were under investigation for; b) investigated for; c) charged with; or d) convicted of any violation of a statute, rule or regulation governing your practice as a physician by any medical licensing board, hospital, medical society, governmental entity or other agency other than the Nevada State Board of Medical Examiners? ______ Yes __X__ No

12. Have you ever surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? ______ Yes __X__ No

13. List all hospitals where you have had staff privileges denied, suspended, limited, revoked or not renewed by the hospital. List any and all resignations from any medical staff in lieu of disciplinary or administrative action. (Please Note: Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance).

Hospital	Mailing Address	Type of Action	Dates of Action From (Mo./Yr.) To (Mo./Yr.)
None			

(If more space is needed, attach a separate sheet.)

CHILD SUPPORT STATEMENT

Please place a check mark next to one of the following statements:

_______ (a) I am not subject to a court order for the support of a child;

X (b) 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 public agency enforcing the order for the repayment of the amount owed pursuant to the order; OR

_______ (c) 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.

CONTINUING MEDICAL EDUCATION (CME) STATEMENT

Please place a check mark next to one of the following statements:

X (a) I completed a minimum of 40 hours of AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics and 20 hours of which were in my scope of practice or specialty, during the past biennial period of July 1, 1999 through June 30, 2001.

_______ (b) I was initially licensed in Nevada during the time period January 1, 2000 through June 30, 2000, the second six months of the past biennial period, and completed a minimum of 30 hours of AMA Category I continuing medical education (CME), 2 hours of which were in medical ethics and 20 hours of which were in my scope of practice or specialty;

_______ (c) I was initially licensed in Nevada during the time period July 1, 2000 through December 31, 2000, the third six months of the past biennial period, and completed a minimum of 20 hours of AMA Category I continuing medical education (CME), 2 hours of which were in medical ethics and 18 hours of which were in my scope of practice or specialty;

_______ (d) I was initially licensed in Nevada during the time period January 1, 2001 through June 30, 2001, the fourth six months of the past biennial period, and completed a minimum of 10 hours of AMA Category I continuing medical education (CME), 2 hours of which were in medical ethics and 8 hours of which were in my scope of practice or specialty; OR

_______ (e) I am exempt from submitting proof of completion of continuing medical education (CME) because I have completed a full year of residency or fellowship training during the biennial period July 1, 1999 through June 30, 2001.

- **ATTACH COPIES OF PROOF OF YOUR COMPLETION OF CONTINUING MEDICAL EDUCATION (CME) HOURS.**
- **IF YOU COMPLETED A FULL YEAR OF RESIDENCY OR FELLOWSHIP TRAINING DURING THE BIENNIAL PERIOD JULY 1, 1999 THROUGH JUNE 30, 2001, ATTACH A COPY OF PROOF OF COMPLETION OF YOUR TRAINING.**
- **YOUR COPIES OF PROOF OF CME OR TRAINING COMPLETION WILL NOT BE RETURNED TO YOU.**

I HAVE ✓ HAVE NOT ____ *(CHECK ONE)* ACTIVELY PRACTICED MEDICINE IN NEVADA WITHIN THE PAST 12 MONTHS.

BY SIGNING ON THE SIGNATURE LINE BELOW:

1) **I HEREBY REPRESENT THAT I AM THE PERSON NAMED IN THIS *APPLICATION FOR REGISTRATION RENEWAL* OF LICENSE TO PRACTICE MEDICINE IN THE STATE OF NEVADA AND THAT ALL STATEMENTS I HAVE MADE HEREIN ARE TRUE;**
2) **I UNDERSTAND THAT THIS *APPLICATION FOR REGISTRATION RENEWAL* WILL BE DENIED IF I HAVE NOT PLACED A CHECK MARK NEXT TO (a), (b), OR (c) UNDER THE CHILD SUPPORT STATEMENT SECTION; AND**
3) **I UNDERSTAND THAT THIS *APPLICATION FOR REGISTRATION RENEWAL* WILL BE DENIED IF I HAVE NOT ANSWERED ALL QUESTIONS THEREON AND/OR ATTACHED THERETO: (a) THE APPROPRIATE COPIES OF PROOF OF CONTINUING MEDICAL EDUCATION (CME), OR RESIDENCY OR FELLOWSHIP TRAINING COMPLETION; (b) PAYMENT OF THE APPROPRIATE REGISTRATION RENEWAL FEE; AND (c) WRITTEN EXPLANATION(S) TO ANY "YES" ANSWER(S).**

3/30/2001

Date ______ Signature (SIGNATURE STAMP UNACCEPTABLE)

PHYSICIAN
APPLICATION FOR RENEWAL REGISTRATION
NEVADA STATE BOARD OF
MEDICAL EXAMINERS
Post Office Box 7238 Reno, Nevada 89510 Phone (775) 688-2559

Date Received by Board
APR 29 1999
(Board Use Only)

License No. 6135
File No.______

I hereby apply for renewal of biennial registration and enclose the appropriate fee(s) as indicated below:

X	ACTIVE STATUS	$600.00
______	INACTIVE STATUS	$200.00
______	RETIRED STATUS	$ 50.00
X	~~SUPERVISING/COLLABORATING PHYSICIAN~~	~~$200.00~~

Adam V. Levy, MD
2020 Goldring Ave #404
Las Vegas NV 89106

0008817

Make checks payable to:
NEVADA STATE BOARD OF MEDICAL EXAMINERS
(Foreign checks must indicate "U.S. FUNDS")

PLEASE NOTE

NEVADA HAS NO GRACE PERIOD ----- LICENSES NOT RENEWED BY JULY 1, 1999 ARE AUTOMATICALLY SUSPENDED FOR NON-PAYMENT.
EXTENSIONS OF TIME ARE NOT ALLOWED FOR ANY REASON.
YOUR LICENSE WILL NOT BE RENEWED WITHOUT ANSWERING ALL QUESTIONS.
ALL YES ANSWERS MUST BE EXPLAINED.
YOU MUST INCLUDE PROOF OF 40 HOURS OF AMA CATEGORY 1 CME WHICH INCLUDES 2 HOURS IN MEDICAL ETHICS AND 20 HOURS IN YOUR SCOPE OF PRACTICE OR SPECIALTY.
ALL FEES MUST BE PAID AND ARE NON-REFUNDABLE.
DO NOT SEND CASH THROUGH THE MAIL.
PLEASE ALLOW SIXTY (60) DAYS FOR PROCESSING OF YOUR APPLICATION.

PLEASE TYPE OR PRINT LEGIBLY

1. **YOUR CURRENT M.D. LICENSE EXPIRES ON JUNE 30, 1999. THIS IS THE NOTICE TO RENEW YOUR M.D. LICENSE.**

2. To be eligible to act as a supervising physician for a physician's assistant, or as a collaborating physician for an advanced practitioner of nursing, complete the enclosed Application for Approval as Supervising/Collaborating Physician.

3. **ACTIVE STATUS REGISTRATION RENEWAL REQUIRES THE SUBMISSION OF PROOF OF 40 HOURS OF AMA CATEGORY 1 CONTINUING MEDICAL EDUCATION** which includes 2 hours of medical ethics and 20 hours in your scope of practice or specialty completed during the period July 1, 1997 through June 30, 1999. Submit your proof of CME with your completed Application for Registration Renewal form.

4. In order to provide sufficient time for processing, please complete and return your Application for Registration Renewal form and Application for Approval as Supervising/Collaborating Physician form (if applicable) with your proof of 40 hours AMA Category I CME and the correct fee(s) **BY JUNE 30, 1999.** Use the enclosed self-addressed envelope to return your completed form(s) and fee(s).

5. If your name and/or address has changed from that printed on this form, clearly indicate the change in the space provided. A notarized or certified copy of the document authorizing your name change (marriage license, divorce decree, etc.) must be included.

Name______________________________
Street______________________________
City__________ County__________ State__________ Zip__________

. IF YOU HAVE RETIRED OR MOVED YOUR PRACTICE, INDICATE THE LOCATION OF PATIENT RECORDS BELOW:

Name______________________________
Street______________________________
City__________ County__________ State__________ Zip__________

7. Are you currently active in medicine?

a. [ ] YES, in training.
b. [X] YES, working full-time
c. [ ] YES, working part-time
d. [ ] NO, retired.
e. [ ] NO, other (specify________________________________)

8. Please indicate your primary, secondary and tertiary specialties and percent of practice time spent in each, using the following codes:

SCOPE OF PRACTICE
SPECIALTY CODES

102 ADDICTION MEDICINE
1 ADOLESCENT MEDICINE
2 AEROSPACE MEDICINE
3 ALLERGY/IMMUNOLOGY
104 ALTERNATIVE MEDICINE
4 ANESTHESIOLOGY
5 BLOODBANKING
6 BRONCO-ESOPHAGOLOGY
7 CARDIOVASCULAR DISEASES
8 CATSCAN/ULTRASOUND
9 CHILD NEUROLOGY
10 CHILD PSYCHIATRY
11 CLINICAL PHARMACOLOGY
12 CRITICAL CARE
13 DERMATOLOGY
14 EMERGENCY MEDICINE
15 ENDOCRINOLOGY
16 FAMILY PRACTICE
17 GASTROENTEROLOGY
18 GENERAL PRACTICE
19 GERIATRICS
20 GYNECOLOGY
21 HEMATOLOGY
105 HOMEOPATHY
22 HYPNOSIS
23 IMMUNOLOGY
24 INFECTIOUS DISEASES
25 INFERTILITY
26 INTERNAL MEDICINE
27 LARYNGOLOGY
28 LEGAL MEDICINE
29 MATERNAL/FETAL MEDICINE
106 MEDICAL ACUPUNCTURE
107 MEDICAL ETHICS
30 NEO/PERINATAL MEDICINE
31 NEOPLASTIC DISEASES
32 NEPHROLOGY
33 NEUROLOGY
34 NEUROPATHOLOGY
35 NEURORADIOLOGY
36 NUCLEAR MEDICINE
37 NUTRITION
38 OBSTETRICS/GYNECOLOGY
39 OBSTETRICS
40 OCCUPATIONAL MEDICINE
41 ONCOLOGY
45 ONCOLOGY, GYNECOLOGICAL
42 ONCOLOGY, HEMATOLOGY
43 ONCOLOGY, RADIATION
44 ONCOLOGY, SURGICAL
46 OPHTHALMOLOGY
47 OTOLARYNGOLOGY
48 OTOLOGY
49 PAIN MANAGEMENT
50 PATHOLOGY
51 PATHOLOGY, ANATOMIC
52 PATHOLOGY, CLINICAL
53 PATHOLOGY, FORENSIC
54 PEDIATRIC, ALLERGY
55 PEDIATRIC, CARDIOLOGY
99 PEDIATRIC, CRITICAL CARE
97 PEDIATRIC, EMERGENCY MEDICINE
56 PEDIATRIC, ENDOCRINOLOGY
57 PEDIATRIC, HEMATOLOGY/ONCOLOGY
58 PEDIATRIC, INFECTIOUS DISEASES
59 PEDIATRIC, INTENSIVIST
60 PEDIATRIC, NEPHROLOGY
98 PEDIATRIC, NEUROLOGY
101 PEDIATRIC, OPHTHALMOLOGY
61 PEDIATRIC, PHYSIATRY
95 PEDIATRIC, PULMONARY
62 PEDIATRIC, RADIOLOGY
63 PEDIATRIC, SURGERY
64 PEDIATRIC, UROLOGY
65 PEDIATRICS
66 PHYSICAL MEDICINE/REHABILITATION
67 PREVENTIVE MEDICINE
68 PSYCHIATRY
69 PSYCHOANALYSIS
70 PSYCHOMATIC MEDICINE
71 PUBLIC HEALTH
72 PULMONARY DISEASES
73 RADIOLOGY
74 RADIOLOGY, DIAGNOSTIC
75 RADIOLOGY, NUCLEAR
76 RADIOLOGY, THERAPEUTIC
77 RHEUMATOLOGY
78 RHINOLOGY
79 SLEEP DISORDERS
100 SPORTS MEDICINE
80 SURGERY, ABDOMINAL
103 SURGERY, CARDIOTHORACIC
81 SURGERY, CARDIOVASCULAR
91 SURGERY, COLON/RECTAL
82 SURGERY, GENERAL
83 SURGERY, HAND
84 SURGERY, HEAD/NECK
92 SURGERY, MAXILLOFACIAL
93 SURGERY, NEUROLOGICAL
85 SURGERY, ORTHOPEDIC
86 SURGERY, PLASTIC
87 SURGERY, THORACIC
88 SURGERY, TRAUMATIC
89 SURGERY, UROLOGIC
90 SURGERY, VASCULAR
94 UROLOGY

