COPY

BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

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In The Matter of Charges and
Complaint Against
Frank Silver, M.D.,
Respondent.

NO. Case No. 06-4041-1
FILED 13 July 2006
EXECUTIVE DIRECTOR

COMPLAINT

The Investigative Committee of the Board of Medical Examiners of the State of Nevada, composed of Sohail U. Anjum, M.D., Chairman, Mrs. Marlene J. Kirch, Member, and S. Daniel McBride, M.D., Member, by and through Lyn E. Beggs, Deputy General Counsel for the Nevada State Board of Medical Examiners, having a reasonable basis to believe that Frank Silver, M.D., hereinafter referred to as "Respondent," has violated the provisions of NRS Chapter 630, hereby issues its formal Complaint, stating the Investigative Committee's charges and allegations, as follows:

1. Respondent is currently licensed in active status, and at all times alleged herein, was so licensed by the Nevada State Board of Medical Examiners, pursuant to the provisions of Chapter 630 of the Nevada Revised Statutes.

2. Patient A was a thirty-year-old female at the time of the incident in question. Her true identity is not disclosed to protect her privacy, but her identity is disclosed in the Patient Designation served on Respondent along with a copy of this Complaint.

3. Patient A initially presented to Respondent in September 2004 and Respondent performed a total abdominal hysterectomy on Patient A in October 2004.

4. Subsequent to the surgery, Patient A developed discomfort on her right side which was suspected to be an ovarian cyst and/or adhesions. Diagnostic laparoscopy with possible aspiration of

the ovarian cyst with lysis of adhesions was recommended after failing to resolve Patient A's symptoms with anti-inflammatory medications.

5. Patient A underwent the recommended surgical procedure on June 17, 2005, during which lysis of the adhesions was completed as well as drainage of the right ovarian cyst.

6. Patient A began experiencing abdominal pain and illness on June 18, 2005, and presented to the emergency room at North Vista Hospital on June 19, 2005, with these symptoms. Patient A's condition worsened and an exploratory laparotomy was to be performed, however, Patient A expired before undergoing surgery.

7. An autopsy was performed which stated the cause of death to be fibrinous peritonitis due to perforation of the sigmoid colon during the laparoscopic procedure and made the specific finding that the sigmoid colon showed an open defect with darkened, curled, and what appear to be, burnt edges.

Count I

8. All of the allegations in the above paragraphs are incorporated herein as if set forth in full.

9. Respondent was overly aggressive in his efforts to lyse Patient A's adhesions resulting in an injury to the sigmoid colon and thus his care of Patient A fell below the accepted standard of care.

10. Respondent's failure to provide Patient A with the accepted standard of care constitutes malpractice and thus violates Section 630.301(4) of the Nevada Revised Statues.

11. By reason of the foregoing, Respondent is subject to discipline by the Nevada State Board of Medical Examiners as provided in Section 630.352 of the Nevada Revised Statutes.

Count II

12. All of the allegations in the above paragraphs are incorporated herein as if set forth in full.

13. Respondent failed to recognize the injury to Patient A's sigmoid colon during the laparascopic procedure and take immediate action to repair the injury and thus his care fell below the standard of care.

14. Respondent's failure to provide Patient A with the accepted standard of care constitutes malpractice and thus violates Section 630.301(4) of the Nevada Revised Statues.

15. By reason of the foregoing, Respondent is subject to discipline by the Nevada State Board of Medical Examiners as provided in Section 630.352 of the Nevada Revised Statutes.

WHEREFORE, the Investigative Committee prays:

1. That the Nevada State Board of Medical Examiners fix a time and place for a formal hearing;

2. That the Nevada State Board of Medical Examiners give respondent notice of the charges herein against him, the time and place set for the hearing, and the possible sanctions against him;

3. That the Nevada State Board of Medical Examiners determine what sanctions it determines to impose for the violation or violations committed by Respondent;

4. That the Nevada State Board of Medical Examiners make, issue and serve on Respondent its findings of facts, conclusions of law and order, in writing, that includes the sanctions imposed; and

5. That the Nevada State Board of Medical Examiners take such other and further action as may be just and proper in these premises.

DATED this 7th day of July, 2006.

INVESTIGATIVE COMMITTEE OF
THE NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____
Lyn E. Beggs
Attorney for the Investigative Committee of the Nevada
State Board of Medical Examiners

VERIFICATION

STATE OF NEVADA)
: ss.
COUNTY OF CLARK)

SOHAIL U. ANJUM, M.D., having been duly sworn, hereby deposes and states under penalty of perjury that he is the Chairman of the Investigative Committee of the Nevada State Board of Medical Examiners that authorized the complaint against the Respondent herein; that he has read the foregoing Complaint; and that based upon information discovered in the course of the investigation into a complaint against Respondent, he believes that the allegations and charges in the foregoing Complaint against Respondent are true, accurate, and correct.

DATED this 12th day of July, 2006.

SOUHAIL U. ANJUM, M.D.

ORIGINAL

BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

* * * * *

In The Matter of Charges and Complaint Against Frank Silver, M.D., Respondent.

NO. _____

FILED Case No. 06-4041-1 8 Dec 06

_____
EXECUTIVE DIRECTOR

AMENDED COMPLAINT

The Investigative Committee of the Board of Medical Examiners of the State of Nevada, composed of Sohail U. Anjum, M.D., Chairman, Mrs. Marlene J. Kirch, Member, and S. Daniel McBride, M.D., Member, by and through Lyn E. Beggs, Deputy General Counsel for the Nevada State Board of Medical Examiners, having a reasonable basis to believe that Frank Silver, M.D., hereinafter referred to as "Respondent," has violated the provisions of NRS Chapter 630, hereby issues its formal Amended Complaint, stating the Investigative Committee's charges and allegations, as follows:

1. Respondent is currently licensed in active status, and at all times alleged herein, was so licensed by the Nevada State Board of Medical Examiners, pursuant to the provisions of Chapter 630 of the Nevada Revised Statutes.

2. Patient A was a thirty-year-old female at the time of the incident in question. Her true identity is not disclosed to protect her privacy, but her identity is disclosed in the Patient Designation served on Respondent along with a copy of this Complaint.

3. Patient A initially presented to Respondent in September 2004 and Respondent performed a total abdominal hysterectomy on Patient A in October 2004.

4. Subsequent to the surgery, Patient A developed discomfort on her right side which was suspected to be an ovarian cyst and/or adhesions. Diagnostic laparoscopy with possible aspiration of

the ovarian cyst with lysis of adhesions was recommended after failing to resolve Patient A's symptoms with anti-inflammatory medications.

5. Patient A underwent the recommended surgical procedure on June 17, 2005, during which lysis of the adhesions was completed as well as drainage of the right ovarian cyst.

6. Patient A began experiencing abdominal pain and illness on June 18, 2005, and presented to the emergency room at North Vista Hospital on June 19, 2005, with these symptoms. Patient A's condition worsened and an exploratory laparotomy was to be performed, however, Patient A expired before undergoing surgery.

7. An autopsy was performed which stated the cause of death to be fibrinous peritonitis due to perforation of the sigmoid colon during the laparoscopic procedure and made the specific finding that the sigmoid colon showed an open defect with darkened, curled, and what appear to be, burnt edges.

Count I

8. All of the allegations in the above paragraphs are incorporated herein as if set forth in full.

9. Respondent was overly aggressive in his efforts to lyse Patient A's adhesions resulting in an injury to the sigmoid colon and thus his care of Patient A fell below the accepted standard of care.

10. Respondent's failure to provide Patient A with the accepted standard of care constitutes malpractice and thus violates Section 630.301(4) of the Nevada Revised Statues.

11. By reason of the foregoing, Respondent is subject to discipline by the Nevada State Board of Medical Examiners as provided in Section 630.352 of the Nevada Revised Statutes.

WHEREFORE, the Investigative Committee prays:

1. That the Nevada State Board of Medical Examiners fix a time and place for a formal hearing;

2. That the Nevada State Board of Medical Examiners give respondent notice of the charges herein against him, the time and place set for the hearing, and the possible sanctions against him;

3. That the Nevada State Board of Medical Examiners determine what sanctions it determines to impose for the violation or violations committed by Respondent;

4. That the Nevada State Board of Medical Examiners make, issue and serve on Respondent its findings of facts, conclusions of law and order, in writing, that includes the sanctions imposed; and

5. That the Nevada State Board of Medical Examiners take such other and further action as may be just and proper in these premises.

DATED this 19th day of December, 2006.

INVESTIGATIVE COMMITTEE OF
THE NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: Lyn E. Beggs
Lyn E. Beggs
Attorney for the Investigative Committee of the Nevada
State Board of Medical Examiners

VERIFICATION

STATE OF NEVADA)
: ss.
COUNTY OF CLARK)

SOHAIL U. ANJUM, M.D., having been duly sworn, hereby deposes and states under penalty of perjury that he is the Chairman of the Investigative Committee of the Nevada State Board of Medical Examiners that authorized the complaint against the Respondent herein; that he has read the foregoing Complaint; and that based upon information discovered in the course of the investigation into a complaint against Respondent, he believes that the allegations and charges in the foregoing Complaint against Respondent are true, accurate, and correct.

DATED this 8th day of December, 2006.

SOHAIL U. ANJUM, M.D.

BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

* * * * *

In The Matter of Charges and Complaint Against FRANK SILVER, M.D., Respondent.	NO. Case No. 06-4041-1 FILED 24 June 2008 EXECUTIVE DIRECTOR

ORDER OF DISMISSAL

The above-entitled matter came on regularly for decision before the Nevada State Board of Medical Examiners, hereinafter "Board," on June 13, 2008, at the Board's Offices located at 1105 Terminal Way, Reno, Nevada, on the complaint filed herein pursuant to Nevada's Open Meeting Laws, NRS and NAC chapters 630, and NRS .Chapter 233B. Neither Frank Silver, M.D.("Respondent") nor his attorney, John Cotton, Esq., were present for the proceedings.

The members of the Board participating in the decision were Jean Stoess, M.A., Cindy Lamerson, M.D., Benjamin Rodriguez, M.D., Charles Held, M.D. and Javaid Anwar, M.D. Rene West was absent and thus did not participate in the adjudication of the matter. All other remaining members of the Board, being members of the Investigative Committee that issued the complaint in this matter, were excused from participating and took no part in the proceedings of the Board.

The Board having received and read the Synopsis of the Hearing Officer of the hearing conducted in this matter, having received and read a copy of the hearing transcript, and having been provided with the complaint and exhibits in this matter, and having reviewed and read all the above, proceeded to make a decision pursuant to the provisions of NRS 630.352.

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The Board, after due consideration of the record, evidence and law, and being fully advised in the premises, hereby finds Respondent not guilty of the count alleged against him in the above identified matter.

IT IS HEREBY ORDERED that the complaint against Frank Silver, M.D., is hereby dismissed.

Done in open session this 13th day of June, 2008.

Javaid Anwar, M.D., President
Nevada State Board of Medical Examiners

INSURER: **ST. PAUL MEDICAL LIABILITY INSURANCE COMPANY**
PHOENIX MEDICAL OFFICE - 02A
8900 N 22nd Avenue
Apt/ste 300
Phoenix, AZ 850216018

NEVADA STATE BOARD OF
MEDICAL EXAMINERS
P.O. Box 7238
Reno, NV 89510

Claim No.: DM06628927-02A001/YY00152 **Date:** January 31, 2002

Date of Loss: November 8, 1996
Date Suit Filed: September 30, 1998
Date of Claim: November 3, 1998
Date Closed: January 17, 2002

MLSP Complaint No: L98-10-1574
Findings: Reasonable probability of malpractice.
Other Dispositions: Case settled prior to trial.

Settlement of $450,000.00

INSURED: Frank P. Silver, M.D.
Address: 341 N Buffalo, Apt/ste B
Las Vegas, NV 89128

Loss Description Complaint alleges insured was negligent during ablation surgery and burned two holes in patient's bladder resulting in urine leak and sepsis in then 47 year old woman.

