#8917

STATE OF NEVADA BOARD OF MEDICAL EXAMINERS APPLICATION FOR LICENSURE

RECEIVED SEP 27 1990 \$400

1. Name LEW	Adam	Vincent	MEDICAL I	TE BOARD OF EXAMINERS
Last*	Firet	Middle		Maiden
if you have ever used anoth	ner name, please indicate YO.O.			
2. Business and/or Mailing Ac	Idress 554 th MG /SG	HSO, NELLIS AFF	3, NV 89	20 .
3. Home Address	Street #	City State		Zio
4. Telephone Number (702)		704 652	<u>- 3357 (</u>	office
5. Date of Birth	57 Place of Bi	San Franci	3co ; C	CA
6. Citizenship: US Citizen	Alien Registration #.	zation and/or Alian Panistration	Other	
	pplied for medical licensure in Nevad	_	oard with this applic	ation.
If YES, give date of previou				
List name and address of a Have each school submit ar	Il colleges or universities attended of a official transcript directly to the boss	ther than schools where profess rd.	ional medical instru	ction was received
Name		Address	Dates of / From (Mo/Yr)	Mendance To (Mo/Yr)
Unw of Calif S	vanta Crue San	ta Craz, Calif	9/75	6/76
49	•	•	9177	6180
List name and address of all directly to the board.	schools where professional medical	instruction was received. Have e	ach school submit a	n official transcript
Name	Address	Place Where Instruction Received	Dates of A	Itendence
Univ. of Southern	2025 Zonal Ave	School of Mad.	8/80	5/84
0. Doctor of Medicine Degree	granted by:			
Name of Medical School	Address of Med	lical School	Exact Date of la	tuance
Univer. of South			nay 1984	
 Have you taken any part of of scores submitted from Na 	the National Boards? Yes Notional Boards to the board.	o if YES, list location, parts take	on, date and score(s). Have certificate
Location	Part Taken	Date	Result (Score(s))
Los Angeles CA	1 +	6/82	PASS	555

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3185

PASS

PASS

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Location	Part Taken	Date	Result	(Score(s))
lava vau takan any nart at i	ECFMG or FMGEMS? [] Yes	a If VEQ its name) below		
lave certification of examin	ation(s) submitted from the ECFMG of	directly to the board.	ocation, date and resul	(s) or exam
Location	Part Taken	Date	Result	(Score(s))
lave you received ACGME* equested below. Accreditation Council on Gr	approved postgraduate training in the	e United States or Canada?	Yes No If YES, fil	II in the info
Hospital/	Mailing	Type of Service	Dates of A	
iv. of Southern a A Co. Med Ctr	Address AL 2025 Zonal Ave Los Angeles, CA 90033	or Specialty Interm 0016m	From (Mo/Yr)	10 (Mo.
lley Med Ctr (UCS≠)	445 5. Cedar Ave Fresna CA 93702	OB/Gy Raid	. 685°	-6/89
(#e3#)				
lave you completed any A	CGME*approved Fellowship program Mailing Address	ms? Yes No If YES Type of Fellowship	Dates of A	
			11011(110) 117	TO (IAIO)
let any other postgraduate n	nedical education not accounted for i	in questions 14 and 16 above	. (2)	
Institution	Mailing Address	Type of Service or Specialty	Dates of Al	tendance To (Mo/
•				
Area of Specialty: 08.1	STET RICS / GYN	ECOLOGY		
are you Board Certified by a	STET RICS / EYN Board recognized by the American		10?	ES, comple
	a Board recognized by the American		Dates Certification	

19.	Location of	medica	practice s	ince gradu	uation (include	Military S	3ervice)

	City/State	From (Mo/Yr)	To (Mo/Yr)
News AFB	Las VEGAS NV 89191	8/89	Present
			,
	,		,

indicate.

Hospital	Complete Mailing Address	Date of Appointment From (Mo/Yr) To (Mo	
	•		
554 MG. Support	554 05W Hospital Nellis AFB NV 89191	8/89	Present
Hospitale			
		t	1

State or Country	License #	Date of Issuance	Detec of Practice in Agency's Juried From (Mo/Yr) To (Mo/Yr)	
CALIFORNIA	660065	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.

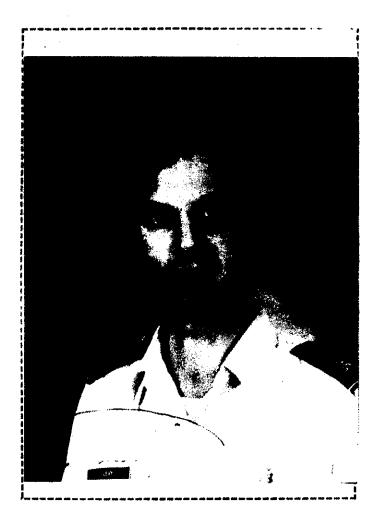
 Yes ZNo
- 23. Have you ever been denied a license, permission to practice medicine or any other healing arts, or permission to take an examination to practice medicine or any other healing art in any state, country or U.S. territory?

 ☐ 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
- 28. 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 COMMITTE MOOREMENT (PROPERTY OF THE PROPERTY OF TH
 - maipractice, 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?

	m a medical society or other professional medical organization?
30. Have you ever received psychiatric or psychologic treatment.	• •
□ Yes ÇNo	ness, drug addiction, or acute or chronic substance, drug or alcohol abuse?
32. Do you regularly take any prescription drugs for theraped	utic purposes? 🗆 Yes 🖟 No
	led substance registration or had it restricted in any way? Yes Division
Are you now or were you in the past, addicted to controll	led substances, including, but not limited to narcotics or alcohol? 🗆 Yes 📜 No
relating to the manufacture, distribution, or dispensing of	cted of, or pied noto contenders to a violation of any federal, state or local law f controlled substances, or to drug addiction? Yes S No
	or convicted of, or pled noto contendere to any offense, misdemeaned or felony cept violations of traffic laws resulting in fines of \$75 or less.) Yes (No
NOTE: You are required to list any conviction that has been a	set aside and dismissed under any other provision of law.
If you answered YES to any of questions 22 through 35 ples to this application.	see explain the circumstances and disposition on a separate sheet(s) and attach
37. If granted a license, do you intend to practice in Nevada?	? X Yee □ No
IFYES: Location LOS VEEKS	- ASAP
8. Personal Information	URIO J
•	241
AgeHeightWeight 175	
Color of Hair BLD Social Security Number	
Adam Vincent	
II	, somit day entri, depose and any, that the
in the credentials to be submitted; and that the same we	ide in the above application are true and correct; that I am the person named are procured in the regular course of instruction and examination without fraud part of this application is found to be false or fraudulent, that I forfeit the right
40. Please check one of the following:	
TAt the time of oral examination, I wish to be examined in At the time of oral examination, I wish to be examined in	in the area of my specialty as indicated in Number 17 of this application.
-C: At the time of oral examination, I want to be examined i	in the area of general medicine.
(
`	XIM
	Signature of Applicant
	Subscribed and sworn to before me this 2 4 7#
	day of SEPTEMBER 1996
	Patricia O Lundle
(Notery Seel)	Notary Public for State of NEWADA
(roun)	Trong I would be write by the state of the s
Notary Public State Of Moreds COUNTY OF CLARK	My Commission Expires 31 MARCH 1992
My Appointment Empires	
#################################	and the contract of the contra
	Residing at 4535 W. SANACA AVE.



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

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 separated 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

licensure i	n the State of Nev		vn
	<u> </u>	2	, are still true and
valid on	12-01-90	2	the date
	examination	- الم	
Signet:			والمراجع

System Automation

Reports Home Page

Renewal Questions for License Number 6135

PO	METHED
	WY

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	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?	Y		4/7/2011
Vincent	Please include: who, what, where (provide state), and when in the textbox directly below this question.			

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,	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?	
Adam Vincent	If "Yes" during the time period July 1, 2009 - June 30, 2011 type an explanation in the textbox directly below this question.	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 N 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.	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 N art in any state, country or U.S. territory?	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, ilmited, revoked or not renewed by the hospital, including any and all resignations from any

	medical staff in lieu of disciplinary or administrative action?		
LEVY, Adam	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.	N	4/7/2011
Vincent	(<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 maipractice insurance.)	l	
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,	Are you out of compliance with court ordered child support? If this does not apply to you, please answer "no".		
Adam Vincent	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,	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.		
Adam Vincent	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,	Do you want to change your scope of practice or specialty?		
Adam Vincent	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.		
	I have completed the required amount of AMA Category 1 CME within the current biennial. (Review CME information online at www.medboard.nv.gov)		
LEVY, Adam Vincent	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.	Y	4/7/2011
	If renewing to an <u>Inactive</u> status, CME is not required and "No" can be selected.		
LEVY,	I SWEAR OR AFFIRM UNDER THE PENALTY OF PERJURY THAT I PERSONALLY ANSWERED ALL OF THE		
Adam Vincent	QUESTIONS IN THIS APPLICATION AND THAT THE ANSWERS I HAVE PROVIDED ARE TRUE AND CORRECT.	Y	4/7/2011

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LEVY, Adam Vincent	LEVY, Adam Vincent	LEVY, Adam Vincent	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.	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 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?	Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable
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5/7/2009	5/7/2009	5/7/2009	5/7/2009

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LEVY, Adam Vincent	LEVY, Adam Vincent	LEVY, Adam Vincent	LEVY, Adam Vincent	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?	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?	Have you been arrested, investigated for, charged with, convicted of, or pled guilty or noto 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.	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.	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.
Z	Z	z	Z	Z
5/7/	5/7/	<i>5/</i> 7)	<i>\$1</i> 7.	5 <i>/</i> 7
5/7/2009	5/7/2009	5/7/2009	5/7/2009	5/7/2009

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	LEVY, Adam Vincent	LEVY, Adam Vincent	LEVY, Adam Vincent	LEVY, Adam Vincent	LEVY, Adam Vincent
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.)	Have you had hospital staff privileges denied, suspended, limited, revoked or not renewed by the hospital, including	Have you surrendered your state or federal controlled substance registration or had it revoked or restricted in	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?	Have you been denied membership, been asked to resign or expelled from a medical society or other professional medical organization (including the ABMS)?	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?
	Z	z	z	z	z
	5/7/2009	5/7/2009	5/7/2009	5/7/2009	5/7/2009

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LEVY, Adam Vincent		LEVY, Adam Vincent	LEVY, Adam Vincent	LEVY, Adam Vincent	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.	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.	question. I have completed the required amount of AMA Category 1 CME within the current biennial. (Review CME	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	this question. I hereby request my license to be placed on inactive status, which means I will not physically practice in the state of Nevada.	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
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5/7/2009		5/7/2009	5/7/2009	5/7/2009	5/7/2009

6135	9135	6135	6135	6135	License Number Licensee Name
LEVY, Adam Vincent	LEVY, Adam Vincent	LEVY, Adam Vincent	LEVY, Adam Vincent	LEVY, Adam Vincent	Licensee Name
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?	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?	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 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?	Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety?	Question Text
2	2	2	2		Answer
3/29/2007	3/29/2007	3/29/2007	3/29/2007	3/29/2007	

6135	6135	6135	6135	6135
LEVY, Adam Vincent	LEVY, Adam Vincent	LEVY, Adam Vincent	LEVY, Adam Vincent	LEVY, Adam Vincent
Have you been denied membership or expelled from a medical society or other professional medical organization?	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?	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?	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?	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.
z	Z	2	Z	2
3/29/2007	3/29/2007	3/29/2007	3/29/2007	3/29/2007

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LEVY, Adam Vincent	LEVY, Adam Vincent		LEVY, Adam Vincent	LEVY, Adam Vincent	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?	is your license currently contingent upon compliance with the Diversion program also known as the Nevada Health Professionals Assistance Foundation?	nave 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 elicensensbrae@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.)	Have you had hospital staff privileges denied, suspended, limited, revoked or not renewed by the hospital? If you	Have you surrendered your state or federal controlled substance registration or had it revoked or restricted in any way?	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?
	Z		Z	2	Z
3/29/2007	3/29/2007		3/29/2007	3/29/2007	3/29/2007