	Code	Percent of Time	Board Certified (Indicate Yes/No)
Primary	38	100	Yes
Secondary			
Tertiary			

PLEASE INDICATE ALL AMERICAN BOARD OF MEDICAL SPECIALTIES BOARD OR SUBBOARD CERTIFICATIONS:

	Date of Initial Certification (Mo./Yr.)	Date of Last Certification (Mo./Yr.)
Board ABOG	12/91	
Subboard		
Board		
Subboard		

9. Form of employment is 1001. (Use one of the following codes.)

SELF-EMPLOYED:
1001 Solo Practice
1002 Partnership or Group Practitioners

SALARIED, EMPLOYED BY:
1003 Individual Practitioner
1004 Partnership or Group of Practitioners
1005 Group Health Plan Facility (such as H.M.O.)

SALARIED, EMPLOYED BY: (continued)
1006 Other Non-Government Employer (hospital, school, etc.)
1007 Federal Government (armed services personnel only)
1008 Federal Government (civilian, P.H.S., etc.)
1009 State Government
1010 County Government
1011 Local Government

1012 Other (specify)________________________

All of the following questions refer to the time period July 1, 1997, through the present date only.

For the purposes of the following questions, these phrases or words have these meanings:

"Ability to practice medicine" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments;
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks such as physician examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to, orthopedic, vision, speech, hearing, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, emotional or mental illness, HIV disease, tuberculosis, drug addiction, and alcoholism.

"Chemical substances" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction.

"Currently" does not mean on the day of, or even in the weeks or months preceding the completing of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee.

FOR ALL "YES" RESPONSES TO THE FOLLOWING QUESTIONS, YOU MUST SUBMIT YOUR EXPLANATION(S) ON A SEPARATE SHEET ATTACHED TO YOUR COMPLETED REGISTRATION APPLICATION FORM

1. Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? ____Yes __X__No

2. If you have a medical condition which in any way impairs or limits your ability to practice medicine, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? ____Yes ____No __X__N/A

3. If you use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety? ____Yes __X__No ____N/A

4. Have you failed to initiate the performance of public service within one year after the date the public service is required to begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local government for your medical education? ____Yes __X__No ____N/A

5. Have you been a defendant in a legal action involving professional liability (malpractice) or had a professional liability claim paid in your behalf or paid such a claim yourself? __X__Yes ____No

6. Have you ever 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, excluding any minor traffic offense (driving or in control of a motor vehicle while under the influence of any chemical substance is not considered **a minor traffic offense**) or which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? __X__Yes ____No

7. Have you ever been denied a license, permission to practice medicine or any other healing art(s), or permission to take an examination to practice medicine or any other healing art(s) in any state, country or U.S. territory? ____Yes __X__No

8. Have you ever had a medical license or license to practice any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory? ____Yes __X__No

9. Have you ever voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory? ____Yes __X__No

10. Have you ever been denied membership or expelled from a medical society or other professional medical organization? ____Yes __X__No

11. Have you ever been investigated for, charged with, or convicted of any violation of a statute, rule or regulation governing the practice of medicine by any medical licensing board, hospital, medical society, governmental entity or other agency?

_______Yes___X___No

12. Have you ever surrendered your state or federal controlled substance registration or had it revoked or restricted in any way?

_______Yes___X___No

13. List all hospitals where you have had staff privileges denied, suspended, limited, revoked or not renewed by the hospital. List any and all resignations from any medical staff in lieu of disciplinary or administrative action. (Please Note: Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance).

Hospital	Mailing Address	Type of Action	Dates of Action From (Mo./Yr.) To (Mo./Yr.)
	(None)		

(If more space is needed, attach a separate sheet.)

PLEASE CHECK ONE OF THE FOLLOWING:

______ I am not subject to a court order for the support of a child.

__X__ 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 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____

(SIGNATURE STAMP UNACCEPTABLE)

PLEASE CHECK ONE OF THE FOLLOWING:

__X__ 1. I have earned a minimum of 40 hours approved AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics, and 20 hours of which were in my scope of practice or specialty during the biennial period July 1, 1997, through June 30, 1999.

______ 2. I was initially licensed in Nevada during the second six months of the biennial period July 1, 1997, through June 30, 1999, and have earned a minimum of 30 hours approved AMA Category I continuing medical education (CME).

______ 3. I was initially licensed in Nevada during the third six months of the biennial period July 1, 1997, through June 30, 1999, and have earned a minimum of 20 hours approved AMA Category I continuing medical education (CME).

______ 4. I was initially licensed in Nevada during the fourth six months of the biennial period July 1, 1997, through June 30, 1999, and have earned a minimum of 10 hours approved AMA Category I continuing medical education (CME).

______ 5. I am exempt from submitting proof of continuing medical education (CME) because I have completed a full year of residency or fellowship training during the biennial period July 1, 1997, through June 30, 1999.

IMPORTANT

ATTACH COPIES OF PROOF OF DECLARED CME CREDITS - PROOF OF CME CREDITS WILL NOT BE RETURNED.

Signature____

(SIGNATURE STAMP UNACCEPTABLE)

I HAVE __X__ HAVE NOT ____ ACTIVELY PRACTICED IN NEVADA WITHIN THE PAST 12 MONTHS. (CHECK ONE)

I HEREBY CERTIFY THAT I AM THE PERSON NAMED IN THIS APPLICATION FOR REGISTRATION RENEWAL OF LICENSE TO PRACTICE MEDICINE IN THE STATE OF NEVADA AND THAT ALL STATEMENTS I HAVE MADE HEREIN ARE TRUE.

702 366 1376   4/6/99

Business Telephone #   Date   Signature (SIGNATURE STAMP UNACCEPTABLE)

APPLICATION FOR RENEWAL REGISTRATION
NEVADA STATE BOARD OF
MEDICAL EXAMINERS

Post Office Box 7238 Reno, Nevada 89510 Phone (702) 688-2559

Date received by Board
MAR 24 1997
(Board Use Only)

License No. 6135

File No.__________

I hereby apply for renewal of biennial registration and enclose the appropriate fees as indicated below:

✓	ACTIVE STATUS	$600.00
___	INACTIVE STATUS	$150.00
___	RETIRED STATUS	$ 50.00
___	P.A. SUPERVISING PHYSICIAN	$200.00

PLEASE NOTE: NEVADA HAS NO GRACE PERIOD. LICENSES NOT RENEWED BY JULY 1, 1997 ARE AUTOMATICALLY SUSPENDED FOR NON-PAYMENT

Adam V. Levy, MD
2020 Goldring Ave #404
Las Vegas, NV 89106

Make checks payable to:
VADA STATE BOARD OF MEDICAL EXAMINERS
(Foreign checks must indicate "U.S. FUNDS")

INSTRUCTIONS - TYPE OR PRINT LEGIBLY

1. **YOUR CURRENT M.D. LICENSE EXPIRES ON JUNE 30, 1997. THIS IS THE NOTICE TO RENEW YOUR M.D. LICENSE.**
2. To be eligible to act as a supervising physician for a physician assistant, complete the enclosed Application for Approval as Supervising Physician form.
3. **ACTIVE STATUS REGISTRATION RENEWAL REQUIRES THE SUBMISSION OF PROOF OF 40 HOURS OF AMA CATEGORY I, CONTINUING MEDICAL EDUCATION** completed during the period July 1, 1995 through June 30, 1997. Submit your proof of CME with your completed Application for Registration Renewal form.
4. In order to provide sufficient time for processing, please complete and return your Application for Registration Renewal form and Application for Approval as Supervising Physician form (if applicable) with your proof of 40 hours AMA Category I CME and the correct fee(s) **PRIOR TO JULY 1, 1997.** Use the enclosed self-addressed envelope to return your completed form(s) and fee(s).
5. If your name and/or address has changed from that printed on this form, clearly indicate the change in the space provided. A notarized or certified copy of the document authorizing your name change (marriage license, divorce decree, etc.) must be included.

Name____________________

Street____________________

City________ County________ State________ Zip________

6. **IF YOU HAVE RETIRED OR MOVED YOUR PRACTICE, PLEASE INDICATE THE LOCATION OF FORMER PATIENT RECORDS BELOW:**

Name____________________

Street____________________

City________ County________ State________ Zip________

YOUR LICENSE REGISTRATION WILL NOT BE RENEWED WITHOUT SUBMISSION OF THE CORRECT FEE(S),

PROPERLY COMPLETED FORM(S) AND PROOF OF 40 HOURS OF AMA CATEGORY I, CME'S

ALL PAGES OF THE FORM(S) MUST BE COMPLETED AND RETURNED

ALL FEES ARE NON-REFUNDABLE

DO NOT SEND CASH THROUGH THE MAIL

PLEASE ALLOW SIXTY (60) DAYS FOR THE PROCESSING OF YOUR REGISTRATION RENEWAL

1. Are you currently active in medicine?

a. [ ] YES, in training. b. [ ] YES, working full-time
c. [ ] YES, working part-time d. [ ] NO, retired.
e. [ ] NO, other (specify______________________________)

2. Please indicate your primary, secondary and tertiary specialties and percent of time spent in each, using the following codes.