Loss Location: Lake Mead Hospital, Las Vegas, NV

CLAIMANT: Pauline Lam
Patient: Same as Claimant DOB/Age: [redacted] 53 years old
Address: c/o Daniel Marks, Esq., 302 E. Carson, Suite 702, Las Vegas, NV 89101

Person Making Report: Connie Heinsohn, Claim Specialist
Address: 8900 N 22nd Ave, Ste 300, Phoenix, AZ 85021
Phone: (602) 678-3424

Summons & Complaint Attached. If Summons & Complaint not attached, Case No.: A414074

INSURER: ST. PAUL FIRE & MARINE INSURANCE COMPANY
P.O. BOX 39600
PHOENIX, AZ 85069-9600
(602) 678-3400

NEVADA STATE BOARD OF
MEDICAL EXAMINERS
P.O. Box 7238
Reno, NV 89510

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NEVADA STATE BOARD OF
MEDICAL EXAMINERS

Claim No.: DM08900582-02A001 Date: DECEMBER 17, 1997

Date of Loss: 04/04/91 Date of Claim: 06/14/91
Date Suit Filed: Date Closed: 10/29/97

MLSP Complaint No.:
Findings:
Other Dispositions: $65,000

INSURED: FRANK SILVER, MD
Address: 2031 McDaniel St., Suite 210, North Las Vegas, NV 89030

Loss Description: Suit alleges insured negligently injured bowel of 44-year old woman during hysterectomy procedure.
Loss Location: Las Vegas, NV

CLAIMANT: BRENDA FAYE YOUNG
Patient: {*Same as Claimant*} DOB/Age: 44
Address: c/o Atty. Rick Petrone, 3900 Paradise Ln., #181, Las Vegas, NV 89109

Person Making Report: Connie Heinsohn - Claim Representative
Address: P.O. Box 39600, Phoenix, AZ 85069-9600
Phone: (602) 678-3400

☐ Summons & Complaint Attached. If Summons & Complaint not attached, Case No.: N/A

CH/tlj

Nevada State Board of Medical Examiners
P. O. Box 7238
Reno, NV 89510

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NEVADA STATE BOARD OF MEDICAL EXAMINERS

INSURER: St. Paul Fire & Marine Insurance Company
Address: P.O. Box 10291, Phoenix, AZ **Zip Code:** 85064
Telephone: (602) 553-3400 **Claim ID No.:** DM06610233-02A003
Date Of Alleged Injury: 08/29/94 **Date Of Claim:** 08/21/95
MLSP Complaint Number: Unknown
Findings: Claim settled prior to being reviewed by the Medical Legal Screening Panel. Medical Legal Screening Panel case has been dismissed.
Date Suit Filed: N/A $65,000 **Date Closed:** 11/05/96
Other Dispositions: Lump sum payment paid in exchange for full release of any and all claims against insured and dismissal of the Medical Legal Screening Panel complaint. Settlement includes release agreement with a confidentiality and non-disclosure.

INSURED'S NAME: Frank R. Silver, M.D.
Address: 2031 McDaniel Street, Suite 210, North Las Vegas, NV **Zip Code:** 89030
Place Of Occurrence: Lake Mead Hospital Medical Center
Address: 1409 E. Lake Mead Blvd., North Las Vegas, NV **Zip Code:** 89030

DESCRIPTION OF ACTION OR INJURY PRECIPITATING CLAIM OR SUIT:
Insured physician failed to diagnose tubal pregnancy in 31 year old woman, with subsequent rupture. Patient had to undergo removal of one tube. Patient now pregnant.

CLAIMANT'S NAME: Gwendolyn Chaney-Braimoh
PATIENT'S NAME: Gwendolyn Chaney-Braimoh **Birth Date:** [redacted]
Address: c/o Anita A. Webster, Esq., 325 S. Maryland Parkway, Las Vegas, NV 89101

PERSON MAKING THIS REPORT: Connie Heinsohn
Address: P.O. Box 10291, Phoenix, AZ **Zip Code:** 85064
Telephone: (602) 553-3400

☐ **Summons and Complaint Attached**

If Summons And Complaint not attached, Case No.: N/A
Rev. 5/89

CH:mkl

Nevada State Board
of Medical Examiners
P.O. Box 7238
Reno, Nevada 89510

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NEVADA STATE BOARD OF
MEDICAL EXAMINERS

REPORT OF MEDICAL MALPRACTICE CLAIM
PURSUANT TO NEVADA REVISED
STATUTES - §690b.045
NOT FOR PUBLICATION

INSURER: St. Paul Fire and Marine Insurance Company
Address: P.O. Box 10291, Phoenix, AZ **Zip Code:** 85064-0291
Telephone: (602) 553-3400 **Claim ID No.:** DM08900183-02A001
Date Of Alleged Injury: 12/9/86 **Date Of Claim:** 3/11/88
Date Suit Filed: 1/31/89
Settlement: $ **Award:** $99,090.93 **Date:** 5/17/93
Other Dispositions:

INSURED'S NAME: [redacted]
Address: **Zip Code:**
Place Of Occurrence: Women's Hospital
Address: 2025 E. Sahara Ave., Las Vegas, NV **Zip Code:** 89106

OTHER DEFENDANTS NAMED IN SAME CLAIM OR SUIT:
1. Ranjit Jain, M.D.
2. John Dudek, M.D.
3.
4.

DESCRIPTION OF ACTION OR INJURY PRECIPITATING CLAIM OR SUIT:
Failure to diagnose and properly treat the plaintiff's vesicovaginal fistula resulting in urinary incontinence. Plaintiff originally underwent hysterectomy which resulted in the fistula that Insured tried to repair.

CLAIMANT'S NAME: Jerlean McFarland
PATIENT'S NAME: Jerlean McFarland **Birth Date:** [redacted]
Address: c/o Atty. Gerald Gillock, 43053 3rd St., Las Vegas, NV
Zip Code: 89101

PERSON MAKING THIS REPORT: Cindy R. Robertson
Address: P.O. Box 10291, Phoenix, AZ **Zip Code:** 85064-0291
Telephone: (602) 553-3400

[ ] **Summons and Complaint Attached**

If Summons And Complaint not attached, Case No.: 22646

Rev. 5/89 ik

INSURER: ST. PAUL MEDICAL LIABILITY INSURANCE COMPANY
PHOENIX MEDICAL OFFICE - 02A
8900 N. 22nd Avenue, #300
Phoenix, AZ 85021-6018

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NEVADA STATE BOARD OF
MEDICAL EXAMINERS
P.O. Box 7238
Reno, NV 89510

Claim No.: DM06628927-02A002 / HT00145

Date: June 19, 2003

Date of Loss: October 20, 1997
Date Suit Filed: August 16, 2000

Date of Claim: July 1, 1999
Date Closed: April 30, 2003

MLSP Complaint No: L99-06-1706
Findings: Probable malpractice
Other Dispositions: Case settled -- amount confidential

INSURED: FRANK P. SILVER, M.D.
Address: 341 N. Buffalo, Suite B
Las Vegas, NV 89128

Loss Description: THE CLAIMANT, A 62 YEAR OLD FEMALE, ALLEGES SHE DEVELOPED A RECTOVAGINAL FISTULA FOLLOWING A HYSTERECTOMY PERFORMED BY INSURED. SHE ALSO ALLEGES LACK OF POST-OP CARE AND OTHER SIGNIFICANT POST-OP COMPLICATIONS AS WELL.

Loss Location: Las Vegas, Nevada

CLAIMANT: MARLENE LEWIN
Patient: Same as Claimant DOB/Age: [redacted]
Address: c/o Burris & Thomas
844 E. Sahara Avenue
Las Vegas, NV 89104-3017

Person Making Report: Connie Heinsohn, Medical Claim Specialist
Address: 8900 N. 22nd Avenue, #300
Phoenix, AZ 85021-6018
Phone: (602) 678-3424

Summons & Complaint Attached. If Summons & Complaint not attached, Case No.: A423093

Nevada Medical Professional Liability Closed Claim Report

I. Background

1. Name of Insurer **ST. PAUL MEDICAL LIABILITY INSURANCE COMPANY**		2. Insurer Claim No. **DM06628927-02A002 / HT00145**
3. Injury Date (Date of Loss) **10/20/1997**	4. Report Date **06/30/1999**	5. Closure Date **04/30/2003**
6. Policy Type (choose a, b, or c) a) ☐ Occurrence b) ☒ **Claims made** c) ☐ Tail/Reporting Endorsement		
7. Policy Limits (Per Claim/Aggregate) **$ 1 MIL. / $ 3 MIL.**		8. Date This Closed Claim Report Submitted **06/20/2003**
9. Type of Report (choose a or b) a) ☒ **Initial Report** b) ☐ Updated Report		

II. Defendant & Co-Defendants

1. Defendant's Name	Last **SILVER**	First **FRANK**	M.I. **P**	Credentials (e.g. MD, DO, DMD, DDS) **M.D.**
2. License Number **2641**	3. Specialty Description **OB/GYN** ISO Code _____			4. Co-Defendant(s)? ☐ Yes ☒ **No** ☐ Unknown
5. Number of Co-Defendant(s): _____ or _____ Unknown				
6. Name, License Number and Insurer of Each Co-Defendant, if known: **N/A**				

III. Injured & Injury

1. Injured Party's Name	Last **LEWIN**	First **MARLENE**	M.I.	2. Sex: ☐ Male ☒ **Female**
3. Age **62**	4. Date of Birth (MM/DD/YY) [redacted]	5. Malpractice code (per Appendix 1): **PO**		6. Injury Code (per appendix 2): **ORG**
7. Description of Alleged Malpractice and Injuries (Attach Additional Sheet(s) if Necessary.) **Claimant alleges she developed a rectovaginal fistula following a hysterectomy performed by insured. She also alleges lack of post-op care and other significant post-op complications as well.**				
8. City Where Injury Occurred **Las Vegas**		9. Name of Institution (If Injury Occurred in Institution)		

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

1. Case Filed with Panel? ☒**Yes**, ☐No, ☐Unknown (IF YES, ANSWER QUESTIONS 2 AND 3)
2. Panel Case Number **L99-06-1706**
3. Panel Decision: Is there Reasonable Probability of Malpractice? a) ☒**Yes** b) ☐No c) ☐Unable to Decide d) ☐Case Dismissed e) ☐Other [case settled/withdrawn before panel met]
4. Court Case Filed After Panel Decision ☒**Yes** ☐No ☐Unknown

V. Court Case

1. Court Case Filed? ☒**Yes**, ☐No, ☐Unknown (IF YES, ANSWER QUESTIONS 2 - 7)		
2. Court Case Number **A423093**	3. Court Name **Dist. Court, Clark County, Nevada**	4. Court Department Number **21**
5. Date Court Case Was Filed **08/16/2000**	6. Date Verdict Was Filed, if Applicable **N/A**	7. Date Settlement Offer Accepted, if Applicable **04/23/2003**

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

1. Reserves	Initial **$150,000**	Highest **$350,000**	Last **$350,000**

VII. Claim Disposition (Attributed to this Defendant Only)

1. Claim Disposition (check one)	a) ☐ Decided By Trial in Favor of Plaintiff	a) ☐ Decided By Trial in Favor of Defendant	b) ☐ Decided by Arbitrator in Favor of Plaintiff	c) ☐ Decided by Arbitrator in Favor of Defendant
d) ☒ **Settled w/o Court or Prior to Trial**	e) ☐ Claim Denied	f) ☐ Claim Inactive	g) ☐ Claim Withdrawn	h) ☐ Other
2. If Claim Disposition is e, f, g or j, Please Explain				

Name of Insurer **ST. PAUL MEDICAL LIABILITY INSURANCE COMPANY**	Insurer Claim No. **DM06628927-02A002 / HT00145**
Defendant's Name (Last, First, M.I.) **SILVER, FRANK M.D.**	Date This Closed Claim Report Submitted **06/20/2003**

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

1. Verdict Awarded $ or ☒ N/A

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

1. Verdict or Settlement Awarded **$550,000** or ☐ N/A		2. Verdict or Settlement Paid **$550,000** or ☐ N/A	
3. Reasons for Amount Awarded (1) Not Being Equal to Amount Paid (2), if Applicable (Check More than One, if Applicable) a) ______ Post Verdict Settlement b) ______ Award Reduced to Present Value c) ______ Interest Awarded d) ______ Court Costs Awarded e) ______ Non-economic damages limited by Judge to $350,000 f) ______ Award Capped by Judge at Policy Limit g) ______ Other (Explain)			
4. How Will/Did Plaintiff Receive Payments?	a) ☒ **Lump Sum**	b) ☐ Periodic Payments	c) ☐ N/A
5. If Periodic Payments, What is the Present Value (as of Date of Award) of the Payments? $ **N/A**			
6. Sources of Award Payments	a) Company **$550,000**	b) Defendant $	c) Other (describe) $
7. Allocated Loss Adjustment Expenses	Total **$53,113.23**	Attorney's Fees **$40,655.00**	Other **$12,458.23**

X. Claim Information (Amounts Attributed to Other Defendants)

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

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

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

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

(Attach Additional Sheet(s) if Necessary.)