6135 LEVY, Adam Vincent	6135 LEVY, Adam Vincent	6135 LEVY, Adam Vincent	6135 LEVY, Adam Vincent	6135 LEVY, Adam Vincent	6135 LEVY, Adam Vincent	6135 LEVY, Adam Vincent	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.	I hereby request my license to be placed on inactive status. I will not physically practice in the state of	I have actively practiced medicine in Nevada within the past 12 months.	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.	to elicensensbme@medboard.nv.gov 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	Do you want to change your scope of practice or specialty? If you answer "Yes" please email your request	Are you out of compliance with court ordered child support? If this does not apply to you please answer "no".	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?
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3/29/2007	3/29/2007	3/29/2007	3/29/2007	3/29/2007	3/29/2007	3/29/2007	3/29/2007

Date Received by Board **PHYSICIAN** License No. MAR 2 8 2005 APPLICATION FOR REGISTRATION RENEWAL FOR THE BIENNIAL REGISTRATION PERIOD 2005 - 2007 APR 1 5 2005 **NEVADA STATE BOARD OF MEDICAL EXAMINERS** (For Board Use Only) Post Office Box 7238 Reno, Nevada 89510 Phone (775) 688-2559 Physical Address: 1105 Terminal Way, Suite 301 Reno, Neveda 89502 I hereby apply for renewal of biennial registration and enclose the appropriate fee(s) as indicated below: \$600.00.hi **ACTIVE STATUS** \$300.00.....(INACTIVE STATUS DOES NOT PERMIT **INACTIVE STATUS** THE PRACTICE OF MEDICINE INCLUDING I REQUEST NON-RENEWAL OF MY LICENSE* THE WRITING OF PRESCRIPTIONS IN NEVADA) ("IF YOU ARE REQUESTING NON-RENEWAL, SEE BELOW) FIGNO XXX License No. 8135 Make checks payable to: Adam Vincent LEVY M.D. **NEVADA STATE BOARD OF MEDICAL EXAMINERS** 1670 E Flamingo Rd # C (Foreign checks must indicate "U.S. FUNDS") 89119-Las Vegas 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. Signature (SIGNATURE STAMP UNACCEPTABLE) Date 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.) Nama Street

Fax Number

State

County

City

Phone Number

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Be l		County	State		Zip
y		Journey	Otate		·
on	e Number		dary scopes of practice using the fo	allowi	ing codes:
m	dicate below your primary	and secon	daily acobes of bractice dainy the id)110 W	ang couce.
		;	SCOPES OF PRACTICE CODES		
	ADDICTION MEDICINE	4:	3 NEPHROLOGY		PEDIATRIC, SURGERY
	ADOLESCENT MEDICINE		4 NEUROLOGY		PEDIATRIC, UROLOGY
	AEROSPACE MEDICINE		5 NEURO-OPHTHALMOLOGY	87	PEDIATRICS PHYSICAL MEDICINE/REHABILIT
	ALLERGY		8 NEUROPATHOLOGY		PREVENTIVE MEDICINE
	ALLERGY/IMMUNOLOGY		7 NEURORADIOLOGY 8 NEUROTOLOGY		PSYCHIATRY
	AMBULATORY MEDICINE ANESTHESIOLOGY	4			PSYCHOANALYSIS
	BLOODBANKING	5			PSYCHOMATIC MEDICINE
	BRONCO-ESOPHAGOLOGY		1 NUTRITION		PUBLIC HEALTH
)	CARDIOVASCULAR DISEASES		2 OBSTETRICS		PULMONARY DISEASES
	CATSCAN/ULTRASOUND	5	3 OBSTETRICS/GYNECOLOGY		OCCUPATIONAL MEDICINE
	CHILD NEUROLOGY		4 OCCUPATIONAL MEDICINE		RADIOLOGY
3	CHILD PSYCHIATRY	5	5 ONCOLOGY	97	RADIOLOGY, DIAGNOSTIC RADIOLOGY, INTERVENTIONAL
	CLINICAL PHARMACOLOGY		6 ONCOLOGY, GYNECOLOGICAL 7 ONCOLOGY, HEMATOLOGY		RADIOLOGY, NUCLEAR
	CRITICAL CARE	5 5			0 RADIOLOGY, THERAPEUTIC
	DERMATOLOGY DERMATOPATHOLOGY		9 ONCOLOGY, SURGICAL	101	1 RADIOLOGY, VASCULAR
	EMERGENCY MEDICINE		O OPHTHALMOLOGY		2 RHEUMATOLOGY
	ENDOCRINOLOGY		1 OTOLARYNGOLOGY		3 RHINOLOGY
	FAMILY PRACTICE		2 OTOLOGY		4 SLEEP DISORDERS
ĺ	FORENSIC MEDICINE	ě	3 PAIN MANAGEMENT	105	5 SPORTS MEDICINE
	GASTROENTEROLOGY		4 PATHOLOGY		8 SURGERY, ABDOMINAL
3	GENERAL PRACTICE	6	5 PATHOLOGY, ANATOMIC		7 SURGERY, CARDIOTHORACIC
4	GERIATRIC PSYCHIATRY	_	6 PATHOLOGY, CLINICAL	106	6 SURGERY, CARDIOVASCULAR
5	GERIATRICS		7 PATHOLOGY, FORENSIC		9 SURGERY, COLON/RECTAL
8	GYNECOLOGY	6	8 PEDIATRIC, ALLERGY		0 SURGERY, CRANIOFACIAL
7	HAIR TRANSPLANTATION		9 PEDIATRIC, ANESTHESIOLOGY		1 SURGERY, GENERAL 2 SURGERY, HAND
8	HEMATOLOGY		0 PEDIATRIC, CARDIOLOGY 1 PEDIATRIC, CRITICAL CARE		3 SURGERY, HEAD/NECK
))	HOMEOPATHY HYPNOSIS		2 PEDIATRIC, EMERGENCY MEDICINE		4 SURGERY, MAXILLOFACIAL
,	IMMUNOLOGY	7	3 PEDIATRIC, ENDOCRINOLOGY		5 SURGERY, NEUROLOGICAL
2	INFECTIOUS DISEASES	7.	4 PEDIATRIC, GASTROENTEROLOGY		6 SURGERY, ORTHOPEDIC
i	INFERTILITY	Ť	5 PEDIATRIC, HEMATOLOGY/ONCOLOGY		7 SURGERY, PLASTIC
ĺ	INTERNAL MEDICINE	7	6 PEDIATRIC, INFECTIOUS DISEASES		8 SURGERY, THORACIC
	LARYNGOLOGY		7 PEDIATRIC, INTENSIVIST		9 SURGERT, TRANSPLANT
3	LEGAL MEDICINE	7	8 PEDIATRIC, NEPHROLOGY		O SURGERY, TRAUMATIC
7	MATERNAL/FETAL MEDICINE		9 PEDIATRIC, NEUROLOGY		1 SURGERY, UROLOGIC
3	MEDICAL ACUPUNCTURE		0 PEDIATRIC, OPHTHALMOLOGY		2 SURGERY, VASCULAR
9	MEDICAL ETHICS		1 PEDIATRIC, PHYSIATRY		3 TOXICOLOGY
9	MEDICAL GENETICS		2 PEDIATRIC, PULMONARY 3 PEDIATRIC, RADIOLOGY		4 TRANSPLANTATION 5 URGENT CARE
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2	NEOLDIO DIOGUSEO	Code	· · · · · · · · · · · · · · · · · · ·	1.4	∴ Code
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'ni	mary Scope of Practice _		Secondary Scop	10 OT I	PTACUCO
LE	ASE INDICATE AMERICAL	BOARD C	F MEDICAL SPECIALTIES BOARD (ERT	IFICATION & RECERTIFICA
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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.

		K REGISTRATION I		14L
Do you have a medical or safety?	condition which in any v	vay impairs or limits your a	ibility to practice medicine	with reasonable skill and YesNo
2. If you have a medical of limitation reduced or amel practice?	condition which in any literated because of the	way impairs or limits your e field of practice, the set	ting, or the manner in wh	ne, is that impairment or ich you have chosen to esNoN/A
If you use chemical subskill and safety?	ostances, does your us	e in any way impair or limi	it your ability to practice m	edicine with reasonable
4. Have you failed to initial begin to satisfy a require government for your medical power medical satisfy.	ment of your receiving		from the federal governm	
5. Have you been a defend paid in your behalf or paid			y (malpractice) or had a pi 	rofessional liability claim YesNo
6. Have you ever been in violation of any federal, st felony, excluding any minor substance is not consider dispensing of controlled su	ate or local law, includ or traffic offense (drivin red a minor traffic of	ling any foreign country, v g or in control of a motor	which is a misdemeanor, vehicle while under the in	gross misdemeanor, or fluence of any chemical
7. Have you ever been de examination to practice me				
8. Have you ever had a me any state, country or U.S.		to practice any other heal	ing art revoked, suspende 	d, limited, or restricted in
9. Have you ever voluntar territory?	ily surrendered a licens	se to practice medicine or	any other healing art in ar	ny state, country or U.S. YesNo
10. Have you ever been d	enied membership or e	expelled from a medical so	ciety or other professiona	al medical organization? YesNo
11. Have you ever been: a any violation of a statute, a medical society, government	ule or regulation gover	ning your practice as a pl	hysician by any medical lic	censing board, hospital,
12. Have you ever surrend way?	dered your state or fed	eral controlled substance	registration or had it revo	
13. List all hospitals where List any and all resignations suspensions or restrictions maintain required malprace Hospital	s from any medical staf s for failure to complete	f in lieu of disciplinary or a hospital medical records	dministrative action. (<u>Plea</u> , attend hospital departme n a separate sheet)	ese <u>Note</u> : Do not include
Morrie				· · · · · · · · · · · · · · · · · · ·

CHILD SUPPORT STATEMENT

Date

Dinger	the construction which was a first of allowing adulance and a
riease p	lace 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;
complian	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 ace with a plan approved by the district attorney or other public agency enforcing the order for the repayment of the bowed pursuant to the order; OR
a plan ap	(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 approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed to the order.
CONTIN	UING MEDICAL EDUCATION (CME) STATEMENT
Were in r	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 nedical ethics and 20 hours of which were in my scope of practice or specialty, and an additional 4 hours of AMA of 1 continuing medical education in acts of terrorism, during the past biennial period of July 1, 2003 through June 30,
months of (CME), 2	b) I was initially licensed in Nevada during the time period January 1, 2004 through June 30, 2004, the second six of the past biennial period, and completed a minimum of 34 hours of AMA Category 1 continuing medical education hours of which were in medical ethics and 20 hours of which were in my scope of practice or specialty, and an 4 hours of AMA Category 1 continuing medical education in acts of terrorism;
months of (CME), 2	c) I was initially licensed in Nevada during the time period July 1, 2004 through December 31, 2004, the third six of the past biennial period, and completed a minimum of 24 hours of AMA Category 1 continuing medical education hours of which were in medical ethics and 18 hours of which were in my scope of practice or specialty, and an 44 hours of AMA Category 1 continuing medical education in acts of terrorism;
months of (CME), 2	d) I was initially licensed in Nevada during the time period January 1, 2005 through June 30, 2005, the fourth six if the past biennial period, and completed a minimum of 14 hours of AMA Category 1 continuing medical education hours of which were in medical ethics and 8 hours of which were in my scope of practice or specialty, and an I 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 r of residency or fellowship training during the biennial period July 1, 2003 through June 30, 2005.
JULY	ACH COPIES OF PROOF OF YOUR COMPLETION OF CONTINUING MEDICAL EDUCATION (CME) HOURS. J COMPLETED A FULL YEAR OF RESIDENCY OR FELLOWSHIP TRAINING DURING THE BIENNIAL PERIOD 1, 2003 THROUGH JUNE 30, 2005, ATTACH A COPY OF PROOF OF COMPLETION OF YOUR TRAINING. COPIES OF PROOF OF CME OR TRAINING COMPLETION WILL NOT BE RETURNED TO YOU.
I HAVE 12 MONTI	HAVE NOT (CHECK ONE) ACTIVELY PRACTICED MEDICINE IN NEVADA WITHIN THE PAST
1) I HER OF L	ING ON THE SIGNATURE LINE BELOW: REBY REPRESENT THAT I AM THE PERSON NAMED IN THIS APPLICATION FOR REGISTRATION RENEWAL ICENSE TO PRACTICE MEDICINE IN THE STATE OF NEVADA AND THAT ALL STATEMENTS I HAVE MADE EIN ARE TRUE;
	DERSTAND THAT THIS APPLICATION FOR REGISTRATION RENEWAL WILL BE DENIED IF I HAVE NOT SED A CHECK MARK NEXT TO (a), (b), OR (c) UNDER THE CHILD SUPPORT STATEMENT SECTION; AND
ANSV PROC COM	DERSTAND THAT THIS APPLICATION FOR REGISTRATION RENEWAL WILL BE DENIED IF I HAVE NOT VERED ALL QUESTIONS THEREON AND/OR ATTACHED THERETO: (a) THE APPROPRIATE COPIES OF OF CONTINUING MEDICAL EDUCATION (CME), OR RESIDENCY OR FELLOWSHIP TRAINING PLETION; (b) PAYMENT OF THE APPROPRIATE REGISTRATION RENEWAL FEE; AND (c) WRITTEN ANATION(S) TO ANY "YES" ANSWER(S).
2/3/	/65