SPECIALTY CODE:

1 ADOLESCENT MEDICINE
2 AEROSPACE MEDICINE
3 ALLERGY/IMMUNOLOGY
4 ANESTHESIOLOGY
5 BLOODBANKING
6 BRONCO-ESOPHAGOLOGY
7 CARDIOVASC DISEASES
8 CATSCAN/ULTRASOUND
9 CHILD NEUROLOGY
10 CHILD PSYCHIATRY
11 CLINICAL PHARMACOL
12 CRITICAL CARE
13 DERMATOLOGY
14 EMERGENCY MEDICINE
15 ENDOCRINOLOGY
16 FAMILY PRACTICE
17 GASTROENTEROLOGY
18 GENERAL PRACTICE
19 GERIATRICS
20 GYNECOLOGY
21 HEMATOLOGY
22 HYPNOSIS
23 IMMUNOLOGY
24 INFECTIOUS DISEASES
25 INFERTILITY
26 INTERNAL MEDICINE
27 LARYNGOLOGY
28 LEGAL MEDICINE
29 MATERNAL/FETAL MED
30 NEO/PERINATAL MED
31 NEOPLASTIC DISEASES
32 NEPHROLOGY
33 NEUROLOGY
34 NEUROPATHOLOGY
35 NEURORADIOLOGY
36 NUCLEAR MEDICINE
37 NUTRITION
38 OBSTETRIC/GYNECOLOGY
39 OBSTETRICS
40 OCCUPATIONAL MED
41 ONCOLOGY
45 ONCOLOGY, GYNECOLOGIC
42 ONCOLOGY, HEMATOLOGY
43 ONCOLOGY, RADIATION
44 ONCOLOGY, SURGICAL
46 OPHTHALMOLOGY
47 OTOLARYNGOLOGY
48 OTOLOGY
49 PAIN MANAGEMENT
50 PATHOLOGY
51 PATHOLOGY, ANATOMIC
52 PATHOLOGY, CLINICAL
53 PATHOLOGY, FORENSIC
54 PED. ALLERGY
55 PED. CARDIOLOGY
99 PED. CRITICAL CARE
97 PED. EMERGENCY MED
56 PED. ENDOCRINOLOGY
57 PED. HEMAT/ONCOLOGY
58 PED. INFECTIOUS DIS
59 PED. INTENSIVIST
60 PED. NEPHROLOGY
98 PED. NEUROLOGY
101 PED. OPHTHALMOLOGY
61 PED. PHYSIATRY
95 PED. PULMONARY
62 PED. RADIOLOGY
63 PED. SURGERY
64 PED. UROLOGY
65 PEDIATRICS
66 PHYSICAL MED/REHAB
96 PHYSICIAN ASSISTANT
67 PREVENTIVE MED
68 PSYCHIATRY
69 PSYCHOANALYSIS
70 PSYCHOMATIC MEDICINE
71 PUBLIC HEALTH
72 PULMONARY DISEASES
73 RADIOLOGY
74 RADIOLOGY, DIAGNOSTIC
75 RADIOLOGY, NUCLEAR
76 RADIOLOGY, THERAPEUT
77 RHEUMATOLOGY
78 RHINOLOGY
79 SLEEP DISORDERS
100 SPORTS MEDICINE
80 SURGERY, ABDOMINAL
81 SURGERY, CARDIOVASC
91 SURGERY, COLON/RECTAL
82 SURGERY, GENERAL
83 SURGERY, HAND
84 SURGERY, HEAD/NECK
92 SURGERY, MAXILLOFAC
93 SURGERY, NEUROLOGICAL
85 SURGERY, ORTHOPEDIC
86 SURGERY, PLASTIC
87 SURGERY, THORACIC
88 SURGERY, TRAUMATIC
89 SURGERY, UROLOGIC
90 SURGERY, VASCULAR
94 UROLOGY

	Code	Percent of Time	Board Certified (Indicate Yes/No)
Primary	38	100	Yes
Secondary			
Tertiary			

PLEASE INDICATE AMERICAN BOARD OF MEDICAL SPECIALTIES BOARD CERTIFICATION:

		Date of Initial Certification	Date of Last Certification
Board	Amer. Board OB/Gyn	12/91 (Mo./Yr.)	(Mo./Yr.)
Subboard		(Mo./Yr.)	(Mo./Yr.)

3. Form of employment is 1001 (Use the following codes)

SELF-EMPLOYED
1001 Solo Practice
1002 Partnership or Group Practitioners

SALARIED, EMPLOYED BY:
1003 Individual Practitioner
1004 Partnership or Group of Practitioners
1005 Group Health Plan Facility (such as H.M.O.)

SALARIED, EMPLOYED BY (continued)
1006 Other Non-Government Employer (hospital, school, etc.)
1007 Federal Government (armed services personnel only)
1008 Federal Government (civilian, P.H.S., etc.)
1009 State Government
1010 County Government
1011 Local Government

1012 Other (specify)______________________________

All of the following questions refer to the time period July 1, 1995, through the present date only.
FOR ALL YES RESPONSES, PLEASE EXPLAIN ON A SEPARATE SHEET AND RETURN WITH THIS REGISTRATION APPLICATION

For the purposes of the following questions, these phrases or words have these meanings:
"Ability to practice medicine" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments; and
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physician capability to perform medical tasks such as physician examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to, orthopedic, vision, speech, and hearing, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, emotional or mental illness, HIV disease, tuberculosis, drug addiction, and alcoholism.

"Chemical substances" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction.

"Currently" does not mean on the day of, or even in the weeks or months preceding the completing of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee.

ALL QUESTIONS ANSWERED 'YES' MUST BE EXPLAINED ON A SEPARATE ATTACHED SHEET OF PAPER

1. Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? ______Yes ✓ No

2. If you have a medical condition which in any way impairs or limits your ability to practice medicine is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? ______Yes ______No ✓ N/A

3. If you use chemical substances, does your use of chemical substance(s) in any way impair or limit your ability to practice medicine with reasonable skill and safety? ______Yes ______No ✓ N/A

4. Have you failed to initiate the performance of public service within one year after the date the public service is required to begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local government for your medical education? ______Yes ✓ No

5. Have you been a defendant in a legal action involving professional liability (malpractice) or had a professional liability claim paid in your behalf or paid such a claim yourself? ______Yes ✓ No

6. Have you ever 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, excluding any minor traffic offense (Driving of in control of a motor vehicle while under the influence of any substance is not considered a minor traffic offense) or which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? ______Yes ✓ No

7. Have you ever been denied a license, permission to practice medicine or any other healing arts, or permission to take an examination to practice medicine or any other healing arts in any state, country or U.S. territory? ______Yes ✓ No

8. Have you ever had a medical license revoked, suspended, limited, or restricted in any state, country or U.S. territory? ______Yes ✓ No

9. Have you ever voluntarily surrendered a license to practice a healing art in any state, country or U.S. territory? ______Yes ✓ No

10. Have you ever been denied membership or expelled from a medical society or other professional medical organization? ______Yes ✓ No

11. Have you ever been investigated for, charged with, or convicted of any violation of a statute, rule or regulation governing the practice of medicine by any medical licensing board, hospital, medical society, governmental entity or other agency? ______Yes ✓ No

12. Have you ever surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? ______Yes ✓ No

13. List all hospitals where you have had staff privileges denied, suspended, limited, revoked or not renewed by the hospital. List any and all resignations from any medical staff in lieu of disciplinary or administrative action. (Please Note: Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance).

Hospital	Mailing Address	Type of Action	Dates of Action From (Mo./Yr.) To (Mo./Yr.)
~~[illegible]~~	~~[illegible]~~		None
~~[illegible]~~			

If more space is needed, attach separate sheet.

PLEASE CHECK ONE OF THE FOLLOWING:

✓ 1. I have earned a minimum of 40 hours approved AMA Category I continuing medical education (CME) for the biennial period July 1, 1995, through June 30, 1997.

______ 2. I was initially licensed in Nevada during the second six months of the biennial period July 1, 1995, through June 30, 1997 and have earned a minimum of 30 hours approved AMA Category I continuing medical education (CME).

______ 3. I was initially licensed in Nevada during the third six months of the biennial period July 1, 1995, through June 30, 1997 and have earned a minimum of 20 hours approved AMA Category I continuing medical education (CME).

______ 4. I was initially licensed in Nevada during the fourth six months of the biennial period July 1, 1995, through June 3, 1997 and have earned a minimum of 10 hours approved AMA Category I continuing medical education (CME).

______ 5. I am exempt from submitting proof of continuing medical education (CME) because I have completed a full year of residency or fellowship training during the biennial period July 1, 1995, through June 30, 1997.

Signature______________________

IMPORTANT: ATTACH COPIES OF PROOF OF DECLARED CME CREDITS. PROOF OF CME CREDITS WILL NOT BE RETURNED.

I HAVE ✓ HAVE NOT ____ ACTIVELY PRACTICED IN NEVADA WITHIN THE PAST 12 MONTHS. (CHECK ONE)

I HEREBY CERTIFY THAT I AM THE PERSON NAMED IN THIS APPLICATION FOR REGISTRATION RENEWAL OF LICENSE TO PRACTICE MEDICINE IN THE STATE OF NEVADA AND THAT ALL STATEMENTS I HAVE MADE HEREIN ARE TRUE.

366-1326	8-15-97	
Business Telephone # (702)	Date	Signature (SIGNATURE STAMP UNACCEPTABLE)

APPLICATION FOR REGISTRATION RENEWAL
NEVADA STATE BOARD OF MEDICAL EXAMINERS
Post Office Box 7238 Reno, Nevada 89510 Phone (702) 688-2559

Date Received by State Board: MAY 0 1 1995
License No.:
File No.:
This shaded section for Board use only

[I h]ereby apply for renewal of biennial registration and enclose the appropriate fees as indicated below:

✓ ACTIVE STATUS $420
_____ INACTIVE STATUS $150 (see attached NRS 630.255 & 630.257)
_____ RETIRED STATUS $ 50 (see attached NRS 630.256 & 630.257) (must not be practicing medicine in any state)
_____ P.A. SUPERVISING PHYSICIAN $200

PLEASE NOTE: NEVADA HAS NO GRACE PERIOD. LICENSES NOT RENEWED BY JULY 1, 1995 ARE AUTOMATICALLY SUSPENDED FOR NON-PAYMENT.

Adam V. Levy, MD 0008817
2010 Goldring #302
Las Vegas NV 89106-0000

INSTRUCTIONS - TYPE OR PRINT LEGIBLY

1. YOUR CURRENT M.D. LICENSE EXPIRES ON **JUNE 30, 1995.** THIS IS THE NOTICE TO RENEW YOUR M.D. LICENSE.
2. To be eligible to act as a supervising physician for a physician assistant, complete the enclosed Application for Approval as Supervising Physician form.
3. ACTIVE STATUS REGISTRATION RENEWAL REQUIRES THE SUBMISSION OF PROOF OF 40 HOURS AMA CATEGORY I, CONTINUING MEDICAL EDUCATION completed during July 1, 1993 through June 30, 1995. Submit your proof of CME with your completed Application for Registration Renewal form.
4. In order to provide sufficient time for processing, please complete and return your Application for Registration Renewal form and Application for Approval as Supervising Physician form (if applicable) with your proof of 40 hours AMA Category I CME and the correct fee(s) **PRIOR TO JULY 1, 1995.** Use the enclosed self-addressed envelope to return your completed form(s) and fee(s).
5. If your name and/or address has changed from that printed on this form, clearly indicate that change in the space provided. A notarized or certified copy of the document authorizing your name change (marriage license, divorce decree, etc.) must be included.

Name ______________________
Street 2020 Goldring Ave Ste 404
City Las Vegas County ____________ State NV Zip Code 89106

6. IF YOU HAVE RETIRED OR MOVED YOUR PRACTICE, PLEASE INDICATE THE LOCATION OF FORMER PATIENT RECORDS BELOW:

Name ______________________
Street ______________________
City ____________ County ____________ State ________ Zip Code ________

YOUR LICENSE REGISTRATION WILL NOT BE RENEWED WITHOUT SUBMISSION OF THE CORRECT FEE(S), PROPERLY COMPLETED FORM(S) AND PROOF OF 40 HOURS OF CME.

ALL PAGES OF THE FORM(S) MUST BE COMPLETED AND RETURNED.