XI. Closed Claim Report Information

1. Contact Person's Name (Last, First) **Heinsohn, Connie**
2. Contact Person's Phone Number {(999) 999-9999} **(602) 678-3424**
3. Contact Person's Address **8900 N. 22nd Avenue, #300** **Phoenix, AZ 85021-6018**

Name of Person Responsible for Report (Last, First) **Todd, Theodore**
Signature of Person Responsible for Report Ted Todd/ew

ST. PAUL DOES NOT UTILIZE ISO CODES

Reports Home Page

Renewal Questions for License Number 2641

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License Type	Sort Name	Question	Answer	Date
Medical Doctor	SILVER, Frank Paul	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	5/5/2009
Medical Doctor	SILVER, Frank Paul	**Explanation 1: For the above question if your answer is "Yes" for the time period July 1, 2007 - June 30, 2009, or since your last renewal, please type your explanation in this text box.**		
Medical Doctor	SILVER, Frank Paul	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	5/5/2009
Medical Doctor	SILVER, Frank Paul	**Explanation 2: For the above question if your answer is "Yes" for the time period July 1, 2007 - June 30, 2009, or since your last renewal, please type your explanation in this text box.**		
Medical Doctor	SILVER, Frank Paul	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	5/5/2009
Medical Doctor	SILVER, Frank Paul	**Explanation 3: For the above question if your answer is "Yes" for the time period July 1, 2007 - June 30, 2009, or since your last renewal, please type your explanation in this text box.**		
Medical Doctor	SILVER, Frank Paul	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.	N	5/5/2009
Medical Doctor	SILVER, Frank Paul	**Explanation 4: For the above question if your answer is "Yes" for the time period July 1, 2007 - June 30, 2009, or since your last renewal, please type your explanation in this text box.**		
Medical Doctor	SILVER, Frank Paul	**Explanation 5: For the above question if your answer is "Yes" for the time period July 1, 2007 - June 30, 2009, 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.		
Medical Doctor	SILVER, Frank Paul	Have you been arrested, investigated for, charged with, convicted of, or pled guilty or nolo contendere to any criminal offense related to the manufacture, distribution, prescribing, or dispensing of controlled substances? **Please note that you MUST disclose ANY investigation or arrest, including those where the final disposition was dismissal, sealing of a record, or expungement.**	N	5/5/2009
Medical Doctor	SILVER, Frank Paul	**Explanation 6: For the above question if your answer is "Yes" for the time period July 1, 2007 - June 30, 2009, or since your last renewal, please type your explanation in this text box.**		
Medical Doctor	SILVER, Frank Paul	Have you been denied a license, permission to practice medicine or any other healing art, or permission to take an examination to practice medicine or any other healing art in any state, country or U.S. territory?	N	5/5/2009
Medical Doctor	SILVER, Frank Paul	**Explanation 8: For the above question if your answer is "Yes" for the time period July 1, 2007 - June 30, 2009, or since your last renewal, please type your explanation in this text box.**		
Medical Doctor	SILVER, Frank Paul	Have you had a medical license or license to practice any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory?	N	5/5/2009
Medical Doctor	SILVER, Frank Paul	**Explanation 9: For the above question if your answer is "Yes" for the time period July 1, 2007 - June 30, 2009, or since your last renewal, please type your explanation in this text box.**		
Medical Doctor	SILVER, Frank Paul	Have you voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory in lieu of any disciplinary action?	N	5/5/2009
Medical Doctor	SILVER, Frank Paul	**Explanation 10: For the above question if your answer is "Yes" for the time period July 1, 2007 - June 30, 2009, or since your last renewal, please type your explanation in this text box.**		
Medical Doctor	SILVER, Frank Paul	Have you been denied membership, been asked to resign or expelled from a medical society or other professional medical organization (including the ABMS)?	N	5/5/2009
Medical Doctor	SILVER, Frank Paul	**Explanation 11: For the above question if your answer is "Yes" for the time period July 1, 2007 - June 30, 2009, or since your last renewal, please type your explanation in this text box.**		
		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:		

Medical Doctor	SILVER, Frank Paul	(a) Asked to respond to an investigation; (b) Notified that you were under investigation for; (c) Investigated for; (d) Charged with; or (e) Convicted of any violation of a statute, rule or regulation governing your practice as a physician?	N	5/5/2009
Medical Doctor	SILVER, Frank Paul	**Explanation 12: For the above question if your answer is "Yes" for the time period July 1, 2007 - June 30, 2009, or since your last renewal, please type your explanation in this text box.**		
Medical Doctor	SILVER, Frank Paul	Have you surrendered your state or federal controlled substance registration or had it revoked or restricted in any way?	N	5/5/2009
Medical Doctor	SILVER, Frank Paul	**Explanation 13: For the above question if your answer is "Yes" for the time period July 1, 2007 - June 30, 2009, or since your last renewal, please type your explanation in this text box.**		
Medical Doctor	SILVER, Frank Paul	Have you had hospital staff privileges denied, suspended, limited, revoked or not renewed by the hospital, including any and all resignations from any medical staff in lieu of disciplinary or administrative action? If the answer is " Yes," type the name of the hospital, the hospital's mailing address, the type of action taken, and the date or dates of the actions taken in the textbox directly below this question. **(Please Note:) Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance.)**	N	5/5/2009
Medical Doctor	SILVER, Frank Paul	**Explanation 14: For the above question if your answer is "Yes" for the time period July 1, 2007 - June 30, 2009, or since your last renewal, please type your explanation in this text box.**		
Medical Doctor	SILVER, Frank Paul	Are you out of compliance with court ordered child support? **If this does not apply to you, please answer "no".** If "Yes" during the time period July 1, 2007- June 30, 2009 type an explanation in the textbox directly below this question.	N	5/5/2009
Medical Doctor	SILVER, Frank Paul	**Explanation 15: For the above question if your answer is "YES" for the time period July 1, 2007 - June 30, 2009, or since your last renewal, please type your explanation in this text box.**		
Medical Doctor	SILVER, Frank Paul	I hereby request my license to be placed on Inactive status, which means I will not physically practice in the state of Nevada. If you choose to place your license on Inactive status, make certain to select "Yes" to this question AND choose the Inactive status in the dropdown box located at the end of the questions.	N	5/5/2009
Medical Doctor	SILVER, Frank Paul	**Explanation 16: For the above question, if your answer is "Yes" and you want to change to Inactive status for the next biennial July 1, 2009 – June 30, 2011, please provide a brief explanation in this text box.**		
Medical Doctor	SILVER, Frank Paul	**Explanation 17: For the above question if your answer is "YES" , please type your new scope of practice or specialty in this text box.**		
Medical Doctor	SILVER, Frank Paul	Do you want to change your scope of practice or specialty? If you answer "Yes" type your current scope of practice or specialty in the textbox directly below this question.	N	5/5/2009
Medical Doctor	SILVER, Frank Paul	I have completed the required amount of AMA Category 1 CME within the current biennial. (Review CME information online at www.medboard.nv.gov) I understand that I may be included in a random audit following the July 1st, 2009 renewal. I agree to retain CME's taken between July 1, 2007 and June 30, 2009. If renewing to an Inactive status, CME is not required and "No" can be selected.	Y	5/5/2009
Medical Doctor	SILVER, Frank Paul	I SWEAR OR AFFIRM UNDER THE PENALTY OF PERJURY THAT I PERSONALLY ANSWERED ALL OF THE QUESTIONS IN THIS APPLICATION AND THAT THE ANSWERS I HAVE PROVIDED ARE TRUE AND CORRECT.	Y	5/5/2009

Reports Home Page

Renewal Questions for License Number 2641

POWERED BY MyLicense

License Type	Sort Name	Question	Answer	Date
Medical Doctor	SILVER, Frank Paul	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 answer "Yes" during the time period July 1, 2005 - June 30, 2007 email to elicensensbme@medboard.nv.gov	N	5/4/2007
Medical Doctor	SILVER, Frank Paul	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 answer "Yes" during the time period July 1, 2005 - June 30, 2007 email to elicensensbme@medboard.nv.gov	N	5/4/2007
Medical Doctor	SILVER, Frank Paul	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 answer "Yes" during the time period July 1, 2005 - June 30, 2007 email to elicensensbme@medboard.nv.gov	N	5/4/2007
Medical Doctor	SILVER, Frank Paul	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 answer "Yes" during the time period July 1, 2005 - June 30, 2007 email to elicensensbme@medboard.nv.gov	N	5/4/2007
Medical Doctor	SILVER, Frank Paul	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?	Y	5/4/2007
Medical Doctor	SILVER, Frank Paul	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?	Y	5/4/2007
Medical Doctor	SILVER, Frank Paul	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. If you answer "Yes" during the time period July 1, 2005 - June 30, 2007 email to elicensensbme@medboard.nv.gov	N	5/4/2007
Medical Doctor	SILVER, Frank Paul	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. If you answer "Yes" during the time period July 1, 2005 - June 30, 2007 email to elicensensbme@medboard.nv.gov	N	5/4/2007
Medical Doctor	SILVER, Frank Paul	Have you failed to initiate the performance of public service within one year after the date the public service is required to begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local government for your medical education?	N	5/4/2007
Medical Doctor	SILVER, Frank Paul	Have you failed to initiate the performance of public service within one year after the date the public service is required to begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local government for your medical education?	N	5/4/2007
Medical Doctor	SILVER, Frank Paul	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? If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov.	N	5/4/2007
Medical Doctor	SILVER, Frank Paul	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? If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov.	N	5/4/2007
Medical Doctor	SILVER, Frank Paul	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? If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov.	N	5/4/2007
		Have you had a medical license or license to practice any other healing art revoked, suspended, limited, or		

Medical Doctor	SILVER, Frank Paul	restricted in any state, country or U.S. territory? If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov.	N	5/4/2007
Medical Doctor	SILVER, Frank Paul	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? If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov.	N	5/4/2007
Medical Doctor	SILVER, Frank Paul	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? If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov.	N	5/4/2007
Medical Doctor	SILVER, Frank Paul	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? If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov.	N	5/4/2007
Medical Doctor	SILVER, Frank Paul	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? If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov.	N	5/4/2007
Medical Doctor	SILVER, Frank Paul	Have you been denied membership or expelled from a medical society or other professional medical organization? If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov.	N	5/4/2007
Medical Doctor	SILVER, Frank Paul	Have you been denied membership or expelled from a medical society or other professional medical organization? If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov.	N	5/4/2007
Medical Doctor	SILVER, Frank Paul	Have you surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov.	N	5/4/2007
Medical Doctor	SILVER, Frank Paul	Have you surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov.	N	5/4/2007
Medical Doctor	SILVER, Frank Paul	Have you had hospital staff privileges denied, suspended, limited, revoked or not renewed by the hospital? *If you have answered "Yes" you will be required to submit a list of any and all resignations from any medical staff in lieu of disciplinary or administrative action via email to elicensensbme@medboard.nv.gov (Please Note: Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance.)* If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov.	N	5/4/2007
Medical Doctor	SILVER, Frank Paul	Have you had hospital staff privileges denied, suspended, limited, revoked or not renewed by the hospital? *If you have answered "Yes" you will be required to submit a list of any and all resignations from any medical staff in lieu of disciplinary or administrative action via email to elicensensbme@medboard.nv.gov (Please Note: Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance.)* If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov.	N	5/4/2007
Medical Doctor	SILVER, Frank Paul	Is your license currently contingent upon compliance with the Diversion program also known as the Nevada Health Professionals Assistance Foundation? If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov.	N	5/4/2007
		Is your license currently contingent upon compliance with the Diversion program also known as the Nevada		