Signature (SIGNATURE STAMP UNACCEPTABLE)

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	PHYSICIAN OR REGISTRATION RENEV		eceived by Board	License No.	6135
OR THE BIENNIAL R	EGISTRATION PERIOD 200)3- 2005	FEB 2 1 20	03	
NEVADA STATE BO	OARD OF MEDICAL EXAMI Nevada 89510 Phone (775) 688- ninal Way, Suite 301 Reno, Nevad val of biennial registration and	NERS 1 0 2	03	File No	
hysical Address: 1105 Terr	ninal Way, Suite 301 Reno, Nevac	da 89502	/ Loana Ose Only)		
hereby apply for renew	val of biennial registration and	d enclose the approp	riate fee(s) as inc	dicated below:	
ACTIVE STATE		\$400.00	INACTIVE STAT	US DOES NOT P	FRMIT
	NON-RENEWAL OF MY LIC	• • • • • • • • • • • • • • • • • • • •		OF MEDICINE INC	
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Adam V LEVY		M.D.	Make	checks payable to:	
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Las Vegas NV 8) 3 (13		(Lotathi mere	s must indicate "U.S. F	
Request fo	or NON-RENEWAL	of License to	Practice Me	dicine in Ne	vada
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	gnature line below, I am re	cuestina that my lic	ense to practice	medicine in Nev	ada NOT
	a State Board of Medical E				
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ate	Signature (SIGNAT	URE STAMP UNAC	CEPTABLE)		****
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PLEASE NOTE:					
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	LL NOT BE RENEWED UNI 'ENEWAL FORM. YOU MU!				
ANSWERED "YES				3.112	
	YOU PROVIDE ON THIS A	APPLICATION FOR	REGISTRATION	RENEWAL FOR	W IS <u>PUBLI</u>
INFORMATION.		·			
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Anthen atatus registral	tion renewal requires the sub			صفح	vor 1 continui
	E), which includes 2 hours of (
	ring the period July 1, 2001				
	tion for Registration Renewal				
If your name and/or	address has changed from t	hat neintact on the lai	nation this form	niaadu indiaata tha	abanaa in ti
	Also, please indicate your cu				
	uthorizing your name change				
ama			•		
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	County			•	
IF YOU HAVE RETIF	RED OR MOVED YOUR PRA	ACTICE, indicate the	location of patier	nt records below:	
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ity	County	State		Zip	

Phone Number_

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

SCOPES OF PRACTICE CODES

		*	· A		
1	ADDICTION MEDICINE	41	NEOPLASTIC DISEASES NEPHROLOGY NEURO-OPHTHALMOLOGY NEURO-PATICALOGY	81	PEDIATRIC, RHEUMATOLOGY
2	ADOLESCENT MEDICINE	42	NEPHROLOGY	82	PEDIATRIC, SURGERY
3	AEROSPACE MEDICINE	43	NEUROLOGY	83	PEDIATRIC, UROLOGY
4	ALLERGY	44	NEURO-OPHTHALMOLOGY	84	PEDIATRICS
5	ALLERGY/IMMUNOLOGY	45	NEUROPATHOLOGY	85	PHYSICAL MEDICINE/REHABILITATION
6	AMBULATORY MEDICINE	46	NEURORADIOLOGY	86	
7	ANESTHESIOLOGY	47	NON-CONVENTIONAL MEDICINE	87	PSYCHIATRY
8	BLOODBANKING			88	PSYCHOANALYSIS
9	BRONCO-ESOPHAGOLOGY	49	NUTRITION	89	PUBLIC HEALTH
10	CARDIOVASCULAR DISEASES	60	OBSTETRICS	90	PSYCHOMATIC MEDICINE
11	CATSCAN/ULTRASOUND	51	OBSTETRICS/GYNECOLOGY	91	PULMONARY DISEASES
12	CHILD NEUROLOGY	52	OCCUPATIONAL MEDICINE	92	RADIOLOGY
13	CHILD PSYCHIATRY	53	ONCOLOGY	93	RADIOLOGY, DIAGNOSTIC
14	CLINICAL PHARMACOLOGY	.54	ONCOLOGY, GYNECOLOGICAL	94	RADIOLOGY, INTERVENTIONAL
15	CRITICAL CARE	56	ONCOLOGY, HEMATOLOGY	95	RADIOLOGY, NUCLEAR
16	DERMATOLOGY	56	ONCOLOGY, GYNECOLOGICAL ONCOLOGY, HEMATOLOGY ONCOLOGY, RADIATION ONCOLOGY, SURGICAL OPHTHALMOLOGY OTOLARYNGOLOGY OTOLOGY PAIN MANAGEMENT PATHOLOGY, ANATOMIC PATHOLOGY, CLINICAL PATHOLOGY, FORENSIC PEDIATRIC, ALLERGY PEDIATRIC, CARDIOLOGY PEDIATRIC, CRITICAL CARE PEDIATRIC, EMERGENCY MEDICINE	96	RADIOLOGY, THERAPEUTIC
17	DERMATOPATHOLOGY	57	ONCOLOGY, SURGICAL	97	RADIOLOGY, VASCULAR
18	FMERGENCY MEDICINE	58	OPHTHALMOLOGY	98	RHEUMATOLOGY
19	ENDOCRINOLOGY FAMILY PRACTICE GASTROENTEROLOGY GENERAL PRACTICE GERIATRIC PSYCHIATRY GERIATRICS	59	OTOLARYNGOLOGY	99	RHINOLOGY
20	FAMILY PRACTICE	60	OTOLOGY	100	SLEEP DISORDERS
21	GASTROENTEROLOGY	61	PAIN MANAGEMENT	101	SPORTS MEDICINE
22	GENERAL PRACTICE	62	PATHOLOGY	102	SURGERY, ABDOMINAL
23	GERIATRIC PSYCHIATRY	63	PATHOLOGY, ANATOMIC	103	SURGERY, CARDIOTHORACIC
24	GERIATRICS	64	PATHOLOGY, CLINICAL	104	SURGERY, CARDIOVASCULAR
25	GYNECOLOGY	65	PATHOLOGY, FORENSIC	105	SURGERY, COLON/RECTAL
26	HAIR TRANSPLANTATION	66	PEDIATRIC, ALLERGY	106	SURGERY, GENERAL
27	HEMATOLOGY	67	PEDIATRIC, CARDIOLOGY	107	SURGERY, HAND
28	HOMEOPATHY	68	PEDIATRIC, CRITICAL CARE	108	SURGERY, HEAD/NECK
29	HYPNOSIS				SURGERY, MAXILLOFACIAL
30	IMMUNOLOGY INFECTIOUS DISEASES	70	PEDIATRIC, ENDOCRINOLOGY		SURGERY, NEUROLOGICAL
31	INFECTIOUS DISEASES		PEDIATRIC, GASTROENTEROLOGY	111	
32	INFERTILITY		PEDIATRIC, HEMATOLOGY/ONCOLOGY		SURGERY, PLASTIC
33	INTERNAL MEDICINE		PEDIATRIC, INFECTIOUS DISEASES	113	
34	LARYNGOLOGY		PEDIATRIC, INTENSIVIST		SURGERY, TRANSPLANT
35	LEGAL MEDICINE	75	PEDIATRIC, NEPHROLOGY	115	SURGERY, TRAUMATIC
36	MATERNAL/FETAL MEDICINE	76	PEDIATRIC, NEUROLOGY PEDIATRIC, OPHTHALMOLOGY PEDIATRIC, PHYSIATRY	116	SURGERY, UROLOGIC
37	MEDICAL ACUPUNCTURE	77	PEDIATRIC, OPHTHALMOLOGY	117	SURGERY, VASCULAR
38	MEDICAL ETHICS	78	PEDIATRIC, PHYSIATRY	118	
39	MEDICAL GENETICS	79	PEDIATHIC, PULMONARY	119	URGENT CARE
40	NEO/PERINATAL MEDICINE	80	PEDIATRIC, RADIOLOGY	120	UROLOGY

<u>Code</u>		Code
		3
Primary Scope of Practice	Secondary Scope of Practice	<u> </u>

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;
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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.

 Do you have a medica safety? 	al condition which in any v	vay impairs or limits your ability	to practice medicine with re	easonable skiji and _YesNo
2. If you have a medica limitation reduced or am practice?	I condition which in any velicrated because of the	way impairs or limits your abilit field of practice, the setting,	or the manner in which yo	that impairment or ou have chosen to NoN/A
3. If you use chemical seskill and safety?	ubstances, does your us	e in any way impair or limit you	r ability to practice medicin	e with reasonable
4. Have you failed to init begin to satisfy a requir government for your med	rement of your receiving	oublic service within one year a g a loan or scholarship from	the federal government of	rvice is required to or a state or Joca NoNoNA
5. Have you been a defe paid in your behalf or pai	ndant in a legal action inv id such a claim yourself?	volving professional liability (ma	ulpractice) or had a profess	ional ilability claim YesNo
violation of any federal, a felony, excluding any mit	state or local law, includ nor traffic offense (drivin lered a minor traffic off	d with, convicted of, or plead ing any foreign country, which g or in control of a motor vehic lense) or which is related to the	is a misdemeanor, gross le while under the influenc	misdemeanor, or e of any chemical
7. Have you ever been dexamination to practice r	lenied a license, permiss nedicine or any other he	sion to practice medicine or an aling art in any state, country o	y other healing art, or perr r U.S. territory?	nission to take an _YesNo
8. Have you ever had a n any state, country or U.S	nedical license or license i. territory?	to practice any other healing a	rt revoked, suspended, limi	ted, or restricted in YesNo
9. Have you ever voluntaterritory?	arily surrendered a licens	e to practice medicine or any o		te, country or U.S. YesNo
10. Have you ever been	denied membership or e	xpelled from a medical society		ical organization? YesNo
any violation of a statute,	, rule or regulation gover	under investigation for; b) inves ning your practice as a physici ncy <u>other than</u> the Nevada Sta	an by any medical licensin	g board, hospital,
12. Have you ever surre way?	ndered your state or fed	eral controlled substance regis	tration or had it revoked o	r restricted in any YesNo
List any and all resignatio	ns from any medical staf ns for failure to complete	rileges denied, suspended, limi f in lieu of disciplinary or admini hospital medical records, attei	strative action. (<u>Please No</u> nd hospital department or	ote: Ďo not include
Hospital	Address	Action		Yr.) To (Mo./Yr.)
		4		-
<u> </u>	Y: Y:	1		<u> </u>
-	^			