ALL FEES ARE NON-REFUNDABLE. DO NOT SEND CASH THROUGH THE MAIL.

PLEASE ALLOW 60 DAYS FOR THE PROCESSING OF YOUR REGISTRATION RENEWAL.

PLEASE PROVIDE ALL INFORMATION AS REQUESTED.

1. Are you currently active in medicine?
   a. (   ) YES, in training.
   b. (✓) YES, working full-time.
   c. (   ) YES, working part-time.
   d. (   ) NO, retired.
   e. (   ) NO, other (specify ____________)

2. Please indicate your primary, secondary and tertiary specialties and percent of time spent in each, using the following codes.

SPECIALTY CODE:

Code	Specialty	Code	Specialty	Code	Specialty
1	ADOLESCENT MEDICINE	35	NEURORADIOLOGY	64	PED, UROLOGY
2	AEROSPACE MEDICINE	36	NUCLEAR MEDICINE	65	PEDIATRICS
3	ALLERGY / IMMUNOLOGY	37	NUTRITION	66	PHYSICAL MED / REHAB
4	ANESTHESIOLOGY	38	OBSTETRIC / GYNECOLOGY	96	PHYSICIAN ASSISTANT
5	BLOODBANKING	39	OBSTETRICS	67	PREVENTIVE MED
6	BRONCO-ESOPHAGOLOGY	40	OCCUPATIONAL MED	68	PSYCHIATRY
7	CARDIOVASC DISEASES	41	ONCOLOGY	69	PSYCHOANALYSIS
8	CATSCAN / ULTRASOUND	45	ONCOLOGY, GYNECOLOGIC	70	PSYCHOMATIC MEDICINE
9	CHILD NEUROLOGY	42	ONCOLOGY, HEMATOLOGY	71	PUBLIC HEALTH
10	CHILD PSYCHIATRY	43	ONCOLOGY, RADIATION	72	PULMONARY DISEASES
11	CLINICAL PHARMACOL	44	ONCOLOGY, SURGICAL	73	RADIOLOGY
12	CRITICAL CARE	46	OPHTHALMOLOGY	74	RADIOLOGY, DIAGNOSTIC
13	DERMATOLOGY	47	OTOLARYNGOLOGY	75	RADIOLOGY, NUCLEAR
14	EMERGENCY MEDICINE	48	OTOLOGY	76	RADIOLOGY, THERAPEUT
15	ENDOCRINOLOGY	49	PAIN MANAGEMENT	77	RHEUMATOLOGY
16	FAMILY PRACTICE	50	PATHOLOGY	78	RHINOLOGY
17	GASTROENTEROLOGY	51	PATHOLOGY, ANATOMIC	79	SLEEP DISORDERS
18	GENERAL PRACTICE	52	PATHOLOGY, CLINICAL	100	SPORTS MEDICINE
19	GERIATRICS	53	PATHOLOGY, FORENSIC	80	SURGERY, ABDOMINAL
20	GYNECOLOGY	54	PED, ALLERGY	81	SURGERY, CARDIOVASC
21	HEMATOLOGY	55	PED, CARDIOLOGY	91	SURGERY, COLON/RECTAL
22	HYPNOSIS	99	PED, CRITICAL CARE	82	SURGERY, GENERAL
23	IMMUNOLOGY	97	PED, EMERGENCY MED	83	SURGERY, HAND
24	INFECTIOUS DISEASES	56	PED, ENDOCRINOLOGY	84	SURGERY, HEAD/NECK
25	INFERTILITY	57	PED, HEMAT / ONCOLOGY	92	SURGERY, MAXILLOFAC
26	INTERNAL MEDICINE	58	PED, INFECTIOUS DIS	93	SURGERY, NEUROLOGICAL
27	LARYNGOLOGY	59	PED, INTENSIVIST	85	SURGERY, ORTHOPEDIC
28	LEGAL MEDICINE	60	PED, NEPHROLOGY	86	SURGERY, PLASTIC
29	MATERNAL / FETAL MED	98	PED, NEUROLOGY	87	SURGERY, THORACIC
30	NEO / PERINATAL MED	101	PED, OPHTHALMOLOGY	88	SURGERY, TRAUMATIC
31	NEOPLASTIC DISEASES	61	PED, PHYSIATRY	89	SURGERY, UROLOGIC
32	NEPHROLOGY	95	PED, PULMONARY	90	SURGERY, VASCULAR
33	NEUROLOGY	62	PED, RADIOLOGY	94	UROLOGY
34	NEUROPATHOLOGY	63	PED, SURGERY		

	Code	Percent of Time	Board Certified (Indicate Yes/No)
Primary	38	100	Yes
Secondary			
Tertiary			

PLEASE INDICATE AMERICAN BOARD OF MEDICAL SPECIALTIES BOARD CERTIFICATION:

		Date of Initial Certification (Mo./Yr.)	Date of Last Recertification (Mo./Yr.)
Board	Amer Board OB/Gyn	12/91	
Subboard			

3. How many hours per week do you spend in each of the following activities?

25 hours Patient care or services
5 hours Administration (schools, agencies, associations, etc.)
20 hours Teaching medical courses
____ hours Research
____ hours Other (specify ____________)

4. Form of employment is 1001. (Use the following codes.)

SELF-EMPLOYED
1001 Solo Practice
1002 Partnership or Group Practitioners

SALARIED, EMPLOYED BY
1003 Individual Practitioner
1004 Partnership or Group of Practitioners
1005 Group Health Plan Facility (such as H.M.O.)
1006 Other Non-Government Employer (hospital, school, etc
1007 Federal Government (armed services personnel only)
1008 Federal Government (civilian, P.H.S., etc.)
1009 State Government
1010 County Government
1011 Local Government
1012 Other (specify ____________)

All of the following questions refer to the time period of July 1, 1993 through the present date only.
FOR ALL YES RESPONSES, PLEASE EXPLAIN ON A SEPARATE SHEET AND RETURN WITH THIS REGISTRATION APPLICATION.

For the purpose of the following questions, these phrases or words have these meanings:

"Ability to practice medicine" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments; and
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physician capability to perform medical tasks such as physician examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental or psychological conditions or disorder, such as, but not limited to, orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

"Chemical substances" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. *Rather*, it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or within the past two years.

"Illegal use of controlled dangerous substances" means the use of controlled dangerous substances obtained illegally (e.g. heroin or cocaine) as well as the use of controlled dangerous substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

1. Have you failed to repay, in accordance with the terms of the loan, any direct loan or loan which is insured or guaranteed by the Federal Government or a state or local government which you received to finance all or any part of your medical education? ☐ Yes ☒ No
2. Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? ☐ Yes ☒ No
3. Does your use of chemical substance(s) in any way impair or limit your ability to practice medicine with reasonable skill and safety? ☐ Yes ☒ No
4. Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? ☐ Yes ☒ No
5. Have you been diagnosed as having, or have you been treated for pedophilia, exhibitionism, or voyeurism? ☐ Yes ☒ No
6. Are you currently engaged in the illegal use of controlled dangerous substances? ☐ Yes ☒ No
7. Have you been a defendant in a legal action involving professional liability (malpractice) or had a professional liability claim paid in your behalf or paid such a claim yourself? ☐ Yes ☒ No
8. Have you been 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, prescribing, or dispensing of controlled substances? ☐ Yes ☒ No
9. Have you 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? ☐ Yes ☒ No

Have you previously applied for medical licensure in Nevada (including a residency program)? Twice '09 Renewal ☐ Yes ☐ No — please explain

11. Have you failed to initiate the performance of public service within one year after the date the public service is required to begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local government for your medical education? ☐ Yes ☒ No
12. Have you been denied a license, permission to practice medicine or any other healing arts, or permission to take an examination to practice medicine or any other healing arts in any state, country or U.S. territory? ☐ Yes ☒ No
13. Have you had a medical license revoked, suspended, limited, or restricted in any state, country or U.S. territory? ☐ Yes ☒ No
14. Have you voluntarily surrendered a license to practice in the healing arts in any state, country or U.S. territory? ☐ Yes ☒ No
15. Have you been denied membership or expelled from a medical society or other professional medical organization? ☐ Yes ☒ No
16. List all hospitals where you have had staff privileges denied, suspended, limited, revoked or not renewed by the hospital. List any and all resignations from any medical staff in lieu of disciplinary or administrative action. (Please Note: Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance.)

Hospital	Mailing Address	Type of Action	Dates of Action From (Mo./Yr.)	To (Mo./Yr.)
None				

17. Have you been investigated for, charged with, or convicted of any violation of a statute, rule or regulation governing the practice of medicine by any medical licensing board, hospital, medical society, governmental entity or other agency? ☐ Yes ☒ No
18. Have you surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? ☐ Yes ☒ No

CONTINUING MEDICAL EDUCATION

630.153 Continuing education: General requirements; exemption; failure to comply.

1. Except as otherwise provided in subsection 2 and NAC 630.157, each holder of a license to practice medicine shall, at the time of the biennial registration, submit to the board by the final date set by the board for submitting applications for biennial registration evidence, in such form as the board requires, that he has completed 40 full hours of continuing medical education during the preceding 2 years in one or more educational programs. Each educational program must:

(a) Offer, upon successful completion of the program, a certificate of Category 1 credit as recognized by the American Medical Association to the holder of the license;

(b) Be approved by the board; and

(c) Be sponsored in whole or in part by an organization accredited or deemed to be an equivalent organization to offer such programs by the American Medical Association or the Liaison Committee on Continuing Medical Education.

2. Any holder of a license who has completed a full year of residency or fellowship any time during the period for biennial registration immediately

preceding the submission of the application for biennial registration is exempt from the requirements set forth in subsection 1.

3. If the holder of a license fails to submit evidence of his completion of continuing medical education within the time and in the manner prescribed by subsection 1, his license will not be renewed. Such a person may not resume the practice of medicine unless, within 2 years after the end of the biennial period of registration, he:

(a) Pays a fee to the board which is twice the fee for biennial registration otherwise prescribed by subsection 1 of NRS 630.290;

(b) Submits to the board, in such form as it requires, evidence that he has completed 40 full hours of continuing medical education in addition to that otherwise required by subsection 1 or NAC 630.157; and

(c) Is found by the board to be otherwise qualified for active status pursuant to the provisions of this chapter and chapter 630 of NRS.

(Added to NAC by Bd. of Medical Exam'rs, 7-31-85, eff. 8-1-85; A 6-23-86; 11-21-88; 9-12-91)

PLEASE CHECK ONE OF THE FOLLOWING:

✓ 1. I have earned a minimum of 40 hours approved AMA Category I continuing medical education (CME) for the biennial period July 1, 1993 through June 30, 1995.

____ 2. I was initially licensed in Nevada during the second six months of the biennial period July 1, 1993, through June 30, 1995 and have earned a minimum of 30 hours approved AMA Category I continuing medical education (CME).

____ 3. I was initially licensed in Nevada during the third six months of the biennial period July 1, 1993, through June 30, 1995 and have earned a minimum of 20 hours approved AMA Category I continuing medical education (CME).

____ 4. I was initially licensed in Nevada during the fourth six months of the biennial period July 1, 1993, through June 30, 1995 and have earned a minimum of 10 hours approved AMA Category I continuing medical education (CME).

____ 5. I am exempt from submitting proof of continuing medical education (CME) because I have completed a full year of residency or fellowship training during the biennial period July 1, 1993 through June 30, 1995.