Medical Doctor	SILVER, Frank Paul	Health Professionals Assistance Foundation? If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov.	N	5/4/2007
Medical Doctor	SILVER, Frank Paul	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? If "yes" please fax a copy of proof to (775) 688-2551 ATTN:Online License Renewal.	N	5/4/2007
Medical Doctor	SILVER, Frank Paul	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? If "yes" please fax a copy of proof to (775) 688-2551 ATTN:Online License Renewal.	N	5/4/2007
Medical Doctor	SILVER, Frank Paul	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, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov.	N	5/4/2007
Medical Doctor	SILVER, Frank Paul	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, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov.	N	5/4/2007
Medical Doctor	SILVER, Frank Paul	I HEREBY SWEAR OR AFFIRM UNDER THE PENALTIES OF PERJURY THAT I AM IN FULL COMPLIANCE WITH ANY AND ALL OBLIGATIONS, TERMS OR CONDITIONS OF MY NEVADA MEDICAL LICENSE SPECIFIED BY THE BOARD.	Y	5/4/2007
Medical Doctor	SILVER, Frank Paul	I HEREBY SWEAR OR AFFIRM UNDER THE PENALTIES OF PERJURY THAT I AM IN FULL COMPLIANCE WITH ANY AND ALL OBLIGATIONS, TERMS OR CONDITIONS OF MY NEVADA MEDICAL LICENSE SPECIFIED BY THE BOARD.	Y	5/4/2007
Medical Doctor	SILVER, Frank Paul	I have actively practiced medicine in Nevada within the past 24 months.	Y	5/4/2007
Medical Doctor	SILVER, Frank Paul	I have completed the required amount of AMA Category 1 CME within the current biennial. (Review CME information online at www.medboard.nv.gov) I understand that I may be included in a random audit following July 1st 2007 renewal. I agree to retain CME's taken between July 1, 2005 and June 30, 2007.	Y	5/4/2007
Medical Doctor	SILVER, Frank Paul	Do you want to change your scope of practice or specialty? If you answer "Yes" during the time period July 1, 2005 - June 30, 2007 email to elicensensbme@medboard.nv.gov	N	5/4/2007
Medical Doctor	SILVER, Frank Paul	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 answer "Yes" during the time period July 1, 2005 - June 30, 2007 email to elicensensbme@medboard.nv.gov	N	5/4/2007
Medical Doctor	SILVER, Frank Paul	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 answer "Yes" during the time period July 1, 2005 - June 30, 2007 email to elicensensbme@medboard.nv.gov	N	5/4/2007
Medical Doctor	SILVER, Frank Paul	Are you currently supervising a Physician Assistant or an Advanced Practitioner of Nursing? If you answer "Yes" please email a list of names of those you are supervising to elicensensbme@medboard.nv.gov	Y	5/4/2007
Medical Doctor	SILVER, Frank Paul	Was your license issued contingent upon maintaining certification by the American Board of Medical Specialties in the specialty of Family Practice, Emergency Medicine or Preventative medicine? If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov.	N	5/4/2007
Medical Doctor	SILVER, Frank Paul	I hereby request my license to be placed on Inactive status. I will not physically practice in the state of Nevada.	N	5/4/2007

PHYSICIAN
APPLICATION FOR REGISTRATION RENEWAL
FOR THE BIENNIAL REGISTRATION PERIOD 2005 - 2007
NEVADA STATE BOARD OF MEDICAL EXAMINERS
Post Office Box 7238 Reno, Nevada 89510 Phone (775) 688-2559
Physical Address: 1105 Terminal Way, Suite 301 Reno, Nevada 89502

Date Received by Board
MAR 1 4 2005
(For Board Use Only)

License No. 2641
File No. ____

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

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

File No. [redacted] **License No.** 2641 [redacted]

Frank Paul SILVER M.D.
341 N Buffalo #B
Las Vegas NV 89145-

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

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

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

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

N/A

Date Signature **(SIGNATURE STAMP UNACCEPTABLE)**

PLEASE NOTE:

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

PLEASE TYPE OR PRINT LEGIBLY

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

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

Name FRANK Paul Silver, MD
Street 341 N. Buffalo suite B
City LAS VEGAS County CLARK State NV. Zip 89145
Phone Number (702) 228-4004 Fax Number (702) 228-5653

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

Name_____

Street N/A

City_____ County_____ State_____ Zip_____

Phone Number_____

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

SCOPES OF PRACTICE CODES

1	ADDICTION MEDICINE	43	NEPHROLOGY	85	PEDIATRIC, SURGERY
2	ADOLESCENT MEDICINE	44	NEUROLOGY	86	PEDIATRIC, UROLOGY
3	AEROSPACE MEDICINE	45	NEURO-OPHTHALMOLOGY	87	PEDIATRICS
4	ALLERGY	46	NEUROPATHOLOGY	88	PHYSICAL MEDICINE/REHABILITATION
5	ALLERGY/IMMUNOLOGY	47	NEURORADIOLOGY	89	PREVENTIVE MEDICINE
6	AMBULATORY MEDICINE	48	NEUROTOLOGY	90	PSYCHIATRY
7	ANESTHESIOLOGY	49	NON-CONVENTIONAL MEDICINE	91	PSYCHOANALYSIS
8	BLOODBANKING	50	NUCLEAR MEDICINE	92	PSYCHOMATIC MEDICINE
9	BRONCO-ESOPHAGOLOGY	51	NUTRITION	93	PUBLIC HEALTH
10	CARDIOVASCULAR DISEASES	52	OBSTETRICS	94	PULMONARY DISEASES
11	CATSCAN/ULTRASOUND	53	OBSTETRICS/GYNECOLOGY	95	OCCUPATIONAL MEDICINE
12	CHILD NEUROLOGY	54	OCCUPATIONAL MEDICINE	96	RADIOLOGY
13	CHILD PSYCHIATRY	55	ONCOLOGY	97	RADIOLOGY, DIAGNOSTIC
14	CLINICAL PHARMACOLOGY	56	ONCOLOGY, GYNECOLOGICAL	98	RADIOLOGY, INTERVENTIONAL
15	CRITICAL CARE	57	ONCOLOGY, HEMATOLOGY	99	RADIOLOGY, NUCLEAR
16	DERMATOLOGY	58	ONCOLOGY, RADIATION	100	RADIOLOGY, THERAPEUTIC
17	DERMATOPATHOLOGY	59	ONCOLOGY, SURGICAL	101	RADIOLOGY, VASCULAR
18	EMERGENCY MEDICINE	60	OPHTHALMOLOGY	102	RHEUMATOLOGY
19	ENDOCRINOLOGY	61	OTOLARYNGOLOGY	103	RHINOLOGY
20	FAMILY PRACTICE	62	OTOLOGY	104	SLEEP DISORDERS
21	FORENSIC MEDICINE	63	PAIN MANAGEMENT	105	SPORTS MEDICINE
22	GASTROENTEROLOGY	64	PATHOLOGY	106	SURGERY, ABDOMINAL
23	GENERAL PRACTICE	65	PATHOLOGY, ANATOMIC	107	SURGERY, CARDIOTHORACIC
24	GERIATRIC PSYCHIATRY	66	PATHOLOGY, CLINICAL	108	SURGERY, CARDIOVASCULAR
25	GERIATRICS	67	PATHOLOGY, FORENSIC	109	SURGERY, COLON/RECTAL
26	GYNECOLOGY	68	PEDIATRIC, ALLERGY	110	SURGERY, CRANIOFACIAL
27	HAIR TRANSPLANTATION	69	PEDIATRIC, ANESTHESIOLOGY	111	SURGERY, GENERAL
28	HEMATOLOGY	70	PEDIATRIC, CARDIOLOGY	112	SURGERY, HAND
29	HOMEOPATHY	71	PEDIATRIC, CRITICAL CARE	113	SURGERY, HEAD/NECK
30	HYPNOSIS	72	PEDIATRIC, EMERGENCY MEDICINE	114	SURGERY, MAXILLOFACIAL
31	IMMUNOLOGY	73	PEDIATRIC, ENDOCRINOLOGY	115	SURGERY, NEUROLOGICAL
32	INFECTIOUS DISEASES	74	PEDIATRIC, GASTROENTEROLOGY	116	SURGERY, ORTHOPEDIC
33	INFERTILITY	75	PEDIATRIC, HEMATOLOGY/ONCOLOGY	117	SURGERY, PLASTIC
34	INTERNAL MEDICINE	76	PEDIATRIC, INFECTIOUS DISEASES	118	SURGERY, THORACIC
35	LARYNGOLOGY	77	PEDIATRIC, INTENSIVIST	119	SURGERT, TRANSPLANT
36	LEGAL MEDICINE	78	PEDIATRIC, NEPHROLOGY	120	SURGERY, TRAUMATIC
37	MATERNAL/FETAL MEDICINE	79	PEDIATRIC, NEUROLOGY	121	SURGERY, UROLOGIC
38	MEDICAL ACUPUNCTURE	80	PEDIATRIC, OPHTHALMOLOGY	122	SURGERY, VASCULAR
39	MEDICAL ETHICS	81	PEDIATRIC, PHYSIATRY	123	TOXICOLOGY
40	MEDICAL GENETICS	82	PEDIATRIC, PULMONARY	124	TRANSPLANTATION
41	NEO/PERINATAL MEDICINE	83	PEDIATRIC, RADIOLOGY	125	URGENT CARE
42	NEOPLASTIC DISEASES	84	PEDIATRIC, RHEUMATOLOGY	126	UROLOGY

Code **Code**

Primary Scope of Practice 26 **Secondary Scope of Practice** 33

PLEASE INDICATE AMERICAN BOARD OF MEDICAL SPECIALTIES BOARD CERTIFICATION & RECERTIFICATION

Board AMERICAN BOARD OBGYN **Date of Initial Certification** 1962 (Mo./Yr.) **Date of Last Recertification** NO EXPIRATION (Mo./Yr.)

Subboard_____ (Mo./Yr.) (Mo./Yr.)

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

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

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

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments;

2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and

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

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

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

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

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

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

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

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

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

6. Have you ever been investigated for, charged with, convicted of, or plead guilty or nolo contendere to any offense or violation of any federal, state or local law, including any foreign country, which is a misdemeanor, gross misdemeanor, or felony, excluding any minor traffic offense (driving or in control of a motor vehicle while under the influence of any chemical substance is **not** considered **a minor traffic offense**) or which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? _____Yes ___✓___No

7. Have you ever been denied a license, permission to practice medicine or any other healing art, or permission to take an examination to practice medicine or any other healing art in any state, country or U.S. territory? _____Yes ___✓___No

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

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

10. Have you ever been denied membership or expelled from a medical society or other professional medical organization? _____Yes ___✓___No

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

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

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

Hospital	Mailing Address	Type of Action	Dates of Action From (Mo./Yr.)	To (Mo./Yr.)
N/A				

CHILD SUPPORT STATEMENT

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

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

_____ (b) I am subject to a court order for the support of one or more children and am in compliance with the order or am in compliance with a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order; **OR**

_____ (c) I am subject to a court order for the support of one or more children and am NOT in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

CONTINUING MEDICAL EDUCATION (CME) STATEMENT

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

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

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

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

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

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

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

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

BY SIGNING ON THE SIGNATURE LINE BELOW:

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

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

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

X 2/17/05 X _____

Date **Signature (SIGNATURE STAMP UNACCEPTABLE)**

PHYSICIAN

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

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

Date Received by Board

FEB 24 2003

(For Board Use Only)

License No. 2641

File No._____

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

✓ ACTIVE STATUS $400.00.

_____ INACTIVE STATUS $200.00.....*(INACTIVE STATUS DOES NOT PERMIT THE PRACTICE OF MEDICINE INCLUDING THE WRITING OF PRESCRIPTIONS IN NEVADA)*

_____ I REQUEST NON-RENEWAL OF MY LICENSE*
(*IF YOU ARE REQUESTING NON-RENEWAL, SEE BELOW)

File no: [redacted] License no: 2641 [redacted]

Frank P SILVER
341 N Buffalo #B
Las Vegas, NV 89145

M.D.