CHILD SUPPORT STATEMENT

and the state of t
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 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.
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 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).
7-2-03
2-7-03 Cignoture TeleMATHEE STAND HNACCEDTARI EL

			MM
PHYSICIAN	Date Received b	y Board	11/15
APPLICATION FOR REGISTRATION RENEWAL FOR THE BIENNIAL REGISTRATION PERIOD 2001- 2003	APR 0 6 2	rina.	License No. 0155
NEVADA STATE BOARD OF MEDICAL EXAMINERS	/ 1. 0 0 21	VV1	File No.
Post Office Box 7238 Reno, Nevada 89510 Phone (775) 688-2559	(For Board Use		
I hereby apply for renewal of biennial registration and enclose the ACTIVE STATUS	e appropnate ree(s \$600.00	i) as indicated	1 below:
INACTIVE STATUS	•	RED STATU	S REQUIRES THAT THE
RETIRED STATUS			PRACTICE MEDICINE
SUPERVISING/COLLABORATING PHYSICIAN	\$200.00 <u>ANY</u>	WHERE)	
Adam V LEVY		Make checi	a payable to:
Adam V LEVY M.D. 2501 W Charleston Bivd		TATE BOARD	OF MEDICAL EXAMINERS
Las Vogas NV 89102	(Fore	aign chacks musi	t indicate "U.S. FUNDS")
PLEASE NOTE:			
. YOUR CURRENT M.D. LICENSE EXPIRES ON JUNE 30, 2	2001. COMPLETE	D APPLICAT	TON FOR REGISTRATION
RENEWAL FORMS NOT RECEIVED AT THE BOARD OFF			
SUSPENDED FOR NON-PAYMENT. EXTENSIONS OF THE HAS NO GRACE PERIOD. (USE THE ENCLOSED ENVEI			
REGISTRATION RENEWAL FORM.)			
- YOUR LICENSE WILL NOT BE RENEWED UNLESS YOU			
REGISTRATION RENEWAL FORM. YOU MUST <u>PROVID</u> ANSWERED "YES."	E WRITTEN EXPL	ANALIONS F	OR ALL QUESTIONS
 ALL INFORMATION YOU PROVIDE ON THIS APPLICATION 	ON FOR REGISTRA	ATION RENE	WAL FORM IS PUBLIC
PLEASE TYPE OR	PRINT LE	GIBLY	
			•
1. To be eligible to act as a SUPERVISING PHYSICIAN FOR A PHYSICIAN FOR AN ADVANCED PRACTITIONER OF NURSIN you must complete the enclosed Application for Approval as a payment in the amount of \$200.00 in the enclosed envelope.	IG for the blennial p Supervising/Collai	eriod of July 1 borating Phy	, 2001 through June 30, 2003, s<i>ician</i> and return it with you
 Active status registration renewal requires the submission of p medical education (CME), which includes 2 hours of CME in me specially completed during the period July 1, 1999 through J your completed Application for Registration Renewal form. (See 	dical ethics and 20 June 30, 2001. Sub	hours of CME omit your prod	E in your scope of practice or of of completion of CME with
3. If your name and/or address has changed from that printed on	the label on this for	m clearly ind	licate the change in the space
provided below. Also, please indicate your current telephone and	d fax numbers. [Ple	ase note: a no	otarized or certified copy of the
document authorizing your name change (marriage license, divo	orce decree, etc.) m	nust be includ	ed.]
Name			
Street			
CityCounty			7in
Phone Number Fax Num 4. IF YOU HAVE RETIRED OR MOVED YOUR PRACTICE, ind			
4. IF TOO HAVE RETIRED OR MOVED TOOK PRACTICE, HIS	icate the location of	i pauent reco	igs delom:
Name			
Street			
City County	State		Zip
Phone Number			
5. Indicate below the EXACT NAME AND LOCATION of the Med of graduation:	lical School from wi	nich you grad	uated and your EXACT DATE
University of Southern Call	loni	5-5	3-1984
Medical School Name and Lecation	De		tion (Month / Day / Year)

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

SCOPE OF PRACTICE SPECIALTY CODES

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

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;
- 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, epitepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, emotional or mental litness, 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 med safety?	ical condition which	in any way impairs or limits	your ability to practice medicin	e with reasonable skill andNo
			s your ability to practice medi he setting, or the manner in ———————————————————————————————————	
3. If you use chemical and safety?	substances, does y	our use in any way impair o	limit your ability to practice me	edicine with reasonable skill YesNoN/A
	rement of your rece		n one year after the date the prom the federal government of	
5. Have you been a depaid in your behalf or			liability (malpractice) or had a	professional liability claim YesNo
of any federal, state excluding any minor tr	or local faw, includ affic offense (driving nor traffic offense	ing any foreign country, wi por in control of a motor veh	plead guilty or noto contender nich is a misdemeanor, gross icle white under the influence of manufacture, distribution, pro	misdemeanor, or felony, of any chemical substance is
7. Have you ever bee examination to practic	n denied a license, e medicine or any c	permission to practice me ther healing art in any state	dicine or any other healing and, country or U.S. territory?	t, or permission to take anNo
8. Have you ever had any state, country or l		r license to practice any othe	er healing art revoked, suspen	ded, limited, or restricted inNo
9. Have you ever voluterritory?	untarily surrendered	a license to practice media	ine or any other healing art in	any state, country or U.S. No
10. Have you ever be	en denied member	ship or expelled from a med	lical society or other professio	nai medicai organization? No
any violation of a state	ute, ruie or regulatio	on governing your practice	for; b) investigated for; c) chan as a physician by any medica Nevada State Board of Medica	I licensing board, hospital,
12. Have you ever sur	rendered your state	or federal controlled substa	nnce registration or had it revol	ked or restricted in anyway?No
any and all resignatio	ns from any medications for failure to c	al staff in lieu of disciplinary complete hospital medical r	ended, limited, revoked or not r or administrative action. (Ple ecords, attend hospital depart	ease Note: Do not include
	Mailing	Type of		of Action
Hospital	Address	Action	From (Mo./Y	r.) 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 is 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 plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursual to the order.
	,
	CONTINUING MEDICAL EDUCATION (CME) STATEMENT
Ç	Please place a check mark next to one of the following statements:
2.	(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 blennial period of July 1, 199 through June 30, 2001)
	(b) I was initially licensed in Nevada during the time period January 1, 2000 through June 30, 2000, the second simonths 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 month of the past biennial period, and completed a minimum of 20 hours of AMA Category I continuing medical education (CME), 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 month of the past blennial period, and completed a minimum of 10 hours of AMA Category I continuing medical education (CME), a 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 complete 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 PERIOR 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.
	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 HEREM 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

2 | 30 | 300 |

"YES" ANSWER(S).

Date Received by Board PHYSICIAN APPLICATION FOR RENEWAL REGISTRATION APR 2 9 1999 **NEVADA STATE BOARD OF MEDICAL EXAMINERS** File No. Post Office Box 7238 Reno, Nevada 89510 Phone (775) 688-2559 (Board Use Only) hereby apply for renewal of biennial registration and enclose the appropriate fee(s) as indicated below: \$600.00 ACTIVE STATUS \supersection \$200.00 **INACTIVE STATUS** \$ 50.00 RETIRED STATUS SUPERVISING/COLLABORATING PHYSICIAN Adam V. Levy, MD Make checks payable to: 2020 Goldring Ave #404 **NEVADA STATE BOARD OF MEDICAL EXAMINERS** Las Venas NV 89106 (Foreign checks must indicate "U.S. FUNDS") 0008817 **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 County State City_

7. Are you currently active in me	dicine?	1		\ .	
a. [] YES, in trainin	g.	b. [- كر-]	YES, working full-tin	ne	
c. [] YES, working		d.[]	NO, retired.		
e. [] NO, other (spe	cify		•)
6. [] 110, onle (op-	, on y				
8. Please indicate your prima	v secondar	v and tertiary	specialties and perc	ent of practice time spen	t in each, using the
	y, soconda		OF PRACTICE		
following codes:			ALTY CODES		
		0, 20			•
102 ADDICTION MEDICINE	31	NEOPLASTIC D)ISEASES	62 PEDIATRIC, RADIOL	
1 ADOLESCENT MEDICINE	32	NEPHROLOGY		63 PEDIATRIC, SURGE	
2 AEROSPACE MEDICINE		NEUROLOGY		64 PEDIATRIC, UROLO	GY
3 ALLERGY/IMMUNOLOGY		NEUROPATHO		65 PEDIATRICS	EMELIABILITATION
104 ALTERNATIVE MEDICINE	35 3 6	NEURORADIO		66 PHYSICAL MEDICIN	
4 ANESTHESIOLOGY		NUCLEAR MED NUTRITION	NOME	68 PSYCHIATRY	71174
5 BLOODBANKING 6 BRONCO-ESOPHAGOLOGY	-38		SYNECOLOGY	69 PSYCHOANALYSIS	*
7 CARDIOVASCULAR DISEASES	39	OBSTETRICS		70 PSYCHOMATIC MED	DICINE
8 CATSCAN/ULTRASOUND	40	OCCUPATION	AL MEDICINE	71 PUBLIC HEALTH	
9 CHILD NEUROLOGY	41			72 PULMONARY DISEA	SES
10 CHILD PSYCHIATRY			YNECOLOGICAL	73 RADIOLOGY	, 100770
11 CLINICAL PHARMACOLOGY	42	ONCOLOGY, H ONCOLOGY, R		74 RADIOLOGY, DIAGN 75 RADIOLOGY, NUCLI	
12 CRITICAL CARE 13 DERMATOLOGY	43 44			76 RADIOLOGY, THER	
13 DERMATOLOGY 14 EMERGENCY MEDICINE		OPHTHALMOL		77 RHEUMATOLOGY	"
15 ENDOCRINOLOGY	47			78 RHINOLOGY	•
16 FAMILY PRACTICE	48	OTOLOGY		79 SLEEP DISORDERS	
17 GASTROENTEROLOGY	49	PAIN MANAGE		100 SPORTS MEDICINE	
18 GENERAL PRACTICE		PATHOLOGY		80 SURGERY, ABDOM	
19 GERIATRICS		PATHOLOGY, A		103 SURGERY, CARDIO	
20 GYNECOLOGY		PATHOLOGY,		81 SURGERY, CARDIO 91 SURGERY, COLON	
21 HEMATOLOGY 105 HOMEOPATHY		PATHOLOGY, I PEDIATRIC, A		82 SURGERY, GENERA	
105 HOMEOPATHY 22 HYPNOSIS	55	PEDIATRIC, CA	ARDIOLOGY	83 SURGERY, HAND	- .
23 IMMUNOLOGY		PEDIATRIC, CF		84 SURGERY, HEAD/N	ECK
24 INFECTIOUS DISEASES	97	PEDIATRIC, EN	MERGENCY MEDICINE	92 SURGERY, MAXILLO	FACIAL
25 INFERTILITY			(DOCRINOLOGY	93 SURGERY, NEUROL	
26 INTERNAL MEDICINE	57	PEDIATRIC, HE	EMATOLOGY/ONCOLOG		
27 LARYNGOLOGY		PEDIATRIC, IN	FECTIOUS DISEASES	86 SURGERY, PLASTIC 87 SURGERY, THORAG	
28 LEGAL MEDICINE 29 MATERNAL/FETAL MEDICINE		PEDIATRIC, NE		68 SURGERY, TRAUM	
108 MEDICAL ACUPUNCTURE		PEDIATRIC, NE		89 SURGERY, UROLOG	SIC .
107 MEDICAL ETHICS	101	PEDIATRIC, OF	PHTHALMOLOGY	90 SURGERY, VASCUL	
30 NEO/PERINATAL MEDICINE		PEDIATRIC, PH		94 UROLOGY	
	95	PEDIATRIC, PL	JLMONARY		
•	Code	Percent		Board Certified (Indic	ate Yes/No)
Primary	<u> 38 </u>		<u>v </u>	<u>Va-</u>	Televali
Secondary					
Tertiary					
101041,					
PLEASE INDICATE ALL AMER	ICAN BOAL	OF MEDIC	AL SPECIALTIES E	OARD OR SUBBOARD	CERTIFICATIONS:
LETHOR HIDIOKIE WEE WHEN				Date of	Date of
			ter terminal	nitial Certification	Last Certification
Board ABOR			**	1291	
Board 11 3 O 11					745 N-1
				(Mò./Yr.)	(MoJYr.)
Subboard	····				44.44.
				(Mo.Yr.)	(Mo/Yr.)
Board					
				(Mo./Yr.)	(Mo./Yr.)
Subboard					
-				(Mo./Yr.)	(Mo./Yr.)
	1001				
9. Form of employment is	1001	. (Use	one of the following	codes.)	•
SELF-EMPLOYED:				MPLOYED BY: (continue	ed)
1001 Solo Practice				overnment Employer (ho	
_	Dractitioner			emment (armed services	
SALARIED, EMPLOYE				ernment (civilian, P.H.S., e	NG.)
1003 Individual Practitioner			1009 State Govern		
1004 Partnership or Group			4-4	•	
1004 (difficionsh of Giosh	of Practition	ers	1010 County Gover		
1005 Group Health Plan Fo	of Practition acility (such a	ers as H.M.O.)	1010 County Govern 1011 Local Govern		