Signature ____________________ (SIGNATURE STAMP UNACCEPTABLE)

IMPORTANT: ATTACH COPIES OF PROOF OF DECLARED CME CREDITS.
PROOF OF CME CREDITS WILL NOT BE RETURNED.

I hereby certify that I am the person named in this Application for Registration Renewal of license to practice medicine in the State of Nevada; that all statements I have made herein are true; that I am the original and lawful possessor of and person named in the various documents and credentials furnished to the Board in connection with this renewal application.

I HAVE ☒ HAVE NOT ☐ ACTIVELY PRACTICED IN NEVADA WITHIN THE PAST 12 MONTHS. (CHECK ONE)
If you have not practiced medicine in the State of Nevada during the period July 1, 1994, through June 30, 1995, please contact the Board office for further instruction.

366-1326 — Business Telephone #
4/20/95 — Date
X ____________________ Signature (SIGNATURE STAMP UNACCEPTABLE)

630.288 Biennial registration: Fee; failure to pay fee; revocation and restoration of license; notice to licensee.

1. Each holder of a license to practice medicine must pay to the secretary-treasurer of the board on or before July 1 of each alternate year the applicable fee for biennial registration. This fee must be collected for the period for which a physician is licensed.

2. When a holder of a license fails to pay the fee for biennial registration after it becomes due, his license to practice medicine in this state is automatically suspended. The holder may, within 2 years after the date his license is suspended, upon payment of twice the amount of the current fee for biennial registration to the secretary-treasurer, and after he is found to be in good standing and qualified under the provisions of this chapter, be reinstated to practice.

3. The board shall notify a licensee:

(a) At least once that his fee for biennial registration is due; and

(b) That his license is suspended for nonpayment of the fee. A copy of this notice must be sent to the Drug Enforcement Administration of the United States Department of Justice or its successor agency.

(Added to NRS by 1985, 2223; A 1987, 196)

630.255 Inactive licensees: Leaving state; ceasing or failing to practice; reinstatement.

1. Any licensee who changes the location of his practice of medicine from this state to another state or country, has never engaged in the practice of medicine in this state after licensure or has ceased to engage in the practice of medicine in this state for 12 consecutive months must be placed on inactive status.

2. Before resuming the practice of medicine in this state, the inactive registrant shall:

(a) Notify the board of his intent to resume the practice of medicine in this state;

(b) File an affidavit with the board describing his activities during the period of his inactive status;

(c) Complete the form for registration for active status;

(d) Pay the applicable fee for biennial registration; and

(e) Satisfy the board of his competence to practice medicine.

3. If the board determines that the conduct or competence of the registrant during the period of inactive status would have warranted denial of an application for a license to practice medicine in this state, the board may refuse to place the registrant on active status.

(Added to NRS by 1985, 2222; A 1987, 195; 1993, 2299)

630.256 Retired licensees: Duties; requirements for reinstatement.

1. If a licensee retires from the practice of medicine, he shall notify the board in writing of his intention to retire, and the board shall record the fact of retirement. A licensee who is retired may not engage in the practice of medicine. Any licensee who is retired and desires to return to the practice of medicine, must, before resuming the practice of medicine in this state:

(a) Notify the board of his intent to resume the practice of medicine in this state;

(b) File an affidavit with the board describing his activities during the period of his retired status;

(c) Complete the form for registration for active status;

(d) Pay the applicable fee for biennial registration; and

(e) Satisfy the board of his competence to practice medicine.

2. If the board determines that the conduct or competence of the registrant during the period of retirement would have warranted denial of an application for a license to practice medicine in this state, the board may refuse to place the registrant on active status.

(Added to NRS by 1985, 2222; A 1987, 195)

630.257 Re-examination of inactive or retired licensee. If a licensee does not practice allopathic medicine for a period of more than 12 consecutive months, the board may require him to take the same examination to test medical competency as that given to applicants for a license.

(Added to NRS by 1985, 2222; A 1993, 2300)

APPLICATION FOR REGISTRATION

NEVADA STATE BOARD OF MEDICAL EXAMINERS

Post Office Box 7238 Reno, Nevada 89510 Phone (702) 688-2559

Date Received by State Board: [illegible] 5332
License No. 6135
File No.
New ☐ Renewal ☐
This shaded section for BOARD USE ONLY

I hereby apply for certificate of biennial registration and enclose the appropriate fee as indicated below:

- ☒ ACTIVE STATUS $320.00 ✓
- ☐ INACTIVE STATUS $150.00
- ☐ RETIRED STATUS $ 50.00

NOTE: NO GRACE PERIOD – LICENSED NOT RENEWED BY JULY 1 ARE AUTOMATICALLY SUSPENDED FOR NON PAYMENT.

Adam V. Levy, MD 0008817
2010 Goldring #302
Las Vegas NV 89106-0000

Make checks payable to: BOARD OF MEDICAL EXAMINERS (Foreign checks must indicate U.S. Funds)

INSTRUCTIONS – TYPE OR PRINT LEGIBLY

1. YOUR CURRENT LICENSE EXPIRES ON **JUNE 30, 1993.** This is the notice to renew your M.D. license. You may apply for your license renewal upon receipt of this notice.

2. IN ORDER TO PROVIDE SUFFICIENT TIME FOR PROCESSING, PLEASE RETURN THIS RENEWAL APPLICATION WITH THE CORRECT RENEWAL FEE PRIOR TO **JULY 1, 1993.**

3. Use the enclosed self-addressed envelope to return this renewal notice and registration fee. ACTIVE registration requires submission of proof of 40 hours AMA Category I CME. If you register your license INACTIVE or RETIRED, you may not practice medicine in Nevada, including the writing of prescriptions.

4. All fees are non-refundable. Do not send cash through the mail.

5. If your name and/or address has changed from that printed on this notice, clearly indicate that change in the space provided. A NOTARIZED or CERTIFIED copy of the document authorizing your name change (marriage license, divorce decree, etc.) must be included.

Name ______________________________

Street ______________________________

City ____________ County ____________ State ______ Zip Code ________

A LICENSE WILL NOT BE RENEWED WITHOUT THE CORRECT FEE AND SUBMISSION OF THIS PROPERLY COMPLETED FORM.

ACTIVE REGISTRANTS MUST SUBMIT PROOF OF 40 HOURS AMA CATEGORY I CONTINUING MEDICAL EDUCATION (CME). 7-1-91 — 6-30-93

PLEASE ALLOW 60 DAYS FOR THE PROCESSING OF YOUR LICENSE RENEWAL. ALL PAGES MUST BE COMPLETED AND RETURNED.

ANSWER THE FOLLOWING QUESTIONS AND RETURN IN THE ENCLOSED SELF-ADDRESSED ENVELOPE.

1. Are you currently active in medicine?
   - a. ( ) YES, in training.
   - b. (✓) YES, working full-time.
   - c. ( ) YES, working part-time.
   - d. ( ) NO, retired.
   - e. ( ) NO, other (specify ________________)

2. Please indicate your primary, secondary and tertiary specialties and percent of time spent in each, using the following codes:

SPECIALTY CODE:

1	ADOLESCENT MEDICINE	25	INFERTILITY	49	PAIN MANAGEMENT	72	PULMONARY DISEASES
2	AEROSPACE MEDICINE	26	INTERNAL MEDICINE	50	PATHOLOGY	73	RADIOLOGY
3	ALLERGY/IMMUNOLOGY	27	LARYNGOLOGY	51	PATHOLOGY, ANATOMIC	74	RADIOLOGY, DIAGNOSTIC
4	ANESTHESIOLOGY	28	LEGAL MEDICINE	52	PATHOLOGY, CLINICAL	75	RADIOLOGY, NUCLEAR
5	BLOODBANKING	29	MATERNAL/FETAL MED	53	PATHOLOGY, FORENSIC	76	RADIOLOGY, THERAPEUT
6	BRONCO-ESOPHAGOLOGY	30	NEO/PERINATAL MED	54	PED. ALLERGY	77	RHEUMATOLOGY
7	CARDIOVASC DISEASES	31	NEOPLASTIC DISEASES	55	PED. CARDIOLOGY	78	RHINOLOGY
8	CATSCAN/ULTRASOUND	32	NEPHROLOGY	56	PED. ENDOCRINOLOGY	79	SLEEP DISORDERS
9	CHILD NEUROLOGY	33	NEUROLOGY	57	PED. HEMAT/ONCOLOGY	80	SURGERY, ABDOMINAL
10	CHILD PSYCHIATRY	34	NEUROPATHOLOGY	58	PED. INFECTIOUS DIS	81	SURGERY, CARDIOVASC
11	CLINICAL PHARMACOL	35	NEURORADIOLOGY	59	PED. INTENSIVIST	82	SURGERY, COLON/RECTAL
12	CRITICAL CARE	36	NUCLEAR MEDICINE	60	PED. NEPHROLOGY	83	SURGERY, GENERAL
13	DERMATOLOGY	37	NUTRITION	61	PED. PHYSIATRY	84	SURGERY, HAND
14	EMERGENCY MEDICINE	38	OBSTETRIC/GYNECOLOGY	62	PED. RADIOLOGY	85	SURGERY, HEAD/NECK
15	ENDOCRINOLOGY	39	OBSTETRICS	63	PED. SURGERY	86	SURGERY, MAXILLOFAC
16	FAMILY PRACTICE	40	OCCUPATIONAL MED	64	PED. UROLOGY	87	SURGERY, NEUROLOGICAL
17	GASTROENTEROLOGY	41	ONCOLOGY	65	PEDIATRICS	88	SURGERY, ORTHOPEDIC
18	GENERAL PRACTICE	42	ONCOLOGY, GYNECOLOGIC	66	PHYSICAL MED/REHAB	89	SURGERY, PLASTIC
19	GERIATRICS	43	ONCOLOGY, HEMATOLOGY	67	PREVENTATIVE MED	90	SURGERY, THORACIC
20	GYNECOLOGY	44	ONCOLOGY, RADIATION	68	PSYCHIATRY	91	SURGERY, TRAUMATIC
21	HEMATOLOGY	45	ONCOLOGY, SURGICAL	69	PSYCHOANALYSIS	92	SURGERY, UROLOGIC
22	HYPNOSIS	46	OPHTHALMOLOGY	70	PSYCHOMATIC MEDICINE	93	SURGERY, VASCULAR
23	IMMUNOLOGY	47	OTOLARYNGOLOGY	71	PUBLIC HEALTH	94	UROLOGY
24	INFECTIOUS DISEASES	48	OTOLOGY				

	Code	Percent of Time	Board Certified (Indicate Yes/No)
Primary	38	100 %	____
Secondary	____	____	____
Tertiary	____	____	____

PLEASE INDICATE AMERICAN BOARD OF MEDICAL SPECIALTIES BOARD CERTIFICATION:

Board Amer. Board of Ob/Gyn

Subboard ________________

3. How many hours per week do you spend in each of the following activities?
   - 28 hours Patient care or services
   - 2 hours Administration (schools, agencies, association, etc.)
   - 20 hours Teaching medical courses
   - 2 hours Research
   - ____ hours Other (specify ________________)

4. Form of employment is 1001. (Use the following codes.)

SELF-EMPLOYED
- 1001 Solo Practice
- 1002 Partnership or Group Practitioners

SALARIED, EMPLOYED BY
- 1003 Individual Practitioner
- 1004 Partnership or Group of Practitioners
- 1005 Group Health Plan Facility (such as H.M.O.)
- 1006 Other Non-Government Employer (hospital, school, etc.)
- 1007 Federal Government (armed services personnel only)
- 1008 Federal Government (civilian P.H.S., etc.)
- 1009 State Government
- 1010 County Government
- 1011 Local Government
- 1012 Other (specify ________________)

All of the following questions refer to the time period of **July 1, 1991, through the present date** only. FOR ALL **YES** RESPONSES, PLEASE EXPLAIN ON A SEPARATE SHEET AND RETURN WITH THE RENEWAL APPLICATION.