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

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

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

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

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

PLEASE NOTE:

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

PLEASE TYPE OR PRINT LEGIBLY

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

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

Name_____

Street_____

City_____ County_____ State_____ Zip_____

Phone Number (702) 228-4004 Fax Number (702) 228-5653

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

Name_____

Street_____ N/A

City_____ County_____ State_____ Zip_____

Phone Number_____

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

SCOPES OF PRACTICE CODES

1	ADDICTION MEDICINE	41	NEOPLASTIC DISEASES	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	PREVENTIVE MEDICINE
7	ANESTHESIOLOGY	47	NON-CONVENTIONAL MEDICINE	87	PSYCHIATRY
8	BLOODBANKING	48	NUCLEAR MEDICINE	88	PSYCHOANALYSIS
9	BRONCO-ESOPHAGOLOGY	49	NUTRITION	89	PUBLIC HEALTH
10	CARDIOVASCULAR DISEASES	50	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	55	ONCOLOGY, HEMATOLOGY	95	RADIOLOGY, NUCLEAR
16	DERMATOLOGY	56	ONCOLOGY, RADIATION	96	RADIOLOGY, THERAPEUTIC
17	DERMATOPATHOLOGY	57	ONCOLOGY, SURGICAL	97	RADIOLOGY, VASCULAR
18	EMERGENCY MEDICINE	58	OPHTHALMOLOGY	98	RHEUMATOLOGY
19	ENDOCRINOLOGY	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	69	PEDIATRIC, EMERGENCY MEDICINE	109	SURGERY, MAXILLOFACIAL
30	IMMUNOLOGY	70	PEDIATRIC, ENDOCRINOLOGY	110	SURGERY, NEUROLOGICAL
31	INFECTIOUS DISEASES	71	PEDIATRIC, GASTROENTEROLOGY	111	SURGERY, ORTHOPEDIC
32	INFERTILITY	72	PEDIATRIC, HEMATOLOGY/ONCOLOGY	112	SURGERY, PLASTIC
33	INTERNAL MEDICINE	73	PEDIATRIC, INFECTIOUS DISEASES	113	SURGERY, THORACIC
34	LARYNGOLOGY	74	PEDIATRIC, INTENSIVIST	114	SURGERY, TRANSPLANT
35	LEGAL MEDICINE	75	PEDIATRIC, NEPHROLOGY	115	SURGERY, TRAUMATIC
36	MATERNAL/FETAL MEDICINE	76	PEDIATRIC, NEUROLOGY	116	SURGERY, UROLOGIC
37	MEDICAL ACUPUNCTURE	77	PEDIATRIC, OPHTHALMOLOGY	117	SURGERY, VASCULAR
38	MEDICAL ETHICS	78	PEDIATRIC, PHYSIATRY	118	TOXICOLOGY
39	MEDICAL GENETICS	79	PEDIATRIC, PULMONARY	119	URGENT CARE
40	NEO/PERINATAL MEDICINE	80	PEDIATRIC, RADIOLOGY	120	UROLOGY

	Code		Code
Primary Scope of Practice	35	**Secondary Scope of Practice**	99

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

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

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

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments;

2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and

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

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

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

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

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

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

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

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

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

6. Have you ever been investigated for, charged with, convicted of, or plead guilty or nolo contendere to any offense or violation of any federal, state or local law, including any foreign country, which is a misdemeanor, gross misdemeanor, or felony, excluding any minor traffic offense (driving or in control of a motor vehicle while under the influence of any chemical substance is **not** considered **a minor traffic offense**) or which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? _____Yes ___✓___No

7. Have you ever been denied a license, permission to practice medicine or any other healing art, or permission to take an examination to practice medicine or any other healing art in any state, country or U.S. territory? _____Yes ___✓___No

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

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

10. Have you ever been denied membership or expelled from a medical society or other professional medical organization? _____Yes ___✓___No

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

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

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

Hospital	Mailing Address	Type of Action	Dates of Action From (Mo./Yr.) To (Mo./Yr.)
	N/A		

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

CHILD SUPPORT STATEMENT

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

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

_____ (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.**

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

BY SIGNING ON THE SIGNATURE LINE BELOW:

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

X 2/6/03 X _____

Date Signature **(SIGNATURE STAMP UNACCEPTABLE)**

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

Date Received by Board
MAY 2 2 2001
(For Board Use Only)

License No. 2641
File No.

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

✓	ACTIVE STATUS	$600.00
	INACTIVE STATUS	$200.00
	RETIRED STATUS	$ 50.00
	SUPERVISING/COLLABORATING PHYSICIAN	$200.00

(RETIRED STATUS REQUIRES THAT THE APPLICANT NOT PRACTICE MEDICINE ANYWHERE)

[redacted]
Frank P SILVER
341 N Buffalo #B
Las Vegas, NV 89145

M.D.

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

PLEASE NOTE:

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

PLEASE TYPE OR PRINT LEGIBLY

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

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

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

Name FRANK P. SILVER, M.D.
Street 341 N. Buffalo Suite B
City LAS VEGAS County CLARK State NV. Zip 89145
Phone Number (702) 228-4004 Fax Number (702) 228-5653

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

Name
Street
City County State Zip
Phone Number

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

JEFFERSON Medical College — Medical School Name and Location
1961 — Date of Graduation (Month / Day / Year)

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

SCOPE OF PRACTICE
SPECIALTY CODES

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

	Code		Code		Code
Primary Specialty	23	**Secondary Specialty**	29	**Tertiary Specialty**	19

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

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

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

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

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

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

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

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

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

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

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

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

6. Have you ever been investigated for, charged with, convicted of, or plead guilty or nolo contendere to any offense or violation of any federal, state or local law, including any foreign country, which is a misdemeanor, gross misdemeanor, or felony, excluding any minor traffic offense (driving or in control of a motor vehicle while under the influence of any chemical substance is not considered a minor traffic offense) or which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? _____Yes ___✓___No

7. Have you ever been denied a license, permission to practice medicine or any other healing art, or permission to take an examination to practice medicine or any other healing art in any state, country or U.S. territory? _____Yes ___✓___No

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

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

10. Have you ever been denied membership or expelled from a medical society or other professional medical organization? _____Yes ___✓___No

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

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

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

Hospital	Mailing Address	Type of Action	Dates of Action From (Mo./Yr.) To (Mo./Yr.)
N/A			

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

CHILD SUPPORT STATEMENT

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

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

_____ (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, 1999 through June 30, 2001;

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

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

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

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

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

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

BY SIGNING ON THE SIGNATURE LINE BELOW:

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

4/12/01
Date

Signature **(SIGNATURE STAMP UNACCEPTABLE)**

PHYSICIAN
APPLICATION FOR RENEWAL REGISTRATION
NEVADA STATE BOARD OF
MEDICAL EXAMINERS

Post Office Box 7238 Reno, Nevada 89510 Phone (775) 688-2559

Date Received by Board
MAY 14 1999
MAY 20 1999
(Board Use Only)

License No. 2641
File No.

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

✓	ACTIVE STATUS	$600.00
	INACTIVE STATUS	$200.00
	RETIRED STATUS	$ 50.00
	SUPERVISING/COLLABORATING PHYSICIAN	$200.00

Frank P. Silver, MD
2031 McDaniel St #210
N Las Vegas NV 89030

0004041

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

PLEASE NOTE

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

PLEASE TYPE OR PRINT LEGIBLY

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

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

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

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

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

Name FRANK P. SILVER, M.D.
Street 341 N. BUFFALO, STE. "B"
City LAS VEGAS County CLARK State NEVADA Zip 89145

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

Name FRANK P. SILVER, M.D.
Street 341 N. BUFFALO, STE. B
City LAS VEGAS County CLARK State NV Zip 89145

7. 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_____)

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

SCOPE OF PRACTICE
SPECIALTY CODES

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

	Code	Percent of Time	Board Certified (Indicate Yes/No)
Primary	20	60	Yes
Secondary	40	40	Yes ABIME
Tertiary			

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

	Date of Initial Certification (Mo./Yr.)	Date of Last Certification (Mo./Yr.)
Board AMERICAN BOARD OB-GYN.	11/67	
Subboard		
Board AMERICAN BOARD INDEPENDENT MEDICAL EXAM.		6/97
Subboard		

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

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

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

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

1012 Other (specify)_____

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

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

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

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

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

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

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

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

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

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

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

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

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

6. Have you ever been investigated for, charged with, convicted of, or plead guilty or nolo contendere to any offense or violation of any federal, state or local law, including any foreign country, which is a misdemeanor, gross misdemeanor, or felony, excluding any minor traffic offense (driving or in control of a motor vehicle while under the influence of any chemical substance is **not** considered a **minor traffic offense**) or which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? _____Yes ___✓___No

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

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

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

10. Have you ever been denied membership or expelled from a medical society or other professional medical organization? _____Yes ___✓___No

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

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

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

Hospital	Mailing Address	Type of Action	Dates of Action From (Mo./Yr.) To (Mo./Yr.)

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

PLEASE CHECK ONE OF THE FOLLOWING:

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

_____ I am subject to a court order for the support of one or more children and am in compliance with the order or am in compliance with a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order; or

_____ I am subject to a court order for the support of one or more children and am NOT in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

Signature_____
(SIGNATURE STAMP UNACCEPTABLE)

PLEASE CHECK ONE OF THE FOLLOWING:

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

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

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

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

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

IMPORTANT

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

Signature_____
(SIGNATURE STAMP UNACCEPTABLE)

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

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

702-228-4004 4-27-99 _____
Business Telephone # Date Signature **(SIGNATURE STAMP UNACCEPTABLE)**

Date received by Board

APPLICATION FOR RENEWAL REGISTRATION JUN 25 1997 JUN 15 1997 License No. _____

NEVADA STATE BOARD OF MEDICAL EXAMINERS

Post Office Box 7238 Reno, Nevada 89510 Phone (702) 688-2559 (Board Use Only) File No. _____

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

✓	ACTIVE STATUS	$600.00	**PLEASE NOTE:** **NEVADA HAS NO GRACE PERIOD. LICENSES NOT RENEWED BY JULY 1, 1997 ARE AUTOMATICALLY SUSPENDED FOR NON-PAYMENT**
	INACTIVE STATUS	$150.00	
	RETIRED STATUS	$ 50.00	
	P.A. SUPERVISING PHYSICIAN	$200.00	

Frank P. Silver, MD
2031 McDaniel St #210
N Las Vegas, NV 89030

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

INSTRUCTIONS - TYPE OR PRINT LEGIBLY

1. YOUR CURRENT M.D. LICENSE EXPIRES ON JUNE 30, 1997. THIS IS THE NOTICE TO RENEW YOUR M.D. LICENSE.

2. To be eligible to act as a supervising physician for a physician assistant, complete the enclosed Application for Approval as Supervising Physician form.

3. ACTIVE STATUS REGISTRATION RENEWAL REQUIRES THE SUBMISSION OF PROOF OF 40 HOURS OF AMA CATEGORY I, CONTINUING MEDICAL EDUCATION completed during the period July 1, 1995 through June 30, 1997. Submit your proof of CME with your completed Application for Registration Renewal form.

4. In order to provide sufficient time for processing, please complete and return your Application for Registration Renewal form and Application for Approval as Supervising Physician form (if applicable) with your proof of 40 hours AMA Category I CME and the correct fee(s) **PRIOR TO JULY 1, 1997.** Use the enclosed self-addressed envelope to return your completed form(s) and fee(s).