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:

- 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 paisy, 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 medicin			
and safety?	Yes _	conable	skill _No
. If you have a medical condition which in any way impairs or limits your ability to practice medicine limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which practice?	e, is that im th you hav sNo	e_Cuose	en to
3. If you use chemical substances, does your use in any way impair or limit your ability to practice me skill and safety?	edicine with	reason	able N/A
4. Have you failed to initiate the performance of public service within one year after the date the public begin to satisfy a requirement of your receiving a loan or scholarship from the federal government for your medical education?	entor, ast	ate or o	iocai
5. Have you been a defendant in a legal action involving professional liability (malpractice) or back a propaid in your behalf or paid such a claim yourself?	yes Yes	iability o	laim _No
6. Have you ever been investigated for, charged with, convicted of, or plead quilty or noto content violation of any federal, state or local law, including any foreign country, which is a misdemeanor, greateny, excluding any minor traffic offense (driving or in control of a motor vehicle while under the influence is not considered a minor traffic offense) or which is related to the manufacture, distributions of controlled substances?	pross misde luence of a	emeand ny cher escribin	or, or mical g, or
7. Have you ever been denied a license, permission to practice medicine or any other healing art(s), o examination to practice medicine or any other healing art(s) in any state, country or U.S. territory?	r permissio Yes	n to talk	(е ал No
8. Have you ever had a medical license or license to practice any other healing art revoked, suspende in any state, country or U.S. territory?	ed, limited, Yes	or restr	icted _No
Have you ever voluntarily surrendered a license to practice medicine or any other healing art in an	y state, co Yes_	untry.or	U.S. _No
10. Have you ever been denied membership or expelled from a medical society or other professional	l medical o Yes _	rganiza	tion? _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?				
	YesNo				
	12. Have you ever surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? 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)	-	<u> </u>	
		(Now)			
	(If more space is needed, attach a separate sheet.)				
	PLEASE CHECK ONE	OF THE FOLLOWING:		, right thus	
1	I am not subject to a court order for the support of a child.				
j	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	(SIGN)	TURE STAMP UNACCEPTAE	1 E\	
	forestroit attach type in				
X	PLEASE CHECK ONE OF THE FOLLOWING:				
Y	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 blennial period July 1, 1997, through June 30, 1999.				
	IMPORTANT				
	ATTACH COPIES OF PROOF OF DECLARED OME CREDITS - PROOF OF CME CREDITS WILL NOT BE RETURNED.				
	Signature				
	(SIGNATURE STAMP UNACCEPTABLE)				
	HAVE X HAVE NOT ACTIVELY PRACTICED IN NEVADA WITHIN THE PAST 12 MONTHS. (CHECK ONE)				
	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.				
		. 1	י ייין קייון דיין דיין	*	
	Business Telephone #	Pate	Sknoture (SIGNATURE	STAMP UNACCEPTABLE)	
	Dualites i elejnivite #	Dale	oguđuja (orana i UKE	STAMP OPPOCEP (ABLE)	

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PPLICATION FOR RENEWAL REGISTRAT	TION	Date received by Bo	License No. 6135
NEVADA STATE BOARD OF		MR 241967	The second of th
MEDICAL EXAMINERS ost Office Box 7238 Reno, Nevada 89510 Phone (702)\ 888.2550 [°]	(Board Use Only)	File No.
hereby apply for renewal of biennial registrati			
ACTIVE STATUS INACTIVE STATUS	\$600.00 \$150.00		NEVADA HAS NO GRACE PERIOD. LICENSES NOT RENEWED BY
RETIRED STATUS	\$ 50.00		JULY 1, 1997 ARE AUTOMATICALLY
P.A. SUPERVISING PHYSICIAN	\$200.00		SUSPENDED FOR NON-PAYMENT
·			*
Adam V. Levy, MD			Make checks payable to:
2020 Goldring Ave #404			E BOARD OF MEDICAL EXAMINERS
Las Vegas, NV 89106		(Foreign d	hecks must indicate "U.S. FUNDS")
-		 	
INSTRUCT	TIONS - TYP	E OR PRINT LE	GIBLY
. YOUR CURRENT M.D. LICENSE EXPIRICENSE.		·	
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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

	a. [] YES, in training. c. [] YES, working part-time	b. [d. [YES, working full- NO, retired.	time		
	e. [] NO, other (specify 2. Please indicate your primary, secondary	and tertiary s	pecialties and percen	of time spent in eac	th, using the foi	lowing codes.
		Si	PECIALTY CODE:		•	
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	EASE INDICATE AMERICAN BOARD OF MEDIC	ALSPECIAL	TIES BOARD CERTI	Date of Initial Cer	1	Date of Last Certification
Sul	oboard			(M 6 ./Yr.	,	(Mo./Yr.)
	I mai	an the dellarita		(Mo./Yr.)	(Mo./Yr.)
3.	Form of employment is <u>[O U] (U: SELF-EMPLOYED</u>	se the followin	SALARIED, EMPLOY	(ED BY (continued)		
1	1001 Solo Practice		Other Non-Governm			
1	1002 Partnership or Group Practitioners		Federal Government			
	SALARIED, EMPLOYED BY: 1003 Individual Practitioner	100 8 1009	Federal Government State Government	(CIVIHAN, P.H.S., etc	.)	
	1003 Individual Practitioner 1004 Partnership or Group of Practitioners		County Government			
	1005 Group Health Plan Facility (such as H.M.O. 1012 Other	.) 1011			· · · · · · · · · · · · · · · · · · ·	
	All of the following questions re FOR ALL YES RESPO					

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:

Caniplem at a sites with a manuscript of

- 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
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ALL QUESTIONS ANSWERED 'YES' MUST BE EXPLAINED ON A SEPARATE ATTACHED SHE	m. w
1. Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and s	safety?YesNo
2. If you have a medical condition which in any way impairs or limits your ability to practice medicine is that impairment or limital because of the field of practice, the setting, or the manner in which you have chosen to practice?	tion reduged or ancelloratedNoN/A
If you use chemical substances, does your use of chemical substance(s) in any way impair or limit your ability to practice me and safety?	edicine with reasonable skill YesNoNA
4. Have you failed to initiate the performance of public service within one year after the date the public service is required to be of your receiving a loan or scholarship from the federal government or a state or local government for your medical education.	gin to satisfy a requirement ?YesNo
5. Have you been a defendant in a legal action involving professional liability (malpractice) or had a professional liability claim such a claim yourself?	n paid in your behalf or paid YesNo
6. Have you ever been investigated for, charged with, convicted of, or plead guilty or noto contendere to, any offense or violational law, including any foreign country, which is a misdemeanor, gross misdemeanor, or felony, excluding any minor traffic of a motor vehicle while under the influence of any substance is not considered a minor traffic offense) or which is related to the prescribing, or dispensing of controlled substances?	offense (Driving or in control
7. Have you ever been denied a license, permission to practice medicine or any other healing arts, or permission to take an example or any other healing arts in any state, country or U.S. territory?	nination to practice medicineYesNo
8. Have you ever had a medical ficense revoked, suspended, limited, or restricted in any state, country or U.S. territory?	YesNo
9. Have you ever voluntarily surrendered a license to practice a healing art in any state, country or U.S. territory?	YesNo
10. Have you ever been denied membership or expelled from a medical society or other professional medical organization?	YesNo
11. Have you ever been investigated for charged with, or convicted of any violation of a statute, rule or regulation governing any medical licensing board, hospital, medical society, governmental entity or other agency?	the practice of medicine by
12. Have you ever surrendered your state or federal controlled substance registration or had it revoked or restricted in any w	vay?Yes No
13. List all hospitals where you have had staff privileges denied, suspended, limited, revoked or not renewed by the hospital. from any medical staff in the of disciplinary or administrative action. (Please Note: Do not include suspensions or restrictions for medical records, attend hospital department or staff meetings, or maintain required malpractice insurance). Mailing Type of Dates of Action Hospital Address Action From (Mo./Yr.) To (Mo./Yr.)	failure to complete hospital
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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 blennial June 30, 1997. 2. I was initially licensed in Nevada during the second six months of the blennial period July 1, 1995, through June 3 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 blennial period July 1, 1995, through June 3 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 blennial period July 1, 1995, through June	30, 1997 and have earned a 30, 1997 and have earned a 3, 1997 and have earned a
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A	APPLICATION FOR REGISTRATION RENEWAL NEVADA STATE BOARD OF MEDICAL EXAMINERS Post Office Box 7238 Reno, Nevada 89610 Phone (702) 688-2559	Date Received by State Rouge MAY (E.1. 1995) The states	Section Section 1997
	ACTIVE STATUS \$420 INACTIVE STATUS \$150 (see attached NRS 630.2 RETIRED STATUS \$ 50 (see attached NRS 630.2 P.A. SUPERVISING PHYSICIAN \$200	PLEASE NOTE:	
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2. 3.	YOUR CURRENT M.D. LICENSE EXPIRES ON JUN LICENSE. To be eligible to act as a supervising physician form. ACTIVE STATUS REGISTRATION RENEWAL REQUATEGORY I, CONTINUING MEDICAL EDUCATION Submit your proof of CME with your completed A In order to provide sufficient time for processing tration Renewal form and Application for Approve proof of 40 hours AMA Category I CME and the conself-addressed envelope to return your completed if your name and/or address has changed from the space provided. A notarized or certified copy of license, divorce decree, etc.) must be included.	UIRES THE SUBMISSION COMPleted during July Application for Registration, please complete and real as Supervising Physicorrect fee(s) PRIOR TO it form(s) and fee(s).	on OF PROOF OF 40 HOURS AMILY 1, 1993 through June 30, 1995 thou Renewal form. The turn your Application for Registian form (if applicable) with you JULY 1, 1995. Use the enclosed clearly indicate that change in the
	Street 2020 Goldring Ave City Las Vegas county	Ste 404	00.14
6.	IF YOU HAVE RETIRED OR MOVED YOUR PRACE PATIENT RECORDS BELOW:		· · · · · · · · · · · · · · · · · · ·
	Name		
	Street		•

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.