5. Have you been rejected for membership by any medical society? Yes ☐ No ☑
6. Have you been denied a license to practice medicine? Yes ☐ No ☑
7. Have you been denied staff membership with any licensed hospital, nursing home or other hospital care facility with an organized medical staff? Yes ☐ No ☑
8. Have you been censured, reprimanded, disciplined, had privileges limited, had privileges suspended, been put on probation, or been requested to withdraw from any licensed hospital, nursing home, clinic, or other hospital care facility with an organized medical staff, in which you trained, have been a staff member, have been a partner, or have held hospital privileges? Yes ☐ No ☑
9. Have you lost American Board certification because of disciplinary action? Yes ☐ No ☑
10. Have any U.S. state and/or Canadian provincial licensing or disciplinary agencies limited, restricted, suspended or revoked a license you have held or taken any other disciplinary action against you? Yes ☐ No ☑
11. Have you voluntarily surrendered a license issued to you by any state and/or Canadian provincial licensing agency while an investigation or other disciplinary action was pending? Yes ☐ No ☑
12. Have you been notified of any current/pending charges or complaints filed against you with any state and/or Canadian provincial licensing or disciplinary agency? Yes ☐ No ☑
13. Have you been diagnosed or treated for any physical illness that would serve to hinder your ability to practice medicine? Yes ☐ No ☑
14. Have you been diagnosed or treated for mental illness? Yes ☐ No ☑
15. Have you been chemically dependent? Yes ☐ No ☑
16. Have you interrupted your training because of illness or impairment? Yes ☐ No ☑
17. Have you been unable to practice medicine because of illness or impairment? Yes ☐ No ☑
18. Have you been denied a controlled substances registration certificate by the Drug Enforcement Administration (DEA) or State Board of Pharmacy or other lawful authority concerned with controlled substances or been censured, reprimanded, restricted, voluntarily surrendered, placed on probation or had such authority revoked? Yes ☐ No ☑
19. Have you been indicted, arrested, charged with, convicted, pled guilty or nolo contendere in any criminal prosecution under the laws of any state or of the United States, for any offense reasonably related to the qualifications, functions or duties of a physician, for any offense an essential element of which is fraud, dishonesty or an act of violence, or for any offense involving moral turpitude? Yes ☐ No ☑
20. Have you been a defendant in a legal action involving professional liability (malpractice) or had a professional liability claim paid in your behalf or paid such a claim yourself? Yes ☐ No ☑
21. Have you been denied provider participation in any State Medicaid or Federal Medicare Program? Yes ☐ No ☑
22. Have you been terminated from, sanctioned or penalized by, or had to repay monies to any State Medicaid or Federal Medicare Program as a result of administrative or criminal action? Yes ☐ No ☑

PLEASE LIST CURRENT HOSPITAL AFFILIATION(S):

Name	Address
~~Humana Hosp Sunrise~~	~~3186~~ Maryland Pkwy LV, NV 89109
Womens Hospital	2025 E. Sahara Blvd, LV, NV 89104 (2300)
University Med Ctr	1800 W. Charleston Blvd, LV, NV 89102
Vally Hospital	620 Shadow Lane, LV, NV 89106

CONTINUING MEDICAL EDUCATION

630.153 Continuing education: General requirements; exemption; failure to comply.

1. Except as otherwise provided in subsection 2 and NAC 630.157, each holder of a license to practice medicine shall, at the time of the biennial registration, submit to the board by the final date set by the board for submitting applications for biennial registration evidence, in such form as the board requires, that he has completed 40 full hours of continuing medical education during the preceding 2 years in one or more educational programs. Each educational program must:

(a) Offer, upon successful completion of the program, a certificate of Category 1 credit as recognized by the American Medical Association to the holder of the license;

(b) Be approved by the board; and

(c) Be sponsored in whole or in part by an organization accredited or deemed to be an equivalent organization to offer such programs by the American Medical Association or the Liaison Committee on Continuing Medical Education.

2. Any holder of a license who has completed a full year of residency or fellowship any time during the period for biennial registration immediately preceding the submission of the application for biennial registration is exempt from the requirements set forth in subsection 1.

3. If the holder of a license fails to submit evidence of his completion of continuing medical education within the time and in the manner prescribed by subsection 1, his license will not be renewed. Such a person may not resume the practice of medicine unless, within 2 years after the end of the biennial period of registration, he:

(a) Pays a fee to the board which is twice the fee for biennial registration otherwise prescribed by subsection 1 of NRS 630.290;

(b) Submits to the board, in such form as it requires, evidence that he has completed 40 full hours of continuing medical education in addition to that otherwise required by subsection 1 or NAC 630.157; and

(c) Is found by the board to be otherwise qualified for active status pursuant to the provisions of this chapter and chapter 630 of NRS.

(Added to NAC by Bd. of Medical Exam'rs, 7-31-85, eff. 8-1-85; A 6-23-86; 11-21-88; 9-12-91)

PLEASE CHECK ONE OF THE FOLLOWING:

__✓__ 1. I have earned a minimum of 40 hours approved AMA Category I continuing medical education (CME) for the period July 1, 1991, through June 30, 1993.

______ 2. I am exempt because I have completed a full year of residency or fellowship training during the period for biennial registration immediately preceding the submission of this application.

______ 3. I am exempt as I am applying for INACTIVE or RETIRED status.

Signature ______________________________
(SIGNATURE STAMP UNACCEPTABLE)

IMPORTANT: ATTACH COPIES OF CERTIFICATES OF DECLARED CME CREDITS. PROOF OF CME CREDITS WILL NOT BE RETURNED.

<Transcript from ACOG avail on request>

Date of Birth: -57
month/day/year

Social Security Number: ______________

DEA Number: ______________

Medical School: Univ of Southern Cal — City — State: CA

Internship: Univ of CA SF, Fresno CA — City — State: CA

Residency: " " " — City — State: CA

______________________________ City ______ State

______________________________ City ______ State

Fellowship: ______________________________ City ______ State

I hereby certify that I am the person named in this application for renewal of license to practice medicine in the state of Nevada; that all statements I have made herein are true; that I am the original and lawful possessor of and person named in the various documents and credentials furnished to the Board in connection with this renewal application.

I HAVE ☒ HAVE NOT ☐ ACTIVELY PRACTICED IN NEVADA WITHIN THE PAST 12 MONTHS. (CHECK ONE)

366 1326 — Business Telephone #

4/19/97 — Date

x ______________ Signature (SIGNATURE STAMP UNACCEPTABLE)

ALL PAGES MUST BE RETURNED OR YOUR LICENSE WILL NOT BE RENEWED.

APPLICATION FOR REGISTRATION

NEVADA STATE BOARD OF MEDICAL EXAMINERS

Post Office Box 7238 Reno, Nevada 89610 Phone (702) 329-2559

MAY 29 1991

I hereby apply for certificate of biennial registration and enclose the appropriate fee as indicated below:

- ☑ ACTIVE STATUS $400.00 ✓
- ☐ INACTIVE STATUS $150.00
- ☐ RETIRED STATUS $ 50.00

NOTE: NO GRACE PERIOD – LICENSES NOT RENEWED BY JULY 1 ARE AUTOMATICALLY SUSPENDED FOR NON PAYMENT.

NRS630 explanation of status on reverse side

Adam V. Levy, MD 0008817
6038 E Mirror Lake Dr
Las Vegas NV 89110-0000

NAME LEVY (Last) Adam (First) Vincent (Middle)

Social Security #

Business Phone 702 652 3357

BUSINESS OR MAILING ADDRESS 6038 E. Mirror Lake Dr Las Vegas NV 89110 (Street Address or P.O. Box, Suite No., City, State, Zip Code)

If you have retired or moved your practice, please indicate the location of former patient's records for the last 5 years below:

NAME N/A

ADDRESS

PHONE # ( )

BOARD OF CERTIFICATION

Yes ____ No ✓

AM. Bd. of

Date of Certification or Recertification

Primary Specialty (List only one) OB/Gyn Sub-Specialties:

I certify that within the past 24 months, I have completed a minimum of 40 hours of Continuing Medical Education, AMA-Category 1 and that I have in my files documentation of such. I understand that the CME requirement is mandated by NRS 630.253 and NAC 630.153.

Signature: [signature] (No rubber stamps) CME OK Date 5-13-91

SINCE YOUR LAST REGISTRATION: (If any question is answered "yes," attach a detailed explanation.)

1. Have you been investigated by, or charged or convicted of unprofessional conduct, professional incompetence or gross or repeated malpractice by any medical licensing board or other agency, hospital or medical society? Yes ☐ No ☑
2. Have you been arrested, fined (over $100), charged with or convicted of a crime, indicted, imprisoned or placed on probation? Yes ☐ No ☑
3. Have you been investigated, arrested, charged or convicted for the possession, use of, or illegal sale or dispensing of controlled substances? Yes ☐ No ☑
4. Have you been denied a medical license or surrendered your license to practice in another jurisdiction or had your medical license or right to practice medicine revoked, suspended or limited in another jurisdiction? Yes ☐ No ☑
5. Have you had staff privileges in a hospital denied, suspended, limited, revoked or not renewed, or have you resigned from a medical staff in lieu of disciplinary or administrative action, excluding failure to complete medical records? Yes ☐ No
6. Have any malpractice settlements, awards or judgments been made against you in any jurisdiction? Yes ☐ No

STAFF PRIVILEGES: List all Nevada Hospitals in which you have any staff privileges: (Name and Location)

1. N/A ; Currently @ Nellis AFB Hosp USAF
2. Las Vegas NV
3.
4.
5.
6. State

I certify that all my statements in this application are true. I have ☑ have not ☐ actively practiced in Nevada within the past 12 months. (Check one) only AFB - Nellis

Signature [signature] (No rubber stamps) Date 5-13-91

NOTE: Have you signed both "signature" lines.

APPLICATION FOR REGISTRATION

NEVADA STATE BOARD OF MEDICAL EXAMINERS

Post Office Box 7238 Reno, Nevada 89510 Phone (702) 329-2559

Date Received by State Board: 12/1/90

License No. 6135

File No.

New ☒ Renewal ☐

This shaded section for BOARD USE ONLY

...ereby apply for certificate of biennial registration and enclose the appropriate fee as indicated below:

- ☒ ACTIVE STATUS ~~$300.00~~ 150.00
- ☐ INACTIVE STATUS $150.00
- ☐ RETIRED STATUS $ 50.00

NOTE: NO GRACE PERIOD – LICENSES NOT RENEWED BY JULY 1 ARE AUTOMATICALLY SUSPENDED FOR NON PAYMENT.