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

Name Frank P. Silver, MD

Street 2031 McDaniel St. #210

City N. Las Vegas County Clark State N.V. Zip 89030

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

Name _____

Street _____

City _____ County _____ State _____ Zip _____

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

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

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

ALL FEES ARE NON-REFUNDABLE

DO NOT SEND CASH THROUGH THE MAIL

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

1. Are you currently active in medicine?

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

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

SPECIALTY CODE:

1	ADOLESCENT MEDICINE	35	NEURORADIOLOGY	94	PED. UROLOGY
2	AEROSPACE MEDICINE	36	NUCLEAR MEDICINE	95	PEDIATRICS
3	ALLERGY/IMMUNOLOGY	37	NUTRITION	96	PHYSICAL MED/REHAB
4	ANESTHESIOLOGY	38	OBSTETRICS/GYNECOLOGY	97	PHYSICIAN ASSISTANT
5	BLOODBANKING	39	OBSTETRICS	98	PREVENTIVE MED
6	BRONCO ESOPHAGOLOGY	40	OCCUPATIONAL MED	99	PSYCHIATRY
7	CARDIOVASC DISEASES	41	ONCOLOGY	100	PSYCHOANALYSIS
8	CATSCAN/ULTRASOUND	45	ONCOLOGY, GYNECOLOGIC	70	PSYCHOMATIC MEDICINE
9	CHILD NEUROLOGY	42	ONCOLOGY, HEMATOLOGY	71	PUBLIC HEALTH
10	CHILD PSYCHIATRY	43	ONCOLOGY, RADIATION	72	PULMONARY DISEASES
11	CLINICAL PHARMACOL	44	ONCOLOGY, SURGICAL	73	RADIOLOGY
12	CRITICAL CARE	46	OPHTHALMOLOGY	74	RADIOLOGY, DIAGNOSTIC
13	DERMATOLOGY	47	OTOLARYNGOLOGY	75	RADIOLOGY, NUCLEAR
14	EMERGENCY MEDICINE	48	OTOLOGY	76	RADIOLOGY, THERAPEUT
15	ENDOCRINOLOGY	49	PAIN MANAGEMENT	77	RHEUMATOLOGY
16	FAMILY PRACTICE	50	PATHOLOGY	78	RHINOLOGY
17	GASTROENTEROLOGY	51	PATHOLOGY, ANATOMIC	79	SLEEP DISORDERS
18	GENERAL PRACTICE	52	PATHOLOGY, CLINICAL	100	SPORTS MEDICINE
19	GERIATRICS	53	PATHOLOGY, FORENSIC	80	SURGERY, ABDOMINAL
20	GYNECOLOGY	54	PED. ALLERGY	81	SURGERY, CARDIOVASC
21	HEMATOLOGY	55	PED. CARDIOLOGY	91	SURGERY, COLON/RECTAL
22	HYPNOSIS	09	PED. CRITICAL CARE	82	SURGERY, GENERAL
23	IMMUNOLOGY	97	PED. EMERGENCY MED	83	SURGERY, HAND
24	INFECTIOUS DISEASES	56	PED. ENDOCRINOLOGY	84	SURGERY, HEAD/NECK
25	INFERTILITY	57	PED. HEMAT/ONCOLOGY	92	SURGERY, MAXILLOFAC
26	INTERNAL MEDICINE	58	PED. INFECTIOUS DIS	93	SURGERY, NEUROLOGICAL
27	LARYNGOLOGY	59	PED. INTENSIVIST	85	SURGERY, ORTHOPEDIC
28	LEGAL MEDICINE	60	PED. NEPHROLOGY	86	SURGERY, PLASTIC
29	MATERNAL/FETAL MED	98	PED. NEUROLOGY	87	SURGERY, THORACIC
30	NEUR/PERINATAL MED	101	PED. OPHTHALMOLOGY	88	SURGERY, TRAUMATIC
31	NEOPLASTIC DISEASES	61	PED. PHYSIATRY	89	SURGERY, UROLOGIC
32	NEPHROLOGY	96	PED. PULMONARY	90	SURGERY, VASCULAR
33	NEUROLOGY	62	PED. RADIOLOGY	94	UROLOGY
34	NEUROPATHOLOGY	63	PED. SURGERY		

	Code	Percent of Time	Board Certified (Indicate Yes/No)
Primary	70	70	YES
Secondary	46	30	
Tertiary			

PLEASE INDICATE AMERICAN BOARD OF MEDICAL SPECIALTIES BOARD CERTIFICATION:

	Date of Initial Certification	Date of Last Certification
Board The American Board of OB Gyn	11/10/67 (Mo./Yr.)	(Mo./Yr.)
Subboard	(Mo./Yr.)	(Mo./Yr.)

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

	SELF-EMPLOYED		SALARIED, EMPLOYED BY (continued)
1001	Solo Practice	1006	Other Non-Government Employer (hospital, school, etc.)
1002	Partnership or Group Practitioners	1007	Federal Government (armed services personnel only)
	SALARIED, EMPLOYED BY:	1008	Federal Government (civilian, P.H.S., etc.)
1003	Individual Practitioner	1009	State Government
1004	Partnership or Group of Practitioners	1010	County Government
1005	Group Health Plan Facility (such as H.M.O.)	1011	Local Government
		1012	Other (specify)_____

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

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

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

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments; and

2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and

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

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

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

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

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

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

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

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

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

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

6. Have you ever been investigated for, charged with, convicted of, or plead guilty or nolo contendere to, any offense or violation of any federal, state or local law, including any foreign country, which is a misdemeanor, gross misdemeanor, or felony, excluding any minor traffic offense (Driving or in control of a motor vehicle while under the influence of any substance is not considered a minor traffic offense) or which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? ____Yes ✓No

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

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

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

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

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

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

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

Hospital	Mailing Address	Type of Action	Dates of Action From (Mo./Yr.) To (Mo./Yr.)

If more space is needed, attach separate sheet.

PLEASE CHECK ONE OF THE FOLLOWING:

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

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

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

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

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

Signature _____

Signature stamp unacceptable

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

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

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

702-642-4091 Business Telephone #

1/30/97 Date

_____ Signature (SIGNATURE STAMP UNACCEPTABLE)

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

Date Received by State Board
MAY 04 1995

License No. _____
File No. _____

This shaded section for BOARD USE ONLY

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

✓ ACTIVE STATUS $420
_____ INACTIVE STATUS $150 (see attached NRS 630.255 & 630.257)
_____ RETIRED STATUS $ 50 (see attached NRS 630.256 & 630.257) (MUST NOT BE PRACTICING MEDICINE IN ANY STATE)
_____ P.A. SUPERVISING PHYSICIAN $200

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

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

INSTRUCTIONS - TYPE OR PRINT LEGIBLY

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

Name _____

Street _____

City _____ County _____ State _____ Zip Code _____

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

Name _____

Street _____

City _____ County _____ State _____ Zip Code _____

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

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

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

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

PLEASE PROVIDE ALL INFORMATION AS REQUESTED.

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

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

SPECIALTY CODE:

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

	Code	Percent of Time	Board Certified (Indicate Yes/No)
Primary	20	100	YES
Secondary			
Tertiary			

PLEASE INDICATE AMERICAN BOARD OF MEDICAL SPECIALTIES BOARD CERTIFICATION:

	Date of Initial Certification (Mo./Yr.)	Date of Last Recertification (Mo./Yr.)
Board OB/GYN	11/67	
Subboard		

3. How many hours per week do you spend in each of the following activities?
   40 hours Patient care or services
   _____ hours Administration (schools, agencies, associations, etc.)
   _____ hours Teaching medical courses
   _____ hours Research
   10-15 hours Other (specify Surgery)

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

	SELF-EMPLOYED		
1001	Solo Practice	1006	Other Non-Government Employer (hospital, school, etc
1002	Partnership or Group Practitioners	1007	Federal Government (armed services personnel only)
		1008	Federal Government (civilian, P.H.S., etc.)
	SALARIED, EMPLOYED BY	1009	State Government
1003	Individual Practitioner	1010	County Government
1004	Partnership or Group of Practitioners	1011	Local Government
1005	Group Health Plan Facility (such as H.M.O.)	1012	Other (specify _____)

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

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

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

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

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

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

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

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

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

Have you previously applied for medical licensure in Nevada (including a residency program)? ☑ Yes ☐ No

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

Hospital	Mailing Address	Type of Action	Dates of Action From (Mo./Yr.)	To (Mo./Yr.)

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

CONTINUING MEDICAL EDUCATION

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

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

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

(b) Be approved by the board; and

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

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

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

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

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

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

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

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

PLEASE CHECK ONE OF THE FOLLOWING:

1. ✓ I have earned a minimum of 40 hours approved AMA Category I continuing medical education (CME) for the biennial period July 1, 1993 through June 30, 1995.
2. ____ I was initially licensed in Nevada during the second six months of the biennial period July 1, 1993, through June 30, 1995 and have earned a minimum of 30 hours approved AMA Category I continuing medical education (CME).
3. ____ I was initially licensed in Nevada during the third six months of the biennial period July 1, 1993, through June 30, 1995 and have earned a minimum of 20 hours approved AMA Category I continuing medical education (CME).
4. ____ I was initially licensed in Nevada during the fourth six months of the biennial period July 1, 1993, through June 30, 1995 and have earned a minimum of 10 hours approved AMA Category I continuing medical education (CME).
5. ____ I am exempt from submitting proof of continuing medical education (CME) because I have completed a full year of residency or fellowship training during the biennial period July 1, 1993 through June 30, 1995.

Signature _____ (SIGNATURE STAMP UNACCEPTABLE)

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

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

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

642-4091 (Business Telephone #) 4/25/95 (Date) X _____ (Signature (SIGNATURE STAMP UNACCEPTABLE))

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

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

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

3. The board shall notify a licensee:

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

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

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

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

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

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

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

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

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

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

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

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

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

630.256 Retired licensees: Duties; requirements for reinstatement.

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

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

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

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

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

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

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

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

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

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

APPLICATION FOR REGISTRATION

NEVADA STATE BOARD OF MEDICAL EXAMINERS

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

Date Received by State Board: APR 5 1993

License No. 2641

File No. ____

New ☐ Renewal ☑

This shaded section for BOARD USE ONLY

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

☐ ACTIVE STATUS	$320.00
☐ INACTIVE STATUS	$150.00
☐ RETIRED STATUS	$ 50.00

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

Frank P. Silver, MD
2831 McDaniel St #210
N Las Vegas NV 89030-0000

0004041

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

INSTRUCTIONS – TYPE OR PRINT LEGIBLY

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

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

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

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

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

Name_____

Street _____

City _____ County _____ State _____ Zip Code _____

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

ACTIVE REGISTRANTS MUST SUBMIT PROOF OF 40 HOURS AMA CATEGORY I CONTINUING MEDICAL EDUCATION (CME).

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

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

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

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

SPECIALTY CODE:

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

	Code	Percent of Time	Board Certified (Indicate Yes/No)
Primary	20	90%	yes
Secondary	_____	_____	_____
Tertiary	_____	_____	_____

PLEASE INDICATE AMERICAN BOARD OF MEDICAL SPECIALTIES BOARD CERTIFICATION:

Board Am. Board Ob-Gyn.

Subboard _____

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

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

SELF-EMPLOYED	
1001 Solo Practice	1008 Federal Government (civilian P.H.S., etc.)
1002 Partnership or Group Practitioners	1009 State Government
SALARIED, EMPLOYED BY	1010 County Government
1003 Individual Practitioner	1011 Local Government
1004 Partnership or Group of Practitioners	1012 Other (specify _____)
1005 Group Health Plan Facility (such as H.M.O.)	
1006 Other Non-Government Employer (hospital, school, etc.)	
1007 Federal Government (armed services personnel only)	

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

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

PLEASE LIST CURRENT HOSPITAL AFFILIATION(S):

Name	Address
LAKE MEAD	1401 LAKE MEAD BLVD N. LAS VEGAS
UMC	1800 W. Charleston Blvd. LAS VEGAS
Valley	Shadow Lane Las Vegas

CONTINUING MEDICAL EDUCATION

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

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

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

(b) Be approved by the board; and

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

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

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

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

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

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

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

PLEASE CHECK ONE OF THE FOLLOWING:

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

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

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

Signature _____ (SIGNATURE STAMP UNACCEPTABLE)

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

Date of Birth: 8 23 34 (month/day/year) Social Security Number: [redacted] DEA Number: [redacted]

Medical School: Thomas Jefferson - Un- Phila Pa.
City State

Internship: Nazareth Hospital Phila Pa.
City State

Residency: Episcopal Hospital Phila Pa.
City State

City State

City State

Fellowship: ACOG.
City State

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

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

642-4091 (Business Telephone #) 4/1/93 (Date) X _____ (Signature (SIGNATURE STAMP UNACCEPTABLE))

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

APPLICATION FOR REGISTRATION
NEVADA STATE BOARD OF MEDICAL EXAMINERS

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

Date Received by State Board: APR 12 1991

License No. _____

File No. _____

New ☐ Renewal ☐

This shaded section for BOARD USE ONLY

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

☒ ACTIVE STATUS	$400.00
☐ INACTIVE STATUS	$150.00
☐ RETIRED STATUS	$ 50.00

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

NRS630 explanation of status on reverse side

Frank P. SILVER, MD 0000041
1401 E. Lake Mead Blvd Ct
N Las Vegas NV 89030-0000

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

TYPE OR PRINT LEGIBLY

NAME Silver, (Last) Frank P. (First Middle)

Social Security # _____

Business Phone (702) 642 4091

BUSINESS OR MAILING ADDRESS 1401 E.Lake Mead Blvd. N. Las Vegas,NV 89030
(Street Address or P.O. Box, Suite No., City, State, Zip Code)

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

NAME _____

ADDRESS _____

PHONE # (____) _____

BOARD OF CERTIFICATION

Yes * No _____

AM. Bd. of The American Board of OB GYN

Date of Certification or Recertification 1967

Primary Specialty (List only one) GYN Sub-Specialties: _____

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

Signature _____ Date 4/4/91
(No rubber stamps)

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

1. Have you been investigated by, or charged or convicted of unprofessional conduct, professional incompetence or gross or repeated malpractice by any medical licensing board or other agency, hospital or medical society? Yes ☐ No ☒

2. Have you been arrested, fined (over $100), charged with or convicted of a crime, indicted, imprisoned or placed on probation? Yes ☐ No ☒

3. Have you been investigated, arrested, charged or convicted for the possession, use of, or illegal sale or dispensing of controlled substances? Yes ☐ No ☒

4. Have you been denied a medical license or surrendered your license to practice in another jurisdiction or had your medical license or right to practice medicine revoked, suspended or limited in another jurisdiction. Yes ☐ No ☒

5. Have you had staff privileges in a hospital denied, suspended, limited, revoked or not renewed, or have you resigned from a medical staff in lieu of disciplinary or administrative action, excluding failure to complete medical records? Yes ☐ No ☒

6. Have any malpractice settlements, awards or judgments been made against you in any jurisdiction? Yes ☐ No ☒

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

1. Community Hospital N.Las Vegas,NV 89030
2. Valley Hospital Las Vegas,NV 89102
3. University Medical Center Las Vegas,NV 89102
5. _____
6. _____

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

Signature _____ Date 4/4/91
(No rubber stamps)

NOTE: Have you signed both "signature" lines.

