3597	RAMOS, William Douglas	Have you been arrested, investigated for, charged with, convicted of, or pled guilty or nolo contendere to any offense or violation of any federal (including the Uniform Code of Military Justice), state or local law, or the laws of any foreign country, which is a misdemeanor, gross misdemeanor, felony, violation of the Uniform Code of Military Justice, or synonymous thereto in a foreign jurisdiction, excluding any minor traffic offense (driving or being in control of a motor vehicle while under the influence of a chemical substance, including alcohol, is not considered a minor traffic offense), or for any offense which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? Please note that you MUST disclose ANY investigation or arrest, including those where the final disposition was dismissal, or expungement.	N	4/7/2011
3597	RAMOS, William Douglas	Have you been denied a license, permission to practice medicine or any other healing art, or permission to take an examination to practice medicine or any other healing art in any state, country or U.S. territory?	N	4/7/2011
3597	RAMOS, William Douglas	Have you had a medical license or license to practice any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory?	N	4/7/2011
3597	RAMOS, William Douglas	Have you voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory in lieu of any disciplinary action?	N	4/7/2011
3597	RAMOS, William Douglas	Have you been denied membership, been asked to resign or expelled from a medical society or other professional medical organization (including the ABMS)?	N	4/7/2011

3597	RAMOS, William Douglas	Have you been: a) asked to respond to an investigation; b) notified that you were under investigation for; c) investigated for; d) charged with; or e) convicted of any violation of a statute, rule or regulation governing your practice as a physician by any medical licensing board, hospital, medical society, governmental entity or agency other than the Nevada State Board of Medical Examiners?	N	4/7/2011
3597	RAMOS, William Douglas	Have you surrendered your state or federal controlled substance registration or had it revoked or restricted in any way?	N	4/7/2011
3597	RAMOS, William Douglas	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	4/7/2011
3597	RAMOS, William Douglas	Are you out of compliance with court ordered child support? If this does not apply to you, please answer "no". If "Yes" during the time period July 1, 2009 - June 30, 2011 type an explanation in the textbox directly below this question.	N	4/7/2011
3597	RAMOS, William Douglas	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 choose the Inactive status in the dropdown box located at the end of the questions.	N	4/7/2011

3597	RAMOS, William Douglas	Is your license contingent upon maintaining certification with the American Board of Medical Specialties (ABMS) in the specialty of Family Practice, Emergency Medicine, or Preventative Medicine?	N	4/7/2011
3597	RAMOS, William Douglas	Do you want to change your scope of practice or specialty? If you answer "Yes" type your current scope of practice or specialty in the textbox directly below this question.	N	4/7/2011
3597	RAMOS, William Douglas	I have completed the required amount of AMA Category 1 CME within the current biennial. (Review CME information online at www.medboard.nv.gov) I understand that I may be included in a random audit following the July 1st, 2011 renewal. I agree to retain CME's taken between July 1, 2009 and June 30, 2011. If renewing to an Inactive status, CME is not required and "No" can be selected.	Y	4/7/2011
3597	RAMOS, William Douglas	I SWEAR OR AFFIRM UNDER THE PENALTY OF PERJURY THAT I PERSONALLY ANSWERED ALL OF THE QUESTIONS IN THIS APPLICATION AND THAT THE ANSWERS I HAVE PROVIDED ARE TRUE AND CORRECT.	Y	4/7/2011
3597	RAMOS, William Douglas	Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety?	N	5/4/2009
3597	RAMOS, William Douglas	If you have a medical condition which in any way impairs or limits your ability to practice medicine, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice?	N	5/4/2009
3597	RAMOS, William Douglas	If you use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety?	N	5/4/2009