NRS630 explanation of status on reverse side

Make checks payable to: **BOARD OF MEDICAL EXAMINERS** (Foreign checks must indicate "U.S. FUNDS")

TYPE OR PRINT LEGIBLY

NAME: LEVI (Last) Adam (First) Vincent (Middle)

Social Security #

Business Phone ( )

BUSINESS OR MAILING ADDRESS: 6038 E Mirror Lake Dr, Las Vegas NV 89110 (Street Address or P.O. Box, Suite No., City, State, Zip Code)

If you have retired or moved your practice, please indicate the location of former patient's records below:

NAME

ADDRESS

PHONE # ( )

BOARD OF CERTIFICATION

Yes ____ No ____

AM. Bd. of

Date of Certification or Recertification

Primary Specialty (List only one) ____ Sub-Specialties: ____

I certify that within the past 24 months, I have completed a minimum of 40 hours of Continuing Medical Education, AMA-Category 1 and that I have in my files documentation of such. I understand that the CME requirement is mandated by NRS 630.253 and NAC 630.153.

Signed: ____ Date ____

(No rubber stamps)

SINCE YOUR LAST REGISTRATION: (If any question is answered "yes," attach a detailed explanation.)

1. Have you been investigated, charged or convicted of unprofessional conduct, professional incompetence or gross or repeated malpractice by any medical licensing board or other agency, hospital or medical society? Yes ☐ No ☒
2. Have you been arrested, fined (over $100), charged with or convicted of a crime, indicted, imprisoned or placed on probation? Yes ☐ No ☒
3. Have you been investigated, arrested, charged or convicted for the possession, use of, or illegal sale or dispensing of controlled substances? Yes ☐ No ☒
4. Have you been denied a medical license or surrendered your license to practice in another jurisdiction or had your medical license revoked, suspended or limited in another jurisdiction. Yes ☐ No ☒
5. Have you had staff privileges in a hospital denied, suspended, limited, revoked or not renewed, or have you resigned from a medical staff in lieu of disciplinary or administrative action, excluding failure to complete medical records? Yes ☐ No ☒
6. Have any malpractice settlements, awards or judgments been made against you in any jurisdiction? Yes ☐ No ☒

STAFF PRIVILEGES: List all Nevada Hospitals in which you have any staff privileges: (Name and Location)

1.
2.
3.
4.
5.
6.

...ertify that all the above statements are true ~~and that I have actively practiced in Nevada within the past 12 months.~~

Signature ____ Date 1 Dec 90

(No rubber stamps)

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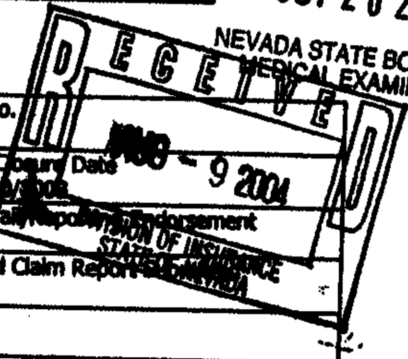
OCT 2 0 2004
NEVADA STATE BOARD OF MEDICAL EXAMINERS

Nevada Medical Professional Liability Closed Claim Report



I. Background

1. Name of Insurer American Physicians Assurance Corporation		2. Insurer Claim No. 19155-01
3. Injury Date (Date of Loss) 3/19/2002	4. Report Date 8/22/2002	5. Closure Date 7/30/2004
6. Policy Type (choose a, b, or c) a) ___ Occurrence b) _X_ Claims made c) ___ Tail/Reporting Endorsement		
7. Policy Limits (Per Claim/Aggregate) $_1M__/$_3M___		8. Date This Closed Claim Report Submitted 8/6/2004
9. Type of Report (choose a or b) a) _X_ Initial Report b) ___ Updated Report		

II. Defendant & Co-Defendants

1. Defendant's Name	Last Levy	First Adam	M.I.	Credentials (e.g. MD, DO, DMD, DDS) MD
2. License Number 6135	3. Specialty Description _OB/GYN_______ ISO Code _______			4. Co-Defendant(s)? _X_ Yes __ No __ Unknown
5. Number of Co-Defendant(s): _2_ or ___ Unknown				
6. Name, License Number and Insurer of Each Co-Defendant, if known: Shayna H. Hollingsworth, DO – Unknown University Medical Center - Unknown				

III. Injured & Injury

1. Injured Party's Name	Last	First	M.I.	2. Sex: __ Male _X_ Female
3. Age	4. Date of Birth (MM/DD/YY)	5. Malpractice code (per Appendix 1): PO		6. Injury Code (per appendix 2): Def
7. Description of Alleged Malpractice and Injuries (Attach Additional Sheet(s) If Necessary.) The patient suffered 2nd and 3rd degree burns to her labia and perenium from a hot weighted speculum used in surgery.				
8. City Where Injury Occurred Las Vegas		9. Name of Institution (If Injury Occurred in Institution) University Medical Center		

IV. Medical/Dental Screening Panel (Hereafter, Panel)

1. Case Filed with Panel? _X_Yes, ___ No, ___Unknown (IF YES, ANSWER QUESTIONS 2 AND 3)
2. Panel Case Number
3. Panel Decision: Is there Reasonable Probability of Malpractice? a)__ Yes b) __ No c) __ Unable to Decide d) __ Case Dismissed e) _X__ Other [case settled/withdrawn before panel met]
4. Court Case Filed After Panel Decision ___ Yes _X__ No ___ Unknown

V. Court Case

1. Court Case Filed? __Yes, _X__ No, ___Unknown (IF YES, ANSWER QUESTIONS 2 - 7)		
2. Court Case Number	3. Court Name	4. Court Department Number
5. Date Court Case Was Filed	6. Date Verdict Was Filed, If Applicable	7. Date Settlement Offer Accepted, If Applicable

VI. Reserves (Amounts Attributed to this Defendant Only, If Multiple Defendants)

1. Reserves	Initial $7001.00	Highest $8,750.00	Last $7,500.00

VII. Claim Disposition (Attributed to this Defendant Only)

1. Claim Disposition (check one)	a) ___ Decided By Trial in Favor of Plaintiff	b) ___ Decided By Trial in Favor of Defendant	c)___ Decided by Arbitrator in Favor of Plaintiff	d)___ Decided by Arbitrator in Favor of Defendant
e) _X__ Settled w/o Court or Prior to Trial	f)___ Claim Denied	g) ___ Claim Inactive	h) ___ Claim Withdrawn	i) ___ Other
2. If Claim Disposition is e, f, g, h or i, Please Explain: Settlement was negotiated before the panel answer was even prepared.				

Form NDOI 1102

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Name of Insurer American Physicians Assurance Corporation	Insurer Claim No. 19155-01
Defendant's Name (Last, First, M.I.) Levy, Adam	Date This Closed Claim Report Submitted 8/6/04

VIII. Verdict Information (Attributed to All Defendants in Case)

1. Verdict Awarded $ or _X_ N/A

IX. Claim Information (Amounts Attributed to this Defendant Only, If Multiple Defendants)

1. Verdict or Settlement Awarded $ or _X_ N/A		2. Verdict or Settlement Paid $50,000.00 or ___ N/A	
3. Reasons for Amount Awarded (1) Not Being Equal to Amount Paid (2), if Applicable (Check More than One, if Applicable) a) ___ Post Verdict Settlement b) ___ Award Reduced to Present Value c) ___ Interest Awarded d) ___ Court Costs Awarded e) ___ Non-economic damages limited by Judge to $350,000 f) ___ Award Capped by Judge at Policy Limit g) ___ Other (Explain)			
4. How Will/Did Plaintiff Receive Payments ?	a) _X_ Lump Sum	b) ___ Periodic Payments	c) ___ N/A
5. If Periodic Payments, What is the Present Value (as of Date of Award) of the Payments? $			
6. Sources of Award Payments	a) Company $7,500.00	b) Defendant $	c) Other (describe) $42,500.00 was paid by co-defendants
7. Allocated Loss Adjustment Expenses	Total $0	Attorney's Fees $0	Other $0

X. Claim Information (Amounts Attributed to Other Defendants)

1. Co-Defendant's Name	Last	First	M.I. A	Credentials (e.g. M.D., D.O) DO
2. License Number	3. Specialty Description ___	ISO Code ___	4. Verdict Awarded a) ___ Yes b) _X_ No c) ___ Unknown	
5. Settlement Made a) ___ Yes b) ___ No c) _X_ Unknown		6. Verdict or Settlement Awarded $ or _X_ N/A		

1. Co-Defendant's Name	Last	First	M.I.	Credentials (e.g. M.D., D.O)
2. License Number	3. Specialty Description ___	ISO Code ___	4. Verdict Awarded a) ___ Yes b) ___ No c) ___ Unknown	
5. Settlement Made a) ___ Yes b) ___ No c) ___ Unknown		6. Verdict or Settlement Awarded $ or ___ N/A		

1. Co-Defendant's Name	Last	First	M.I.	Credentials (e.g. M.D., D.O)
2. License Number	3. Specialty Description ___	ISO Code ___	4. Verdict Awarded a) ___ Yes b) ___ No c) ___ Unknown	
5. Settlement Made a) ___ Yes b) ___ No c) ___ Unknown		6. Verdict or Settlement Awarded $ or ___ N/A		

1. Co-Defendant's Name	Last	First	M.I.	Credentials (e.g. M.D., D.O)
2. License Number	3. Specialty Description ___	ISO Code ___	4. Verdict Awarded a) ___ Yes b) ___ No c) ___ Unknown	
5. Settlement Made a) ___ Yes b) ___ No c) ___ Unknown		6. Verdict or Settlement Awarded $ or ___ N/A		

(Attach Additional Sheet(s) if Necessary.)

XI. Closed Claim Report Information

1. Contact Person's Name (Last, First) Gersten, Suzannah
2. Contact Person's Phone Number ((999) 999-9999) (505) 796-3414
3. Contact Person's Address 7770 Jefferson Street NE, Suite 410 Albuquerque, New Mexico 87109

Name of Person Responsible for Report (Last, First) Gersten, Suzannah
Signature of Person Responsible for Report [signature]

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NEVADA STATE BOARD OF MEDICAL EXAMINERS

Nevada Medical Professional Liability Closed Claim Report

I. Background

1. Name of Insurer National Fire & Marine Insurance Company		2. Insurer Claim No. 1005300
3. Injury Date (Date of Loss) 11/3/2007	4. Report Date 10/31/2008	5. Closure Date 4/6/2011
6. Policy Type (choose a, b, or c) a) ___ Occurrence b) _X_ Claims made c) ___ Tail/Reporting Endorsement		
7. Policy Limits (Per Claim/Aggregate) $1,000,000/$3,000,000__		8. Date This Closed Claim Report Submitted 4/6/2011
9. Type of Report (choose a or b) a) _X_ Initial Report b) ___ Updated Report		

II. Defendant & Co-Defendants

1. Defendant's Name	Last Levy	First Adam	M.I. V.	Credentials (e.g. MD, DO, DMD, DDS) MD
2. License Number 6135	3. Specialty Description _Gynecology_ ISO Code _80277_			4. Co-Defendant(s)? ___ Yes _X_ No ___ Unknown
5. Number of Co-Defendant(s): _0_ or ___ Unknown				
6. Name, License Number and Insurer of Each Co-Defendant, if known: N/A				