_____ State ____ Zip Code _

____ County __

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

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

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, seconda codes.				in each, using the following
		SPEC	IALTY COD	E:	
28 29 30 31 32	BLOODBANKING BRONCO-ESOPHAGOLOGY CARDROVASC DISEASES CATSCAN / ULTRASOUND CHILD NEUROLOGY CHILD PSYCHIATRY CLINICAL PHARMACOL CRITICAL CARE DERMATOLOGY EMERGENCY MEDICINE ENDOCRINOLOGY FAMILY PRACTICE GASTROENTEROLOGY GENERAL PRACTICE GENERAL PRACTICE GENERAL PRACTICE GENERAL PRACTICE GENERAL PRACTICE GENERAL PRACTICE INDELNOLOGY HYPNOSS INDELNOLOGY HYPROSS INDELNOLOGY INFECTIOUS DISEASES INFERTAL MEDICINE LARYNGOLOGY LEGAL MEDICINE MATERNAL MEDICINE MATERNAL PETAL MED NEO / PERINATAL MED NEO / PERINATAL MED NEO / PERINATAL MED NEOPHAGITC DISEASES NEPHBOLOGY	35 NEUI 36 NEUI 37 NUTI 38 OBS: 39 OBS: 40 OBS: 41 ONC 41 ONC 43 ONC 44 ONC 44 ONC 46 OPH: 47 OTO 48 PAIN 50 PAIN 51 PAIN 52 PAIN 53 PAIN 54 PED, 97 PED, 97 PED, 58 PED, 97 PED, 58 PED, 98 PED, 60 PED, 61 PED, 61 PED, 61 PED, 61 PED, 61 PED, 61 PED,	RORADIOLOGY LEAR MEDICINI RETRIC / GYNEC RETRICS UPATIONAL ME OLOGY, GYNEC OLOGY, HEMAT OLOGY, SURGE HALMOLOGY LARTNGOLOGY MANAGEMENT IOLOGY, ANATY IOLOGY, ANATY IOLOGY, ANATY IOLOGY, ANATY IOLOGY, ANATY IOLOGY, CLINIC IOLOGY, ANATY IOLOGY, CHINIC IOLOGY, CRINIC IOLOGY, ANATY IOLOGY, CRINIC INTERISTIBLI INTERISTI	E COLOGY D OLOGIC OLOGY TON CAL CAL CAL RED OGY BLOGY BS	64 PED, UROLOGY 65 PEDIATERS 66 PHYSICAL MED / REHAB 96 PHYSICIAN ASSETANT 67 PREVENTIVE MED 68 PSYCHIATEY 69 PSYCHOMATIC MEDICERE 71 PUBLIC HEALTH 72 PULMONARY DISEASES 73 RADIOLOGY, DIAGNOSTIC 75 RADIOLOGY, DIAGNOSTIC 76 RADIOLOGY, THERAPEUT 77 RHEUMATOLOGY 78 BLEEP DISORDERS 100 SPORTS MEDICINE 80 SURGERY, ABDOMINAL 81 SURGERY, CARDIOVASC 91 SURGERY, CARDIOVASC 91 SURGERY, CHAND 84 SURGERY, HEADNECK 92 SURGERY, HEADNECK 93 SURGERY, MANILLOFAC 93 SURGERY, MEUROLOGICAL 85 SURGERY, MEUROLOGICAL 86 SURGERY, PLASTIC 87 SURGERY, TRAUMATIC 89 SURGERY, TRAUMATIC 89 SURGERY, TRAUMATIC 89 SURGERY, UROLOGIC 90 SURGERY, UROLOGIC 90 SURGERY, UROLOGIC
34	MEUROPATHOLOGY MEUROPATHOLOGY		Percer		Certified (Indicate Yes/No)
Sec	condary .				<u>U</u>
	rtiary		wrandrasinsiansia (* 1-10		**************************************
P	PLEASE INDICATE AMERICAN	BOARD OF	MEDICAL	SPECIALTIES BOA	
	Augus Book	~0 O6	5 /Gum	12/9	
Bo	and Timey 13000	<u> </u>	- 	(M&/Ye.)	(Mo/YL)
			V.		
Su	bboard			(Mo/Tr.)	(Me/Ys.)
	How many hours per week do you specific hours Patient care or services hours Administration (schools, Chours Teaching medical courses hours Research hours Other (specify Form of employment is SELF-EMPLOYED 1001 Solo Practice 1002 Partnership or Group Practitic SALARIED, EMPLOYED BY	agencies, asso	ng codes.) 1006 O: 1007 Pc	:.) ther Non-Government Em	ployer (hospital, school, edd services personnel only)

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 tanks 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, epilopsy, muscular dystrophy, multiple scierosis, cascer, heart disease, disbetes, mental retardation, emotional or mental illness, specific learning disabilities, MIV disease, tuberculosis, drug addiction, and alcoholism.

"Chemical substances" in 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.

"Higgs use of controlled dangerous substances" means the use of controlled dangerous substances obtained Higgsily (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 stance all or any part of your medical education?	Q Yes	(2)
2.	Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety?		6.7
3.	Does your use of chemical substance(s) in any way impair or limit your ability to practice medicine with reasonable skill and safety?	C) Yes	XNo
4.	Are the limitations or impeirments caused by your medical condition reduced or ameliorated because of the field of practice, the	F3 W	XX.
	setting, or the manner in which you have chosen to practice?	Q Yes	
5.			Also.
8.	Are you currently engaged in the illegal use of controlled dangerous substances?	C) ICS	A40
7.	Have you been a defendant in a legal action involving professional Hability (malpractice) or had a professional Hability claim paid in		~
	your behalf or paid such a claim yourself?	LJ Yes	XIII
8.	Have you been investigated for, charged with or convicted of, or pied solo contendere to a violation of any federal, state or local		М.
	law relating to the manufacture, distribution, prescribing, or dispensing of controlled substances?	Q Yes	Mo
9.	Have you been arrested, investigated for, charged with or convicted of, or pied noto contenders to any offense, misdemeanor or		1
des.	felony in any state, the United States, or a foreign country?		200
	Have you previously applied for medical licensure in Nevada (including a residency program)?	O Yes	O No
ì.	Have you falled to initiate the performance of public service within one year after the date the public service is required to begin to	Ola	MR (
	satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local government for your	1	
	medical education?	C) Yes	XINO
12.	Have you been denied a license, permission to practice medicine or any other healing arts, or permission to take an		1.
	examination to practice medicine or any other healing arts in any state, country or U.S. territory?	O Yes	ANO
13.	Have you had a medical license revoked, suspended, limited, or restricted in any state, country or U.S. territory?	Q Yes	M o
14.	Have you voluntarily surrendered a license to practice in the healing arts in any state, country or U.S. territory?	O Yes	9790
15.	Have you been desied membership or expelled from a medical society or other professional medical organization?	C) Yes	MNo
16.	List all hospitals where you have had staff privileges (smight, suspended, limited, revoked or not renewed by the hospital. List any and		- •
	all resignations from any medical staff in Heu 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 snalpractic	oe inour	rance.)
	Maliing Type of Dates of Ac	tion	
	· · · · · · · · · · · · · · · · · · ·	to Mio./	YE)
		•	-
	Have you been investigated for, charged with, or convicted of any violation of a statute, rule or regulation governing the practice of	,	
17.		O 444	χ_{λ}
	medicine by any medical licensing board, hospital, medical society, governmental entity or other agency?	C Inc	CX
i 8 .	Have you surrendered your state or federal controlled substance registration or had it revoked or restricted in any way?	A 144	70

CONTINUING MEDICAL EDUCATION

630, 158 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, in the has completed 40 full hours of continuing medical education during the preceding 2 years in one or more educational programs. Each educational gram 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 Linison 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 blennial 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 falls 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 blennial registration otherwise prescribed by subsection 1 of NRS 630.290;
- (b) Submits to the board, in such form as it requires, evidence that be 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 Ed. of Medical Exam'rs, 7-31-85, eff. 8-1-85; A 6-23-86; 11-21-88; 9-12-91)

lease check one of the following:
1. I have carned 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 blennial 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 blennial period July 1, 1993 through June 30, 1995.
(SIGNATURE STAMP UNACCEPTABLE)
IMPORTANT: ATTACH COPIES OF PROOF OF DECLARED CHE CREDITS.
PROOF OF CME CREDITS WILL NOT BE RETURNED.
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 tatements 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.

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, 1984; through June 30, 1995, p se contact the Board office for further instruction.

Signature (SIGNATURE STRIM

630.288 Bienniai registration: Fee; failure to pay fee; revocation and restoration of license; notice to license

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 see for blennial 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.

The board shall notify a liceusee:

(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 (.e United States Department of Justice or its successor agency.

(Added to NRS by 1985, 2223; A 1987, 198)

- 650.255 Inactive licensees: Leaving state; ceasing or falling 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
 - 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.

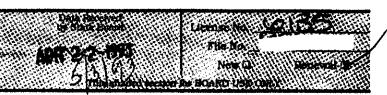
(Added to NRS by 1985, 2222; A 1987, 195; 1993, 2299) 630.256 Retired Hose

- sees; 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 1965, 2222; A 1987, 195)
- tination 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



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

Adam V. Levy, #0
2018 Soldring \$302

Las Vegas

#V \$9186-000

NOTE: NO GRACE PERIOD - LICENSED NOT RENEWED BY JULY 1

ARE AUTOMATICALLY SUSPENDED FOR NON PAYMENT.

Adam V. Levy, #0

2018 Soldring \$302

Las Vegas

#V \$9186-000

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

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 medi	oina?		
1.	.	CIRCI		
	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, secodes:	condary and tertiary spec	laities and percent of time spent	t in each, using the following
		SPECIALT		
	ADOLESCENT MEDICINE AEROSPACE MEDICINE ALLERDY/IMMUNOLOGY ANESTHESIOLOGY BLOODBANKING BRONCO-ESOPHAGOLOGY CARDIOVASC DISEASES CATSCAN/ULTRASOUND CHILD NEUROLOGY CHILD NEUROLOGY CHILD PSYCHATRY CLINICAL PHARMACOL CRITICAL CARE DERMATOLOGY AEMERGENCY MEDICINE DEMOCRINGLOGY FAMILY PRACTICE FAMILY PRACTICE GENERAL PRACTICE HEMATOLOGY HEMATOLOGY HEMATOLOGY INFECTIOUS DISEASES COCIO	25 INPERTILITY 26 INTERNAL MEDICINE 27 LARYNGOLOGY 28 LEGAL MEDICINE 29 MATERNAL/FETAL MED 30 NEO/PERINATAL MED 31 NEOPLASTIC DISEASES 32 NEPHROLOGY 34 NEUROPATHOLOGY 35 NEUROPATHOLOGY 36 NUCLEAR MEDICINE 37 NUTRITION 38 OBSTETRIC/GYNECOLOGY 39 OBSTETRIC/GYNECOLOGY 41 ONCOLOGY, GYNECOLOGIC 43 ONCOLOGY, GYNECOLOGIC 43 ONCOLOGY, HEMATOLOGY 44 ONCOLOGY, HEMATOLOGY 45 ONCOLOGY, SURGICAL 46 OPHTHALMOLOGY 47 OTOLARYNGOLOGY 48 OTOLOGY	49 PAIN MANAGEMENT 50 PATHOLOGY 51 PATHOLOGY, ANATOMIC 52 PATHOLOGY, CLINICAL 33 PATHOLOGY, CLINICAL 33 PATHOLOGY, FORENSIC 54 PED, ALLERGY 55 PED, CARDIOLOGY 56 PED, ENDOCRINOLOGY 57 PED, HEMAT/ONCOLOGY 58 PED, INFECTIOUS DIS 59 PED, INTENSIVIST 60 PED, NEPHROLOGY 61 PED, PHYSIATRY 62 PED, RADIOLOGY 63 PED, SUNGERY 64 PED, UROLOGY 65 PEDIATRICS 66 PHYSICAL MED/REHAB 67 PREVENTATIVE MED 68 PSYCHAARRY 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 80 SURGERY. ABDOMINAL 81 SURGERY. CARDIOVASC 82 SURGERY. COLON/RECTAL 83 SURGERY. COLON/RECTAL 84 SURGERY. HAND 85 SURGERY. HAND 85 SURGERY. HEAD/NECK 86 SURGERY. MEUROLOGICAL 86 SURGERY. NEUROLOGICAL 88 SURGERY. NEUROLOGICAL 89 SURGERY. THORACIC 91 SURGERY. TRAUMATIC 92 SURGERY. VASCULAR 94 UROLOGY
	Primary 58	100 %		,
	•			
	Secondary	•		
	Tertiary			
	PLEASE INDICATE AMERICAN I Board 806 Subboard		CIALTIES BOARD CERTIFICAT	TION:
	•		$t \sim 1$	
3.	How many hours per week do yo	ou spend in each of the fo	llowing activities?	
	18 hours Patient care or se	ervices		
	2 hours Administration (s		tion. etc.)	
	20 hours Teaching medica	•	•	
	2 hours Research	. 0042000		
				1
	hours Other (specify			······································
4.	Form of employment is 1001.	Use the following codes.)		·
	SELF-EMPLOYED		1008 Federal Government (civilian P.	us ato)
	1001 Solo Practice 1002 Partnership or Group Practitioners		1009 State Government	name week
	SALARIED, EMPLOYED BY 1003 Individual Practitioner		1010 County Government 1011 Local Government	
	1004 Partnership or Group of Practitioners 1005 Group Health Plan Facility (such as I	f.M.O.)	1012 Other (specify	
	1006 Other Non-Government Employer (ho 1007 Federal Government (armed services	spital, school, etc.)		