3597	RAMOS, William Douglas	Have you had a professional liability (malpractice) claim paid on your behalf or paid such a claim yourself (including any military tort claims if applicable)? Please include: who, what, where (provide state), when and case number in the textbox directly below this question. Please fax a copy of the complaint, civil or otherwise to 775-688-2551.	N	5/4/2009
3597	RAMOS, William Douglas	Have you been named as a defendant, or been requested to respond as a defendant or potential defendant, to a legal action involving professional liability (malpractice)? Please include: who, what, where (provide state), and when in the textbox directly below this question.	Y	5/4/2009
3597	RAMOS, William Douglas	For the above question if your answer is "Yes" for the time period July 1, 2007 - June 30, 2009, please type your explanation in this text box.		5/4/2009
3597	RAMOS, William Douglas	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	5/4/2009
3597	RAMOS, William Douglas	Have you been arrested, investigated for, charged with, convicted of, or pled guilty or nolo contendere to any criminal offense other than a criminal offense listed in Question #6? Please note that you MUST disclose ANY investigation or arrest, including those where the final disposition was dismissal, sealing of a record, or expungement.	N	5/4/2009

3597	RAMOS, William Douglas	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	5/4/2009
3597	RAMOS, William Douglas	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	5/4/2009
3597	RAMOS, William Douglas	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	5/4/2009
3597	RAMOS, William Douglas	Have you been denied membership, been asked to resign or expelled from a medical society or other professional medical organization (including the ABMS)?	N	5/4/2009
3597	RAMOS, William Douglas	Regarding any medical licensing board, hospital medical society, or other governmental entity or agency (other than the Nevada State Board of Medical Examiners), have you been: (a) Asked to respond to an investigation; (b) Notified that you were under investigation for; (c) Investigated for; (d) Charged with; or (e) Convicted of any violation of a statute, rule or regulation governing your practice as a physician?	N	5/4/2009
3597	RAMOS, William Douglas	Have you surrendered your state or federal controlled substance registration or had it revoked or restricted in any way?	N	5/4/2009

3597	RAMOS, William Douglas	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	5/4/2009
3597	RAMOS, William Douglas	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	5/4/2009
3597	RAMOS, William Douglas	I hereby request my license to be placed on Inactive status, which means I will not physically practice in the state of Nevada.	N	5/4/2009
3597	RAMOS, William Douglas	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	5/4/2009
3597	RAMOS, William Douglas	I have completed the required amount of AMA Category 1 CME within the current biennial. (Review CME information online at www.medboard.nv.gov) I understand that I may be included in a random audit following the July 1st, 2009 renewal. I agree to retain CME's taken between July 1, 2007 and June 30, 2009.	Y	5/4/2009

3597	RAMOS, William Douglas	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	5/4/2009
3597	RAMOS, William Douglas	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	5/4/2009
3597	RAMOS, William Douglas	I hereby request my license to be placed on Inactive status, which means I will not physically practice in the state of Nevada.	N	5/4/2009
3597	RAMOS, William Douglas	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	5/4/2009
3597	RAMOS, William Douglas	I have completed the required amount of AMA Category 1 CME within the current biennial. (Review CME information online at www.medboard.nv.gov) I understand that I may be included in a random audit following the July 1st, 2009 renewal. I agree to retain CME's taken between July 1, 2007 and June 30, 2009.	Y	5/4/2009

3597	RAMOS, William Douglas	Have you been investigated for, arrested for, charged with, convicted of, or plead guilty or nolo contendere to any offense or violation of any federal (including the U.S. Military), state or local law, including any foreign country, which is in a foreign jurisdiction equivalent to, a misdemeanor, gross misdemeanor, court martial, or felony, excluding any minor traffic offense (driving or being in control of a motor vehicle while under the influence of any chemical substance and/or including alcohol, is not considered a minor traffic offense), or for any offense which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? Please note that you MUST disclose ANY investigation or arrest, even if the ultimate disposition was dismissal or expungement.	N	4/20/2007
3597	RAMOS, William Douglas	Have you been denied a license, permission to practice medicine or any other healing art, or permission to take an examination to practice medicine or any other healing art in any state, country or U.S. territory?	N	4/20/2007
3597	RAMOS, William Douglas	Have you had a medical license or license to practice any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory?	N	4/20/2007
3597	RAMOS, William Douglas	Have you voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory by the direct request of a medical board?	N	4/20/2007
3597	RAMOS, William Douglas	Have you been denied membership or expelled from a medical society or other professional medical organization?	N	4/20/2007