III. Injured & Injury

1. Injured Party's Name	Last	First	M.I.	2. Sex: ___Male _X_ Female
3. Age	4. Date of Birth (MM/DD/YY)	5. Malpractice code (per Appendix 1): MP		6. Injury Code (per appendix 2): DTH
7. *Description of Alleged Malpractice and Injuries (Attach Additional Sheet(s) if Necessary.)* Alleged negligent performance of pregnancy termination resulting in death. Patient suffered known complication-perforation of uterus.				
8. City Where Injury Occurred - Las Vegas		9. Name of Institution (If Injury Occurred in Institution) A-Z Women's Center		

IV. Medical/Dental Screening Panel (Hereafter, Panel)

1. Case Filed with Panel? ___Yes, _X_ No, ___ Unknown (IF YES, ANSWER QUESTIONS 2 AND 3)
2. Panel Case Number:
3. Panel Decision: Is there Reasonable Probability of Malpractice? a)___ Yes b) ___ No c) ___ Unable to Decide d) ___ Case Dismissed e) ___ Other [case settled/withdrawn before panel met]
4. Court Case Filed After Panel Decision ___ Yes ___ No ___ Unknown

V. Court Case

1. Court Case Filed? _X_ Yes, ___ No, ___Unknown (IF YES, ANSWER QUESTIONS 2 - 7)		
2. Court Case Number A-10-631369-C	3. Court Name Clark Co. District Court	4. Court Department Number VIII
5. Date Court Case Was Filed 12/10/2010	6. Date Verdict Was Filed, if Applicable	7. Date Settlement Offer Accepted, if Applicable 1/14/2011

VI. Reserves (Amounts Attributed to this Defendant Only, If Multiple Defendants)

1. Reserves	Initial $300,000	Highest $300,000	Last $300,000

VII. Claim Disposition (Attributed to this Defendant Only)

1. Claim Disposition (check one)	a) ___ Decided By Trial in Favor of Plaintiff	b) ___ Decided By Trial in Favor of Defendant	c)___ Decided by Arbitrator in Favor of Plaintiff	d)___ Decided by Arbitrator in Favor of Defendant
e) _X_ Settled w/o Court or Prior to Trial	f)___ Claim Denied	g) ___ Claim Inactive	h) ___ Claim Withdrawn	i) ___ Other
2. If Claim Disposition is e, f, g, h or i, Please Explain - Case settled as a result of mediation.				

APR 11 2011
NEVADA STATE BOARD OF MEDICAL EXAMINERS

Name of Insurer National Fire & Marine Insurance Company	Insurer Claim No. 1005300
Defendant's Name (Last, First, M.I.) Levy, Adam V.	Date This Closed Claim Report Submitted 4/6/2011

VIII. Verdict Information (Attributed to All Defendants in Case)

1. Verdict Awarded $ ____________ or _X_ N/A

IX. Claim Information (Amounts Attributed to this Defendant Only, If Multiple Defendants)

1. Verdict or Settlement Awarded $20,000 or ____ N/A		2. Verdict or Settlement Paid $20,000 or ___ N/A	
3. Reasons for Amount Awarded (1) Not Being Equal to Amount Paid (2), if Applicable (Check More than One, if Applicable) a) ___ Post Verdict Settlement b) ___ Award Reduced to Present Value c) ___ Interest Awarded d) ___ Court Costs Awarded e) ___ Non-economic damages limited by Judge to $350,000 f) ___ Award Capped by Judge at Policy Limit g) ___ Other (Explain)			
4. How Will/Did Plaintiff Receive Payments?	a) _X_ Lump Sum	b) ___ Periodic Payments	c) ___ N/A
5. If Periodic Payments, What is the Present Value (as of Date of Award) of the Payments? $			
6. Sources of Award Payments	a) Company $20,000	b) Defendant $	c) Other (describe) $
7. Allocated Loss Adjustment Expenses	Total $13,884.65	Attorney's Fees $13,534.28	Other $350.37

X. Claim Information (Amounts Attributed to Other Defendants)

1. Co-Defendant's Name	Last	First	M.I.	Credentials (e.g. M.D., D.O)
2. License Number	3. Specialty Description ____________ ISO Code ______		4. Verdict Awarded a) ___ Yes b) ___ No c) ___ Unknown	
5. Settlement Made a) ___ Yes b) ___ No c) ___ Unknown		6. Verdict or Settlement Awarded $ or ___ N/A		

1. Co-Defendant's Name	Last	First	M.I.	Credentials (e.g. M.D., D.O)
2. License Number	3. Specialty Description ____________ ISO Code ______		4. Verdict Awarded a) ___ Yes b) ___ No c) ___ Unknown	
5. Settlement Made a) ___ Yes b) ___ No c) ___ Unknown		6. Verdict or Settlement Awarded $ or ___ N/A		

1. Co-Defendant's Name	Last	First	M.I.	Credentials (e.g. M.D., D.O)
2. License Number	3. Specialty Description ____________ ISO Code ______		4. Verdict Awarded a) ___ Yes b) ___ No c) ___ Unknown	
5. Settlement Made a) ___ Yes b) ___ No c) ___ Unknown		6. Verdict or Settlement Awarded $ or ___ N/A		

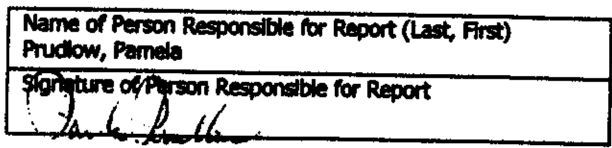
1. Co-Defendant's Name	Last	First	M.I.	Credentials (e.g. M.D., D.O)
2. License Number	3. Specialty Description ____________ ISO Code ______		4. Verdict Awarded a) ___ Yes b) ___ No c) ___ Unknown	
5. Settlement Made a) ___ Yes b) ___ No c) ___ Unknown		6. Verdict or Settlement Awarded $ or ___ N/A		

(Attach Additional Sheet(s) If Necessary.)

XI. Closed Claim Report Information

1. Contact Person's Name (Last, First) Prudlow, Pamela
2. Contact Person's Phone Number {(999) 999-9999} (800) 463-3776 X6370
3. Contact Person's Address 5814 Reed Road Fort Wayne, IN 46835

Name of Person Responsible for Report (Last, First) Prudlow, Pamela
Signature of Person Responsible for Report



Nevada Medical Professional Liability Closed Claim Report

I. Background

1. Name of Insurer The Doctors' Company		2. Insurer Claim No: 106364A
3. Injury Date (Date of Loss) 5/17/95	4. Report Date 8/15/96	5. Closure Date 3/1/07
6. Policy Type (choose a, b, or c) a) ___ Occurrence b) Claims made c) X Tail/Reporting Endorsement		
7. Policy Limits (Per Claim/Aggregate) $1M/$3M		8. Date This Closed Claim Report Submitted 3/30/07
9. Type of Report (choose a or b) a) X Initial Report b) ___ Updated Report		

II. Defendant & Co-Defendants

1. Defendant's Name	Last Levy	First Adam	M.I.	Credentials (e.g. MD, DO, DMD, DDS) M.D.
2. License Number	3. Specialty Description Obstetrics/Gynecologist			4. Co-Defendant(s)? Yes
5. Number of Co-Defendant(s): 3				

6. Name, License Number and Insurer of Each Co-Defendant, if known,
Kenneth Turner, M.D. – PULIC
Rogers Diagnostics – TDC
St. Anna Birthing Center
Shelly Hooper, CNMW

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III. Injured & Injury

1. Injured Party's Name	Last	First	M.I.	1. Sex Female
3. Age	Date of Birth	5. Malpractice code (per Appendix 1): MP		6. Injury Code (per appendix 2): Bth

7. Description of Alleged Malpractice and Injuries (Attach Additional Sheet(s) if Necessary.)
Brain damaged infant as a result of a misinterpretation of sonogram findings, resulting in clearance to deliver the patient at a birthing center.

8. City Where Injury Occurred Las Vegas	9. Name of Institution (If Injury Occurred in Institution) St. Anna Birthing Center

IV. Medical/Dental Screening Panel (Hereafter, Panel)

1. Case Filed with Panel?X Yes No, ___Unknown (IF YES, ANSWER QUESTIONS 2 AND 3)

2. Panel Case Number
L96-07-1197

3. Panel Decision: Is there Reasonable Probability of Malpractice?
a) Yes b) X No c) Unable to Decide d) ___ Case Dismissed e) Other - withdrawn before panel met

4. Court Case Filed After Panel Decision X Yes ___ No ___ Unknown

V. Court Case

1. Court Case Filed? X Yes,No, ___Unknown (IF YES, ANSWER QUESTIONS 2 - 7)

2. Court Case Number A361891	3. Court Name Eighth Judicial District	4. Court Department Number
5. Date Court Case Was Filed 9/19/97	6. Date Verdict Was Filed, If Applicable 1/23/01	7. Date Settlement Offer Accepted, If Applicable

VI. Reserves (Amounts Attributed to this Defendant Only, If Multiple Defendants)

1. Reserves 0.00	Initial $100,000	Highest $1,000,000	Last $1,000,000

VII. Claim Disposition (Attributed to this Defendant Only)

1. Claim Disposition (check one)	a) _X__ Decided By Trial in Favor of Plaintiff	a) Decided By Trial in Favor of Defendant	b) Decided by Arbitrator in Favor of Plaintiff	c)___ Decided by Arbitrator in Favor of Defendant
d) Settled w/o Court or Prior to Trial	e) Claim Denied	f) Claim Inactive	g) Claim Withdrawn	h) Other

2. If Claim Disposition is e, f, g or j, Please Explain

Name of Insurer The Doctors' Company	Insurer Claim No. 106364A
Defendant's Name (Last, First, M.I.) Levy, Adam	Date This Closed Claim Report Submitted 3/30/07

VIII. Verdict Information (Attributed to All Defendants in Case)

1. Verdict Awarded 6,000,000

IX. Claim Information (Amounts Attributed to this Defendant Only, If Multiple Defendants)

1. Settlement Awarded	2. Settlement Paid

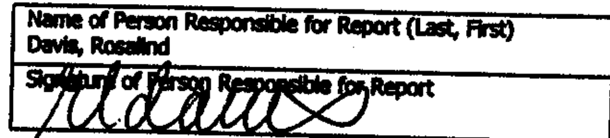
3. Reasons for Amount Awarded (1) Not Being Equal to Amount Paid (2), if Applicable (Check More than One, if Applicable)
a) ___ Post Verdict Settlement b) ___ Award Reduced to Present Value c) _ Interest Awarded d) _ Court Costs Awarded
e) ___ Non-economic damages limited by Judge to $350,000 f) ___ Award Capped by Judge at Policy Limit
g) X Other (Explain) Judgment Paid, plus interest, costs and fees

4. How Will/Did Plaintiff Receive Payments ?	a) X Lump Sum	b) _X_ Periodic Payments	c) ____ N/A
5. If Periodic Payments, What is the Present Value (as of Date of Award) of the Payments? $951,953.32			
6. Sources of Award Payments	Company X	b) Defendant $	c) Other (describe) $
7. Allocated Loss Adjustment Expenses	Total $840,782	Attorney's Fees $750,500	Other $90,282

XI. Closed Claim Report Information

1. Contact Person's Name (Last, First) Davis, Rosalind
2. Contact Person's Phone Number (702) 396-3872
2. Contact Person's Address The Doctors' Company 3157 N. Rainbow Blvd., Suite 522 Las Vegas, NV 89108

Name of Person Responsible for Report (Last, First) Davis, Rosalind
Signature of Person Responsible for Report



Form NDOI-1102