RE	i of the following questions refer to the time period of July 1, 1991, through the present date onl ESPONSES, PLEASE EXPLAIN ON A SEPARATE SHEET AND RETURN WITH THE RENEWAL APPLICA	y. FOR AL VIION,	L YES
5.	Have you been rejected for membership by any medical society?	Yes 🔾	No b
	Have you been denied a license to practice medicine?	Yes 🔾	No/C
	Have you been denled staff membership with any licensed hospital, nursing home or other hospital care facility with an organized medical staff?	Yes 🔾	No D
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 Q	No S
	Have you lost American Board certification because of disciplinary action? 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	Yes 🔾	NoYQ
	against you?	Yes 🔾	No E
	.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 S
	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 S
13	Have you been diagnosed or treated for any physical illness that would serve to hinder your ability to practice medicine?	Yes 🔾	мо/Ф
14	. Have you been diagnosed or treated for mental illness?	Yes 🔾	No Si
15	.Have you been chemically dependent?	Yes 🗀	No/Q
16	.Have you interrupted your training because of illness or impairment?	Yes 🔾	No∕Ø,
	Have you been unable to practice medicine because of illness or impairment?	Yes 🔾	No S
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		7
	moral turpitude?	Yes 🔾	No S
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 S
21	.Have you been denied provider participation in any State Medicaid or Federal Medicare Program?	Yes 🔾	No Q
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):	/ 4.1.	1 2 012
	Name Address	<u> </u>	330
	7110 The all 30258 Solo a Blood !!	V 111	/ catil
	Name Address	IN	3 DIE
	Name Address On Address On	LYN	180110
	Vally Hospital address Stader Loure (U)	UV 8	201/04
	CONTINUING MEDICAL EDUCATION		
€	330.153 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 additional 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. 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 TIPICATES OF DECLARED CME CREDITS IMPORTANT: ATTACE COME Social Security Number: Date of Birth: month/day/year DEA Number: Medical School: City City Residency: City State City City State Fellowship: State City 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. HAVE NOT O ACTIVELY PRACTICED IN NEVADA WIPHIN THE PAST Business Telephone #

APPLICATION FOR REGISTRATION

NEVADA STATE BOARD OF MEDICAL EXAMINERS



ast Office Box 7238 Reno, Nevada 89610 Phone (702) 329-2559 ereby apply for certificate of biennial registration and enclose the appropriate fee as indicated below: tsaoo.oo √ A ACTIVE STATUS NOTE: NO GRACE PERIOD - LICENSES NOT RENEWED BY JULY 1 ARE AUTOMATICALLY SUSPENDED FOR NON PAYMENT \$150,00 I INACTIVE STATUS \$ 50,00 CI RETIRED STATUS NRS630 explanation of status on reverse side 0008817 Adam V. Levy, MD 6038 E Mirror Lake Dr NV 89110-0000 Las Vegas Social Security 4 NAME **BUSINESS OR MAILING ADDRESS** If you have retired or moved your practice, please indicate the location of **BOARD OF CERTIFICATION** former patient's records for the last 5 years below: MAME AM. Rd. of **DDRESS** Date of Certification or Recertification. PHONE # (Sub-Specialties: Primary Specialty (List only one). 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. Lunderstand, that the IME requirement is mandated by NRS 630.253 and NAC 630.153. Signature: SINCE YOUR LAST REGISTRATION: (If any question is answered "yes, attach a detailed explanation.) 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 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 Yes □ NoV 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 the of disciplinary or administrative action, excluding failure to compete medical records? 2. Have you been arrested, fined (over \$100), charged with or convicted of a crime, indicted, imprisoned or placed on probation? Yes \square No \square 3. Have you been investigated, arrested, charged or convicted for the possession, use of, or illegal sale or dispensing of controlled substances?

Yes
No Sile 6. Have any maipractice 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) ertify that all my statements in this application are true. I have to have not mactively practiced in Nevada within the past 12 months. (Check one

(No nubber stamps)

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

by State Board

License No. 4/85

File No:___ New Lac

Date I Dec 90

Renewal []

This shided section for BOARD USE ONLY

creby apply for certificate of biennial registration and enclose the appro	priate fee as indicated below:
ACTIVE STATUS S200.00 / SU, M	
	O GRACE PERIOD — LICENSES NOT RENEWED BY JULY 1 E AUTOMATICALLY SUSPENDED FOR NON PAYMENT
© RETIRED STATUS \$ 50.00	
N	RS630 explanation of status on reverse side
<u> </u>	
'	Militig Ellecoks payable to:
	Pureles Charles man indicate 112 51902
1775.00.F3	INT LEGISCH
NAME LEVI Adam V	incent
IV111	iddle Bustness Phone ()
1020 - 11	
BUSINESS OR MAILING ADDRESS 6038 E Mirror Street Address of P.O. Box	
CHECK PRINTED OF IT COLUMN	State No. City State Zip Code
If you have retired or moved your practice, please indicate the location of former patient's records below:	BOARD OF CERTIFICATION
NAME	YesNo
*ADDRESS.	AM. Bd. of
PHONE * ()	Date of Certification or Recertification
11010	
Primary Speciality (List only one)	Sub-Specialties:
I certify that within the past 24 months, I have completed a minimum of in my files documentation of such. I understand that the CME requirement	40 hours of Continuing Medical Education, AMA-Category 1 and that I have ent 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," atta 1. Have you been investigated, charged or convicted of unprofessional	ch a detailed explanation.) 4. Have you been denied a medical license or surrendered your license
conduct, professional incompetence or gross or repeated malpractice by any medical licensing board or other agency, hospital or medical	to practice in another jurisdiction or had your medical license revoked.
society? Yes [] No [3],	suspended or limited in another jurisdiction. Yes No S
2. Have you been arrested, fined (over \$100), charged with or convicted of a crime, indicted, imprisoned or placed on probation? Yes \(\text{No.} \)	 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
3. Have you been investigated, arrested, charged or convicted for the possession, use of, or illegal sale or dispensing of controlled substances?	medical records? Yes I No IS 6. Have any malpractice settlements, awards or judgments been made
Yes □ No V	against you in any jurisdiction?
STAFF PRIVILEGES: List all Nevada Hospitals in which you have any stal	f privileges: (Name and Location)
1	4
	5.
3	6
ertify that all the above statements are true and that I have netively pro	etteed in Nevada Within the past 12 months.

(N) rubber stuppes

Nevada Medical Professional Liability Closed Claim Report OCT 2 0 2004 NEVADA STATE BOARD I. Background AL EXAMINERS 1. Name of Insurer 2. Insurer Claim No. American Physicians Assurance Corporation 19155-01 3. Injury Date (Date of Loss) 4. Report Date S. Ciberry Date 3/19/2002 8/22/2002 6. Policy Type (choose a, b, or c) Occurrence b) _x_ Claims made 7. Policy Limits (Per Claim/Aggregate) \$_1M /\$ 3M 8. Date This Closed Claim Repor 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 First M.I. Credentials (e.g. MD, DO, DMD, DDS) Levy Adam 2. License Number 3. Specialty 4. Co-Defendant(s)? 6135 Description _OB/GYN **ISO Code** X_Yes __ No __ Unknown 5. Number of Co-Defendant(s): _2_ or Unknown 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 Figt M.I. 2. Sex: __ Male _X_ Female 3. Age 4. Date of Birth (MM/DD/YY) 5. Malpractice code (per Appendix 1): 6. Injury Code (per appendix 2): 7. Description of Alleged Malpractics and Injuries (Attach Additional Sheet(s) if Necessary.) The patient suffered 2nd and 3rd degree burns to her lable and perenium from a hot weighted speculum used in surgery. 8. City Where Injury Occurred 9. Name of Institution (If Injury Occurred in Institution) Las Vegas 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 Maloractice? 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 Highest last \$7001.00 \$8,750,00 \$7,500.00 VII. Claim Disposition (Attributed to this Defendant Only) 1. Claim Disposition a) ___ Decided By Trial b) ___ Decided By Trial Decided by c) Decided by (check one) in Favor of Plaintiff in Favor of Defendant Arbitrator in Favor of Arbitrator in Favor of Plaintiff Defendant e) _X_ Settled w/o f)___ Claim Denied g) ___ Claim Inactive Claim h) __ Other Court or Prior to Trial Withdrawn 2. If Claim Disposition is e, f, g, h or i, Please Explain: Settlement was negotiated before the panel answer was even prepared.

Farm MOOT 4400

Name of Your										Н	EC
Name of Insurer American Physics	ane Assume				Ins	Urer	d misC	lo.	·		
American Physicians Assurance Corporation Defendant's Name (Last, First, M.I.) Levy, Adam				n 19155-01					OCT 2		
				Date This Closed Claim Report Submittell EVAD					ADA STA EDICAL E		
VIII. Verdict Info	mation (Attri	buted to All D	سواما	.da.e.							
1. Verdict Awarded \$	or_	X_ N/A	47 67 j		In Cas				····		
				···			·····			·	
DK. Claim Informa	tion (Amounts	Attributed to	o this	s Defe	endant :	Onh	. If h	lultinia	Defea	famile 1	
N/A		₩ _A_	**	Z. V	eruict or	Sett	ement :	Paid \$50	,000.00	or (WA
3. Reasons for Amount	Awarded (1) Not	Daine Crust to A		1							-
i) Post Verdict Sett i) Non-economic d i) Other (Explain)	lement b) Ai amages limited by	ward Reduced to Judge to \$350,	Prese 000	nt Valu	le c) Award Ca	Inte	rest Av	rarded d lige at Po	lien One, i) Cou dicy Limit	ir Applicad irt Costs Av	ie) vanded
1. How Will/Dld Plaintiff	Receive	a) _X Lump	Sum		Ты	Davis	ville De	ments		***	
ayments ?		1							(c)	N/A	
. If Periodic Payments,	what is the Prese	ent Value (as of I)ate o	Awan	d) of the	Рауп	ents?	\$			
Sources of Award	a) Company \$7,5	00.00	b) 0)efenda	nt \$			c) O	her (deer	ribe) \$42,5	20.00
. Allocated Loss Adjusti	nent Expenses	Total \$0	<u> </u>		A 444	. J- =	35	Was	paid by o	-defendant	3
		, com 40			Attorne	173 Fe	es \$0		Other \$0		
C. Cinina Yadirana 22	·										j
<i>C. Claim Informatic</i> . Co-Defendant's Name	<i>I (Amounts A</i>	stributed to	Other	r Defi	endent:						
-			1 1783	X		M.	r	Credent DO	iels (e.g.	M.D., D.O)	
License Number	3. Specialty Description		•	···········		- ^		dict Awa			
	vescription			ISO Co	de	-	a)	Yes b	_X No	c)	1
Settlement Made Yes_b)No_c) V 161			6. Ven	dict or Se	ttlem	Unkno ent Aw	rarded s	<u> </u>	or_X_	
)_XUnknown		L	N/A					-		
Co-Defendant's Name	Last		Firs	ŧ		T M.I		Credent	ale (a a h	1.D., D.O)	
License Number	3. Specialty		<u></u>							·····, v.u)	
	Description		1	SO Cod	fe	_	7. Ven a) _	fict Awai	Ma.) Uniter	
Settlement MadeYes_b)No_c	Unknown				act or Se	ttlern	ent Awa	orded :		or	
Co-Defendant's Name	Last								, , , , , , , , , , , , , , , , , , , 		
			First			ILM	· T	Credentia	is (e.g. M	.D., D.O)	
License Number	3. Specialty Description					<u> </u>	4. Verd	lct Awan	ded		
Settlement Made	rescribation			50 Cod	_	_	a)	Yes b)	No c	Union	own
Yes b) No c)	Unknown		- 19	o. Verdi	ict or Set	derne	nt Awa	rded \$		or	
Co-Defendant's Name							******	····			
	Last		First			M.I.	1	redentia	is (e.g. M.	D., D.O)	
License Number	3. Specialty		<u></u>			14		ct Award			
Settlement Made	Description			O Code		_ 8) <u> </u>	res b)	No c)	Uniono	win
Yes b) No c)	Unknown		6	i. Verdi	ct or Sett	leme	nt Awa	rded \$	<u>`</u>	or !	
ttach Additional Si		essary.)	<u></u> -	· · · · · · · · · · · · · · · · · · ·	·						
. Closed Claim Re	port Inform	ation									
Contact Person's Name (stan, Suzannah	Last, First)		7	Na	me of Per	mon i	Lesnor	ethle for	Dennet /1	est, First)	
•]	L	<u>790</u>	51	فحر	- Sc	70~~	Jah	
iontact Person's Phone (5) 796-3414	vumber ((999) 99	9-9999}	1	Sig	ustrue of	Pers	on Res	ponsible	for Report		
ontact Person's Address	•		-	<u> </u>	me	12	<u></u>	<u>. 19</u>	لحسيه		
9 Jefferson Street NE, S Iquerque, New Mexico 8	uite 410										
4pe 4pe, rew Mexico 8	/10 9		1								