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

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

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; and

(d) Pay the applicable fee for biennial registration.

3. If the board determines that the conduct 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)

630.256 Retired licensees: Duties; reinstatement. 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. If a licensee who is retired desires to return to the practice of medicine, he shall apply to the board for registration and pay the applicable fee for biennial registration.

(Added to NRS by 1985, 2222)

630.257 Re-examination of inactive or retired licensee. If a licensee does not practice allopathic or homeopathic 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)

REMINDER: NEVADA LAW REQUIRES NOTICE TO THE BOARD PRIOR TO CHANGING YOUR PRACTICE LOCATION OR CLOSURE OF OFFICE.
(NRS 630.254)

APPLICATION FOR REGISTRATION
NEVADA STATE BOARD OF MEDICAL EXAMINERS

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

RECEIVED
APR 24 1989
NEVADA STATE BOARD OF MEDICAL EXAMINERS

License No. 2641
File No. _____
New ☐ Renewal X
for BOARD USE ONLY

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

X ACTIVE STATUS	$300.00
☐ INACTIVE STATUS	$150.00
☐ RETIRED STATUS	$ 50.00

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

NRS630 explanation of status on reverse side

4041

Frank P. SILVER MD

1401 E Lake Mead Blvd
N Las Vegas NV 89030

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

TYPE OR PRINT LEGIBLY

NAME Silver (Last) Frank (First) P. (Middle)

Social Security # _____

Business Phone (702 642-4091

BUSINESS OR MAILING ADDRESS 1401 E. Lake Mead Blvd. C-1 N Las Vegas Nevada 89030
(Street Address or P.O. Box) (Suite No.) (City) (State) (Zip Code)

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

NAME _____

ADDRESS _____

PHONE # (____) _____

BOARD OF CERTIFICATION

Yes _____ No _____

AM. Bd. of _____

Date of Certification or Recertification _____

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

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

Signed: [signature] Date 4/19/89.
(No rubber stamps)

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

1. Have you been investigated, charged or convicted of unprofessional conduct, professional incompetence or gross or repeated malpractice by any medical licensing board or other agency, hospital or medical society? Yes ☐ No X

2. Have you been arrested, fined (over $100), charged with or convicted of a crime, indicted, imprisoned or placed on probation? Yes ☐ No X

3. Have you been investigated, arrested, charged or convicted for the possession, use of, or illegal sale or dispensing of controlled substances? Yes ☐ No X

4. Have you been denied a medical license or surrendered your license to practice in another jurisdiction or had your medical license revoked, suspended or limited in another jurisdiction. Yes ☐ No X

5. Have you had staff privileges in a hospital denied, suspended, limited, revoked or not renewed, or have you resigned from a medical staff in lieu of disciplinary or administrative action, excluding failure to complete medical records? Yes ☐ No X

6. Have any malpractice settlements, awards or judgments been made against you in any jurisdiction? Yes ☐ No X

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

1. UMC
2. Community
3. Valley
4. _____
5. _____
6. _____

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

Signature [signature] Date 4/19/89
(No rubber stamps)

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

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

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; and

(d) Pay the applicable fee for biennial registration.

3. If the board determines that the conduct 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)

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(Added to NRS by 1985, 2222)

630.257 Re-examination of inactive or retired licensee. If a licensee does not practice allopathic or homeopathic 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)

REMINDER: NEVADA LAW REQUIRES NOTICE TO THE BOARD PRIOR TO CHANGING YOUR PRACTICE LOCATION OR CLOSURE OF OFFICE.
(NRS 630.254)

APPLICATION FOR REGISTRATION

NEVADA STATE BOARD OF MEDICAL EXAMINERS

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

RECEIVED
Date Received by State Board
JUN 05 1987
NEVADA STATE BOARD OF MEDICAL EXAMINERS

License No. 75
File No.
New ☐ Renewal ☑
BOARD USE ONLY

I hereby apply for a 1987-89 certificate of biennial registration and enclose the appropriate fee as indicated below:

☑ ACTIVE STATUS	$300.00
☐ INACTIVE STATUS	$150.00
☐ RETIRED STATUS	$ 50.00

NRS630 explanation of status on reverse side

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

TYPE OR PRINT LEGIBLY

NAME Silver, Frank P.
Last First Middle

Social Security #

Business Phone # (702) 642-4091

BUSINESS OR MAILING ADDRESS 1401 E.Lake Mead Blvd. No. Las Vegas,Nevada 89030
Street Address or P.O. Box Suite No. City State Zip Code

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

NAME Frank P. Silver, M.D.

ADDRESS 1401 E. Lake Mead Blvd. N. LV,NV 89030

PHONE # (702) 642-4091

BOARD OF CERTIFICATION

Yes X No 67-2-56Y

AM. Bd. of OB/GYN

Date of Certification or Recertification 11/12/67

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

I certify that since July 1, 1985, I have completed a minimum of 40 hours of Continuing Medical Education, AMA-Category 1 and that I have in my files documentation of such. I understand that the CME requirement is mandated by NRS 630.253 and NAC 630.153.

Signed: [signature] Date 5/28/87
(No rubber stamps please)

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

1. Have you been investigated, charged or convicted of unprofessional conduct, professional incompetence or gross or repeated malpractice by any medical licensing board or other agency, hospital or medical society? Yes ☐ No ☑

2. Have you been arrested, fined (over $100), charged with or convicted of a crime, indicted, imprisoned or placed on probation? Yes ☐ No ☑

3. Have you been investigated, arrested, charged or convicted for the possession, use of, or illegal sale or dispensing of controlled substances? Yes ☐ No ☑

4. Have you been denied a medical license or surrendered your license to practice in another jurisdiction or had your medical license revoked, suspended or limited in another jurisdiction. Yes ☐ No ☑

5. Have you had staff privileges in a hospital denied, suspended, limited, revoked or not renewed, or have you resigned from a medical staff in lieu of disciplinary or administrative action? Yes ☐ No ☑

6. Have any malpractice settlements, awards or judgments been made against you in any jurisdiction? Yes ☑ No ☐

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

1. University Medical Center, LV,NV
2. Valley Hospital, LV,NV
3. Community Hospital, LV,NV
4.
5.
6.

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

Signature [signature] Date 5/28/87
(No rubber stamps please)

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

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

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; and

(d) Pay the applicable fee for biennial registration.

3. If the board determines that the conduct 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)

630.256 Retired licensees: Duties; reinstatement. 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. If a licensee who is retired desires to return to the practice of medicine, he shall apply to the board for registration and pay the applicable fee for biennial registration.

(Added to NRS by 1985, 2222)

630.257 Re-examination of inactive or retired licensee. If a licensee does not practice allopathic or homeopathic 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)

APPLICATION FOR REGISTRATION
NEVADA STATE BOARD OF MEDICAL EXAMINERS

P[illegible] Office Box 7238 Reno, Nevada 89510 Phone (702) 329-2559

Date Received by State Board

Nevada License No. _____

File No. _____

New ☐ Renewal ☐

This shaded section for BOARD USE ONLY

I hereby apply for a 1985-87 certificate of biennial registration and enclose the appropriate prorated fee as indicated below:

☑ ACTIVE STATUS $250.00
☐ INACTIVE STATUS $100.00
☐ RETIRED (NO FEE REQUIRED FOR 1985-87)

Delinquent after September 15, 1985.

4041

Frank P SILVER

1401 E Lake Mead Blvd
N Las Vegas NV 89030

PRACTICE: (Check One Only)
☑ Direct Patient Care ☐ Resident
☐ Administration ☐ Military
☐ Medical Teaching ☐ Retired

TYPE OR PRINT LEGIBLY

NAME Silver (Last) Frank (First) P. (Middle)

Social [illegible]

Business Phone 702 642-4001

BUSINESS OR MAILING ADDRESS 1401 E. Lake Mead Blvd. No. Las Vegas, Nevada 89030
(Street Address or P.O. Box) (Suite No) (City) (State) (Zip Code)

NEW ADDRESS: If your address will change within the next two months, show new address below.
(If longer than two months, notify this office by letter just prior to changing location.)

ADDRESS WILL CHANGE ON: _____ 19____

BUSINESS OR MAILING ADDRESS _____
(Street Address or P.O. Box) (Suite No) (City) (State) (Zip Code)

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

NAME _____

ADDRESS _____

PHONE # ( ) _____

BOARD CERTIFICATION:

Yes X No _____

AM. Bd. of Obstetrics & Gynecology

Date of Certification or Recertification 11-2-67

Primary Specialty (List only one) OB/GYN **Sub-Specialties:** _____

SINCE YOUR LAST REGISTRATION:

1. Have you been investigated, charged or convicted of unprofessional conduct, professional incompetence or gross or repeated malpractice by any medical licensing board or other agency, hospital or medical society? ***
   Yes ☐ No ☑ If "yes" attach a detailed explanation
2. Have you been investigated, charged or convicted for the possession, use of, or illegal sale or dispensing of controlled substances?
   Yes ☐ No ☑ If "yes" attach a detailed explanation
3. Have you surrendered your license to practice medicine in another jurisdiction?
   Yes ☐ No ☒ X If "yes" attach a detailed explanation
4. Have any malpractice settlements, awards or judgment been made against you in any jurisdiction?
   Yes ☐ No ☒ X If "yes" attach a detailed explanation

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

1. Southern Nevada Memorial
2. Valley Hospital
3. Community Hospital
4. _____

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

I certify that all the above statements are true.

Signature _____ M.D.
No rubber stamps please

APPLICATION FOR REGISTRATION
NEVADA STATE BOARD OF MEDICAL EXAMINERS

Post Office Box 7238 · Reno, Nevada 89510 · Phone (702) 329-2369

NOV 13 1984

Delinquent after March 2, 1985 | Nevada License No. NV 2641 | File No.

Date of License | New ☐ Renewal ☑

This shaded section for BOARD USE ONLY

I hereby apply for a 1985 certificate of annual registration AND ENCLOSE the fee for $100.00

2641
SILVER, FRANK P MD
1401 E LAKE MEAD BLVD
NO LAS VEGAS NV 89030

PRACTICE: (Check One Only)
- ☐ Direct Patient Care
- ☐ Administration
- ☐ Medical Teaching
- ☐ Resident
- ☐ Military
- ☐ Retired

TYPE OR PRINT LEGIBLY

NAME: Silver, (Last) Frank P. (First) (Middle)

Social Security No.

Date of Birth: 7-[illegible]-42 4001

BUSINESS OR MAILING ADDRESS: 1401 E. Lakemead Blvd. N. Las Vegas, NV 89030
(Street Address or P.O. Box) (Suite No.) (City) (State) (Zip Code)

NEW ADDRESS: If your address will change within the next two months, show new address below.
(If longer than two months, notify this office by letter just prior to changing location.)

ADDRESS WILL CHANGE ON: ..... 19....

BUSINESS OR MAILING ADDRESS: .....
(Street Address or P.O. Box) (Suite No.) (City) (State) (Zip Code)

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

NAME .....

ADDRESS .....

PHONE ( ) .....

BOARD CERTIFICATION:

Yes ..... No .....

AM. Bd. of .....

Date of Certification or Recertification .....

Primary Specialty (List only one) Ob-GYN Sub-Specialties: .....