3597	RAMOS, William Douglas	Have you been: a) notified that you were under investigation for; b) investigated for; c) charged with; or d) convicted of any violation of a statute, rule or regulation governing your practice as a physician by any medical licensing board, hospital, medical society, governmental entity or agency other than the Nevada State Board of Medical Examiners?	N	4/20/2007
3597	RAMOS, William Douglas	Have you surrendered your state or federal controlled substance registration or had it revoked or restricted in any way ?	N	4/20/2007
3597	RAMOS, William Douglas	Have you had hospital staff privileges denied, suspended, limited, revoked or not renewed by the hospital? If you have answered "Yes" you will be required to submit a list of any and all resignations from any medical staff in lieu of disciplinary or administrative action via email to elicensensbme@medboard.nv.gov (Please Note: Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance.)	N	4/20/2007
3597	RAMOS, William Douglas	Is your license currently contingent upon compliance with the Diversion program also known as the Nevada Health Professionals Assistance Foundation?	N	4/20/2007
3597	RAMOS, William Douglas	Is your license currently contingent upon maintaining certification by the American Board of Medical Specialties in the specialty of Family Practice, Emergency Medicine or Preventative medicine?	N	4/20/2007
3597	RAMOS, William Douglas	Are you a foreign medical doctor, who holds a Conditional Resident Alien Card, Employment Authorization Card, or Visa with the Department of Homeland Security, Immigration and Naturalization Services?	N	4/20/2007

3597	RAMOS, William Douglas	Are you out of compliance with court ordered child support? If this does not apply to you please answer "no".	N	4/20/2007
3597	RAMOS, William Douglas	Do you want to change your scope of practice or specialty? If you answer "Yes" please email your request to elicensensbme@medboard.nv.gov	N	4/20/2007
3597	RAMOS, William Douglas	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	4/20/2007
3597	RAMOS, William Douglas	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	4/20/2007
3597	RAMOS, William Douglas	I have actively practiced medicine in Nevada within the past 12 months.	Y	4/20/2007
3597	RAMOS, William Douglas	I hereby request my license to be placed on Inactive status. I will not physically practice in the state of Nevada.	N	4/20/2007
3597	RAMOS, William Douglas	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	4/20/2007

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
FEB 10 2005
MAR 04 2005
(For Board Use Only)

License No. 3597
File No. 7/1/95

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

dc X ACTIVE STATUS $600.00 DA
_____ 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)

[redacted] License No. [redacted]

William Douglas RAMOS M.D.
1670 E Flamingo Rd Suite C
Las Vegas NV 89119-

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

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

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

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

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

PLEASE NOTE:

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

PLEASE TYPE OR PRINT LEGIBLY

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

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

Name _____

Street _____

City _____ County _____ State _____ Zip _____

Phone Number _____ Fax Number _____

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

Name_____

Street_____

City_____ County_____ State_____ Zip_____

Phone Number_____

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

SCOPES OF PRACTICE CODES

1	ADDICTION MEDICINE	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

Primary Scope of Practice 26 (Code)

Secondary Scope of Practice 64, 65, 66, 67 (Code)

PLEASE INDICATE AMERICAN BOARD OF MEDICAL SPECIALTIES BOARD CERTIFICATION & RECERTIFICATION

	Date of Initial Certification	Date of Last Recertification
Board Am Bd OB-GYN	1976 (Mo./Yr.)	(Mo./Yr.)
Am Bd PATHOLOGY (AP-CP)	1990	
Subboard Am Bd PATHOLOGY (FORENSIC)	1991 (Mo./Yr.)	(Mo./Yr.)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

13. List all hospitals where you have had staff privileges denied, suspended, limited, revoked or not renewed by the hospital. List any and all resignations from any medical staff in lieu of disciplinary or administrative action. (Please Note: Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance.) (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 X HAVE NOT _____ *(CHECK ONE)* ACTIVELY PRACTICED MEDICINE IN NEVADA WITHIN THE PAST 12 MONTHS.