<u> </u>								MEVADA AREDICA			
Name of Insurer Natio	onal Fire & Marine	Insurance Comp	any	Inst	rer	Claim No.	1005	300 TOCA			
Defendant's Name (Las Levy, Adam V.	Defendant's Name (Last, First, M.I.) Levy, Adam V.				Date This Closed Claim Report Submitted 4/6/2011						
VIII. Verdict Infor	mation (Attri	buted to All D oor X N/A	efenda	nts in Cas	9)						

D. Claim Informat	don (Amount	Attributed to	this D	efendant (On!	v. If Mul	tiole	Defendants)			
1. Vertice or Semement	Awarueo <u>\$20.0</u>	<u>uu</u> orr	V/A 2	. Verdict or :	Setti	ement Pai	d <u>\$20</u>	.000 or N/A			
Reasons for Amount / a) Post Verdict Settle Non-economic da	INSTRUCTION AWARDS	ard Kerkinea in Di	nocent V	7 موراد	-			Annual Annua			
(EXDIAIN)						-		•			
4. How Will/Did Plaintiff Payments?		I					ents	c) N/A			
5. If Periodic Payments,	What is the Pres	ent Value (as of D	ate of A	ward) of the	Payr	nents? \$					
6. Sources of Award Payments			٠,	endant \$			c) O	ther (describe) \$			
7. Allocated Loss Adjustr	nent Expenses	Total \$13,884.6	5	Attorne \$13,534				Other \$350.37			
X. Claim Informatio	n (Amounts)	Ittelbestud to c	Mhar t	Zallandana.	. 1						
1. Co-Defendant's Name	Last		First	e/e/scal/ta		I.I. C	reden	tials (e.g. M.D., D.O)			
2. License Number	3. Spedaity Description		ISC) Code		4. Verdic	ct Awa	nded)No c)Unknown			
5. Settlement Made a) Yes b) No c) Unknown		6.	Verdict or Se	ttler	nent Awar	ded	\$ or N/A			
1. Co-Defendant's Name	Last		First		М	.I. Cr	edent	lais (e.g. M.D., D.O)			
2. License Number	3. Specialty Description		iso	Code		4. Verdic		rded)No_c)Unknown			
5. Settlement Made a) Yes b) No c) Unknown		6.	Verdict or Se	ltier	nent Awar	ded	or N/A			
1. Co-Defendant's Name	Last										
			First	·	M.	L Co	edenti	als (e.g. M.D., D.O)			
2. License Number	3. Speciarcy Description	•	ISO	Code		4. Verdici		rded No c) Unknown			
5. Settlement Made a) Yes b) No c)	Unknown			Verdict or Set	tlen	ent Award	led (or N/A			
Co-Defendant's Name	Last		First		М	r I.c.					
2. License Number	3. Specialty		1434		М.			als (e.g. M.D., D.O)			
	Description			Code		4. Verdici a)Ye	s b)	No c) Unknown			
5. Settlement Made a) Yes b) No c)	Unknown		6. \	Verdict or Set	tiem	ent Award	led \$	orN/A			
(Attach Additional Si	heet(s) if Nec	essary.)									
XI. Closed Claim R		nation									
1. Contact Person's Name Prudiow, Pamela				Name of Po	rsoi	n Responsi la	ible fo	r Report (Last, First)			
2. Contact Person's Phone (800) 463-3776 X6370	Number ((999) 9	99-9999}	1	<u>_</u>		-	onsible	e for Report			
3. Contact Person's Addres 5814 Reed Road Fort Wayne, IN 46835	s			Lington Land	-Æ	 -					

Nevada Medical Professional Liability Closed Claim Report

I. Background							
1. Name of Insurer	The Doctors'	Company			2. Insurer	Claim No: 1063	64A
3. Injury Date (Date	of Loss) 5/17	/95	4. Rep	ort Date 8/15/96		5. Closure i	Date 3/1/07
6. Policy Type (cho	ose a, b, or c)	a)	Occurren	ice b) Claims ma	de c) X	Tall/Reporting	Endorsement
7. Policy Limits (Per	Claim/Aggregi	ste) \$1M	/\$3M		Date Th	is Closed Claim I	Report Submitted
9. Type of Report (c	hoose a or b)	a) X Init	al Repor	t b) Updated	3 <u>/30/07</u> Report		
II. Defendant &	Co-Paris	la colle					
1. Defendant's Name				First Adam	M.I.	Credentials (e.g. MD, DO, DMD, DDS)
2. License Number	<u></u>	3. Special			1	M.D. 4. Co	-Defendant(s)?
i. Number of Co-Def	endant(s): 3	Obstetrics	/ Супесо	ogist		Yes	
i. Name, License Nu	mber and Insu	rer of Each (Co-Defen	dant, if known.			<u> </u>
(enneth Turner, M.D Rogers Diagnostics –	PULIC 🗢	•		•		,	· C
St. Anna Birthing Cer Shelly Hooper, CNMV	ter					10	190 E/L
resty mouper, Cherry		,					APP OF THE CE IVE
II. Infured & In					•		TO THE PARTY OF
. Injured Party's Nar	ne Last			Firs	М	.I. 1. Sex f	ernale Ge
Age Date of	of Birth -		5. Malpr	actice code (per App	endix 1):		(per appendix 2):
Description of Alleg	ed Malpractic	and Inturie	s (Attac	h Additional Sheet	s) if Neo	Bth essarv.)	
irain damaged in	fant as a re	sult of a r	nisinter	pretation of son	ogram f	Indings, resu	iting in clearance to
eliver the patien Oty Where Injury (caca pirmi	ng center.)	9. Name of Insti			:
1				St. Anna Birthing	Center	IIIJUIY OCCUITING	in institution)
V. Medical/Dent	el Screenin	g Panel (l	lereeft.	er. Panel)			
Case Filed with Pan	el?X Yes No,			ANSWER QUESTION	NS 2 AND	3)	
Panel Case Number 96-07-1197							
Panel Decision: Is to Yes b) X No c) Una	nere Reasonal sble to Decide	ole Probability	of Malp	ractice? Id e) Other - withdra			
					MU DELOLG	panel met	
Court Case Filed Aft	er Panel Decis	ion X Yes_	No _	Unknown			
Court Case		,				· · · · · · · · · · · · · · · · · · ·	
Court Case Filed? X	Yes,No,U	inknown (IF '	YES, ANS	WER QUESTIONS 2	- 7)		
Court Case Number		3. Co	art Name			. Court Departm	ent Number
61891 Date Court Case Wa	Fled 6	Eighti Date Vertir	Judicial	District led, if Applicable			
9/97		/23/01	A 1103 I R	eu, « Appicable	7. Date S	ettlement Offer /	Accepted, if Applicable
. Reserves (Ame	ounts Attrib	vited to M	is Det	ndant Only, If A	Certolaria -	Defends	· · · · · · · · · · · · · · · · · · ·
A. IVERUITUE	Initial	\$100,000		Highest \$1,000,000))	Last \$1,000	.000
0.00						75,700	
II. Claim Disposi	tion (Attrib	uted to th	is Defe	ndent Only)			. ——
Claim Disposition neck one)	a) _X De Trial in Fav	ecided By	a) D	ecided By Trial in	b) Deck		c) Decided by
	Plaintiff		ravol	of Defendant	Arbitrato Plaintiff	r in Favor of	Arbitrator in Favor of
Settled w/o Court or	e) Claim	Denied	n) a	im Inactive		Withdrawn	Defendant b) Other

Form NDOI-1102

2	. If C	laim Disposition is e, i	f, g	or j, Please E	xplain

Reasons for Amount Awarded (1) Post Verdict Settlement b)	Levy, Adam tipibuted to All unts Attributed Not Being Equal to Award Reckneric	to this De	ts in Case) fendant Only, 17 M	d Claim Report Submitted 3/30/07			
VIII. Verdict Information (A. Verdict Awarded 5,000,000 IX. Claim Information (Amo. Settlement Awarded) R. Reasons for Amount Awarded (1) Post Verdict Settlement b)	ttributed to All units Attributed Not Being Equal to Award Reduced to	to this De	ts in Case) fendant Only, 17 M				
1. Verdict Awarded 6,000,000 IX. Claim Information (Amo 1. Settlement Awarded 3. Reasons for Amount Awarded (1) a) Post Verdict Settlement b)	Not Being Equal to	to this De	fendant Only, If M	uitiple Defendants)			
1. Verdict Awarded 6,000,000 IX. Claim Information (Amo 1. Settlement Awarded 3. Reasons for Amount Awarded (1) a) Post Verdict Settlement b)	Not Being Equal to	to this De	fendant Only, If M	uitiple Defendants)			
Reasons for Amount Awarded (1) Post Verdict Settlement b)	Not Being Equal to Award Reduced t	2. 9	<i>fandant Only, 17 M</i> Settlement Pald	ultiple Defendants)			
Reasons for Amount Awarded (1) Post Verdict Settlement b)	Not Being Equal to Award Reduced t	2. 9	Settlement Paid				
a) Pusk vertakt semement o)	AWAND Keninen t	Amount Dald	2. Settlement Palid				
g) X Other (Explain) Judgment Pa	EG DV JUDGE 10 535	io Present Va 0.000 n	(2), if Applicable (Cher kue c) _ Interest Awan Award Capped by Juc	أواد أوسعيك والمساها المساها			
4. How Will/Did Plaintiff Receive Payments ?	1 '	X Lump Sum b) _X_ Periodic Pa					
5. If Periodic Payments, What is the	Present Value (as of	Date of Awa	ard) of the Payments?	\$951,953.32			
Payments	рапу Х	b) Defen	dant \$	c) Other (describe) \$			
7. Allocated Loss Adjustment Expens	es Total \$840,78	32	Attorney's Fees \$750,500	Other \$90,282			