SINCE YOUR LAST REGISTRATION:

1. Have you been investigated, charged or convicted of unprofessional conduct, professional incompetence or gross or repeated malpractice by any medical licensing board or other agency, hospital or medical society?
   Yes ☐ No ☑ If "yes" attach a detailed explanation

2. Have you been investigated, charged or convicted for the possession, use of, or illegal sale or dispensing of controlled substances?
   Yes ☐ No ☑ If "yes" attach a detailed explanation

3. Have you surrendered your license to practice medicine in another jurisdiction?
   Yes ☐ No ☑ If "yes" attach a detailed explanation

4. Have any malpractice settlements, awards or judgment been made against you in any jurisdiction?
   Yes ☐ No ☑ If "yes" attach a detailed explanation

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

1. Southern Nevada Memorial Hosp. Las Vegas, NV
2. Valley Hospital Las Vegas, NV
3. North Las Vegas Community Hosp. N. Las Vegas, NV
4. .....

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

I certify that all the above statements are true

Signature ..... M.D.
No rubber stamps please

APPLICATION FOR REGISTRATION
NEVADA STATE BOARD OF MEDICAL EXAMINERS

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

NOV 29 1983

Delinquent after March 1, 1984

Nevada License No. 2641 Date of License 8/8/72

File No. ..... New ☐ Renewal ☒

This shaded section for BOARD USE ONLY

I hereby apply for a 1984 certificate of annual registration AND ENCLOSE the fee for $75.00.

2641
SILVER, FRANK P MD
1401 E LAKE MEAD BLVD
NO LAS VEGAS NV 89030

TYPE OR PRINT LEGIBLY

NAME Silver (Last) Frank (First) P. (Middle)

Social Security # ___-___-____

Business Phone ( ) 702-642-4091

BUSINESS ADDRESS 1401 E. Lake Mead (City) North Las Vegas, (State) Nevada 89030 (Zip Code)

MAILING ADDRESS 1401 E. Lake Mead (City) North Las Vegas, (State) Nevada 89030 (Zip Code)

NOTE: Business Address will be used as directory address unless requested otherwise IN WRITING!

NEW ADDRESS: If your address will change within the next two months, show new address below.
(If longer than two months, notify this office by letter just prior to changing location.)

ADDRESS WILL CHANGE ON: ..... 19....

BUSINESS ADDRESS ..... (City) ..... (State) ..... (Zip Code)

MAILING ADDRESS ..... (City) ..... (State) ..... (Zip Code)

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

NAME .....

ADDRESS .....

PHONE # ( ) .....

BOARD CERTIFICATION:

Yes X No .....

AM. Bd. of .....

Date of Certification or Recertification .....

Primary Specialty (List only one) Obstetrics Sub-Specialties: Gynecology

Has any disciplinary action been taken against you in any jurisdiction since your last registration? Yes ☐ No ☒ If "yes" attach a detailed explanation

Has any malpractice action been taken against you in any jurisdiction since your last registration? Yes ☐ No ☒ If "yes" attach a detailed explanation

PRACTICE: (Check One Only)

Direct Patient Care ☐
Administration ☐
Medical Teaching ☐
Military ☐
Retired ☐

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

1. Southern Nevada Memorial 2. Valley Hospital
3. North Las Vegas 4. .....

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

I certify that all the above statements are true

Signature ..... M.D.
No rubber stamps please

AFFIDAVIT AS TO MORAL AND PROFESSIONAL CHARACTER

(To be filled in by two physicians in applicant's county)

Lester Rauer, M.D., being duly sworn, deposes and says:

I reside at 5030 Oxford Avenue, in the County of Philadelphia, in the State of Pennsylvania, and am personally acquainted with Dr. Frank P. Silver, and know him to be the identical person named in the accompanying diploma, and he is of good moral and professional character.

Subscribed and sworn to before me this 28th day of April, A.D. 1962

Notary Public, Philadelphia, Philadelphia Co.
My Commission Expires ... 1972

Name Lester Rauer M.D.
Address 5030 Oxford Avenue
Philadelphia, Pa. 19124

(Suggestion: Endorsement by the Secretary of County Medical Society)

Charles Q. Griffith, M.D., being duly sworn, deposes and says:

I reside at 1789 Washington Lane, in the County of Montgomery, in the State of Pennsylvania, and am personally acquainted with Dr. Frank P. Silver, and know him to be the identical person named in the accompanying diploma, and he is of good moral and professional character.

Subscribed and sworn to before me this 28th day of April, A.D. 1962

MARY T. ZAWISZA
Notary Public, Philadelphia, Philadelphia Co.
My Commission Expires November 27, 1962

Name Charles Q. Griffith M.D.
Address 1789 Washington Lane
Meadowbrook, Pennsylvania

DO NOT FILL THE BLANKS BELOW

RECIPROCITY

With .....

NEVADA STATE BOARD OF MEDICAL EXAMINERS

Certificate No. .....
Issued ....., 19....
Filed ....., 19....
Approved by board ....., 19....
Fee paid ....., 19....
Nevada Basic Science Certificate No. .....
issued ....., 19....
Temporary permit (if any): No. .....
issued ....., 19....
Credentials verified ....., 19....
By ..... Secretary
Credentials returned ....., 19....
By .....

APPLICANT MUST FILL FOLLOWING BLANKS

Address 715 Martin Road, Elkins Park, Pa.
Age 37 Date of birth 8/23/24
Place of birth Philadelphia, Pennsylvania
Name of college issuing medical diploma: Thomas Jefferson Medical College, located at 11th and Walnut Sts., Phila. 19107
Date of graduation 1961
Internship Nazareth Hospital
Located at 2601 Holme Avenue
from July 1,61 to June 30, 1962
Total years of practice 7 years
your specialty Ob-Gyn
Certificate No. 028396 issued by: Pennsylvania State Board of Medical Examiners
on July 16, 1962

Signature of applicant .....

The above photograph and signature must be certified by your State Board of Endorsement.

PHOTOGRAPH NOT AVAILABLE FOR COMPARISON.

Signature of the Secretary .....

FINGER PRINTS OF RIGHT HAND

CERTIFICATE OF STATE ENDORSEMENT

I, Alva R. Cockley of Harrisburg, Pennsylvania

Secretary of the Pennsylvania State Board of Medical Education & Licensure

hereby certify that Dr. Frank Silver of

Philadelphia, Pennsylvania was granted on the 20th day of July, 1962,

Certificate No. 28394 by the Pennsylvania

State Board of Medical Education & Licensure upon examination by the said Board in

the following subjects:

Anatomy & Bacteriology, 77
~~Anatomy ..... rating ..... percent~~
Pathology, 83
~~Chemistry ..... rating ..... percent~~
Symptomatology & Therapeutics, 75
~~Materia Medica and Therapeutics .... rating ..... percent~~
Public Health, Sanitation & Medical Jurisprudence, 79
~~Obstetrics ..... rating ..... percent~~

Chemistry, Physiology & Pharmacology, 83
~~Pathology ..... rating ..... percent~~
Obstetrics, Gynecology & Pediatrics, 85
~~Physiology ..... rating ..... percent~~
Surgery, 84
~~Theory and~~ practice ..... rating ..... percent
~~Surgery ..... rating ..... percent~~

~~Total~~

I further certify that the ratings herein given are true and correct and that the said applicant was awarded a general average of 80.9 percent thereon. I further certify that no certificate issued by this Board to the said Frank Silver has ever been revoked or suspended, and that from the records now on file in this office I believe him to be of good moral character and worthy of professional recognition, and recommend him to the Nevada State Board of Medical Examiners as a fit and proper person to receive reciprocal recognition by the Nevada State Board of Medical Examiners. In testimony thereof witness my hand and seal.

Alva R. Cockley ~~SEAL~~

Secretary of the Pennsylvania State Board of Medical Education & Licensure

[SEAL]

Post office address ... 279 Boas Street, Harrisburg, Pennsylvania 17120

Dated at Harrisburg, Pennsylvania,

this 10th day of May, 19 72

NOTE — The applicant should, in all cases, fill in the information required in this application, certify to the same before the Clerk of a court of record and then forward the application to the Secretary of the Board issuing his original certificate for verification and certification.

STATE OF ~~NEVADA~~ Pennsylvania }
Philadelphia County } ss.

Before me personally appeared FRANK Paul SILVER, whose signature, recent photograph, and fingerprints of right hand on page 4 of this from and made oath and says that all of the foregoing statements are true and correct.

Sworn and subscribed to this 28th day of April, A.D. 19 71

Helen J. Zamagni

~~Clerk of the~~ Notary Public Court

[SEAL] of Phila. County, State of Pennsylvania

~~[illegible]~~ Notary Public, Philadelphia, Philadelphia Co.

The above deposition must in all cases be duly acknowledged before a Notary Public or other proper officer. Diploma, State Certificate, Intern Certificate, Nevada Basic Sciences Certificate, fee and application should in all cases be sent together, if possible, to the Nevada State Board of Medical Examiners, 3660 Baker Lane, Reno, Nevada. (Photostatic copies are acceptable.)

HISTORY OF YEARS OF PRACTICE SINCE GRADUATION (Including Residences)

Where?	What Dates?
Nazareth Hospital (Internship)	1961-1962
Episcopal Hospital Ob-Gyn Residency	1962 - 1965
Private Practice Philadelphia, Pa.	1965 through present time

Have you ever been convicted of a felony? No Morals charge? No

Have you ever been addicted to the use of narcotics? No Alcohol? No

Have you ever been expelled from a Medical Society Yes ..... or No No

If Yes, please give details on separate sheet.

List all State and County Medical Societies of which you are, or have been, a member.

American Medical Association

Philadelphia County Medical Society

Philadelphia Obstetrics Society

American College of Obstetrics-Gynecology

Give the name and address of all Hospitals of which you are, or have been, a Staff member. (Do not give Residences.)

Episcopal Hospital, Front St. and Lehigh Ave., Phila., Pa. 19125

Nazareth Hospital, 2601 Holme Avenue, Philadelphia, Pa. 19152

Northeastern Hospital, 2301 E. Allegheny Ave., Philadelphia, Pa. 19134

Temple University Hospital, Instructor, 3401 N. BroadSt., Phila., Pa. 19140

List Special Societies and Boards of which you are a member.

American Board of Obstetrics-Gynecology

APPLICATION FOR CERTIFICATE TO PRACTICE MEDICINE IN NEVADA

NOTE — No certificate will be issued except in strict accordance with reciprocal agreements. The fee of TWO HUNDRED DOLLARS ($200) must accompany the application, together with State certificate, intern certificate, and college diploma. (Photostatic copies are acceptable.) No certificate as to the possession of these credentials will be accepted in lieu thereof. All applications must be on file with the Secretary of this Board at least ONE MONTH prior to the date of Board meeting.

I, Frank P. Silver, M.D., depose and say that I am an applicant for a certificate to practice medicine, surgery and obstetrics in the State of Nevada under reciprocal agreements with the State of Pennsylvania

That I am a citizen of United States and a native of Pennsylvania

If not a citizen of the United States, have you applied for U. S. citizenship? .....

Aged 37 years, and a resident of 715 Martin Road, Elkins Park

County of Philadelphia, State of Pennsylvania, where I have been engaged in the practice of medicine for a period of 7 years preceding the date of this application. That I received my medical education in

Thomas Jefferson Medical College - 1957 - 1961

(Give names of all medical schools and dates of attendance)

That I was granted a diploma as a graduate in Medicine by Thomas Jefferson Medical College, 11th and Walnut Streets

(Give the name of your medical school of graduation)

located in Philadelphia State of Pennsylvania on the 6th day of June, 19 61; That I was granted Certificate No. 028394 by the Pennsylvania State Board of Medical Examiners dated July 16, 1962, upon Written Examination

(Written examination or diploma)

That I am the identical person to whom said Diploma and Certificate were originally granted.

Signed ....., Applicant

(Name must be signed in full, use no initials)

DECLARATION AS TO PREVIOUS REGISTRATION OR EXAMINATIONS

I, Frank P. Silver, M.D., hereby declare that I am the applicant who signed the foregoing application; that the photograph of myself hereunto attached was taken on or about the 12th day of April, 19 72, my age then being 37 years. I further state that I am not registered as a physician in any other State except as follows: .....

.....

and that no certificate issued to me by any State Board has even been revoked or suspended.

I further state that I have not, previous to this date, applied for examination, license or registration to any State Examining Board except as follows: .....

.....

.....

Signed ....., Applicant

(Name must be signed in full, use no initials)