BY SIGNING ON THE SIGNATURE LINE BELOW:

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

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

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

2/1/2005 _____ _____

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 11 2003
(For Board Use Only)

License No. 3597
File No. [redacted]

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

X	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)	

[redacted]

William D RAMOS
1670 E Flamingo Rd Suite C
Las Vegas, NV 89119

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_____ Fax Number_____

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

Name_____

Street_____

City_____ County_____ State_____ Zip_____

Phone Number_____

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

SCOPES OF PRACTICE CODES

1	ADDICTION MEDICINE	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	25	**Secondary Scope of Practice**	62

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.)
NONE			

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

CHILD SUPPORT STATEMENT

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

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

_____ (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).**

2/7/2003 _____ _____

Date Signature (SIGNATURE STAMP UNACCEPTABLE)

MC

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 18 2001
(For Board Use Only)

License No. 3597
File No. 5299

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

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

7/1/95

[redacted]
William D RAMOS M.D.
1670 E Flamingo Rd Suite C
Las Vegas, NV 89119

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

PLEASE NOTE:

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

PLEASE TYPE OR PRINT LEGIBLY

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

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

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

Name_____

Street_____

City_____ County_____ State_____ Zip_____

Phone Number_____ Fax Number_____

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

Name_____

Street_____

City_____ County_____ State_____ Zip_____

Phone Number_____

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

State U. of New York, Downstate — June 3 1970

Medical School Name and Location — 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**	59	**Tertiary Specialty**	62

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.)
NONE			

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

CHILD SUPPORT STATEMENT

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

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

_____ (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).**

4/15/01 _____ M. D.

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 APR 22 1999
(Board Use Only)

License No.

File No.

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

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

William D. Ramos, MD
2550 E Desert Inn Rd Box # 263
Las Vegas NV 89121

0005299

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 William D. Ramos M.D.
Street 1670 E. [redacted] FLAMINGO ROAD SUITE C
City LAS VEGAS County CLARK State NV Zip 89119

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

Name
Street
City County State Zip

7. Are you currently active in medicine?

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

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

SCOPE OF PRACTICE SPECIALTY CODES

102	ADDICTION MEDICINE	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	95	YES
Secondary	50	4	YES
Tertiary	53	1	YES

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

	Date of Initial Certification	Date of Last Certification
Board OBSTETRICS + GYNECOLOGY	/76	
	(Mo./Yr.)	(Mo./Yr.)
Subboard	/	
	(Mo./Yr.)	(Mo/Yr.)
Board PATHOLOGY, ANATOMIC + CLINICAL	/90	
	(Mo./Yr.)	(Mo./Yr.)
Subboard PATHOLOGY, FORENSIC	/91	
	(Mo./Yr.)	(Mo./Yr.)

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

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

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

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

1012 Other (specify)_____

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PLEASE CHECK ONE OF THE FOLLOWING:

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

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

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

Signature _____ M.D.
(SIGNATURE STAMP UNACCEPTABLE)

PLEASE CHECK ONE OF THE FOLLOWING:

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

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

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

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

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

IMPORTANT

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

Signature _____ M.D.
(SIGNATURE STAMP UNACCEPTABLE)

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

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

(702) 892-0660 — Business Telephone #
4/3/99 — Date
_____ M.D. — Signature **(SIGNATURE STAMP UNACCEPTABLE)**

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

Date received by Board
APR - 3 1997
(Board Use Only)

License No.
APR 1, 04 1997 File No.

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

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

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

William D. Ramos, MD
2550 E Desert Inn Rd #263
Las Vegas, NV 89121

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_____

Street_____

City_____ County_____ State_____ Zip_____

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

Name_____

Street_____

City_____ County_____ State_____ Zip_____

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

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

ALL FEES ARE NON-REFUNDABLE

DO NOT SEND CASH THROUGH THE MAIL

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

1. Are you currently active in medicine?

a. [ ] YES, in training. b. [X] 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	98	YES
Secondary	50	2	YES
Tertiary			

PLEASE INDICATE AMERICAN BOARD OF MEDICAL SPECIALTIES BOARD CERTIFICATION:

	Date of Initial Certification	Date of Last Certification
Board AAFP BD OB/GYN	1/76 (Mo./Yr.)	— (Mo./Yr.)
Subboard AAFP BD PATHOLOGY AP/CP	5/90 (Mo./Yr.)	— (Mo./Yr.)
FORENSIC PATH.	6/91	

3. Form of employment is 1002 (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 _X_No

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

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

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

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

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

8. Have you ever had a medical license revoked, suspended, limited, or restricted in any state, country or U.S. territory? ____Yes _X_No

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

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

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

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

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

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

If more space is needed, attach separate sheet.

PLEASE CHECK ONE OF THE FOLLOWING:

_X_ 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 _____ R.V.
Signature stamp unacceptable

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

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

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

(702) 382-0303 — Business Telephone #
3/25/97 — Date
R.V. — Signature (SIGNATURE STAMP UNACCEPTABLE)

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

RECEIVED
MAY 11 1993
NEVADA STATE BOARD OF MEDICAL EXAMINERS

License No. 3597
FEE RCD.
BOARD USE ONLY

YOUR COMPLETED APPLICATION ... WITHIN 30 DAYS OF RECEIPT.

PLEASE PROVIDE ALL INFORMATION AS REQUESTED.

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 William Douglas Ramos

Street 9 Jennifer Lane

City White River Jct. County Windsor State VT Zip Code 05001

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

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	38	90	YES
Secondary	50	9	YES
Tertiary	53	1	YES

PLEASE INDICATE AMERICAN BOARD OF MEDICAL SPECIALTIES BOARD CERTIFICATION:

	Date of Initial Certification (Mo./Yr.)	Date of Last Recertification (Mo./Yr.)
Board AMER. BOARD OB/GYN	1976	N/A
~~Sub~~Board AMER. BOARD PATHOLOGY (AP + CP)	1990	N/A

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

45 hours Patient care or services
_____ hours Administration (schools, agencies, associations, etc.)
_____ hours Teaching medical courses
_____ hours Research
_____ hours Other (specify _____)

4. Form of employment is 1006 . (Use the following codes.)

	SELF-EMPLOYED	1006	Other Non-Government Employer (hospital, school, etc.)
1001	Solo Practice		
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 _____)

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 you receive ongoing treatment (with or without medications) or participate in a monitoring program? N/A ☐ Yes ☐ No
5. 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? N/A ☐ Yes ☐ No
6. Have you ever been diagnosed as having, or have you ever been treated for pedophilia, exhibitionism, or voyeurism? ☐ Yes ☒ No
7. Are you currently engaged in the illegal use of controlled dangerous substances? ☐ Yes ☒ No
8. Are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? ☐ Yes ☒ No
9. 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
10. Have you ever 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
11. Have you ever been arrested, investigated for, charged with or convicted of, or pled nolo contendere to any offense, misdemeanor or felony in any state, the United States, or a foreign country? ☐ Yes ☒ No
12. Have you previously applied for medical licensure in Nevada (including a residency program)? ☒ Yes ☐ No
13. 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
14. 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
15. Have you ever had a medical license revoked, suspended, limited, or restricted in any state, country or U.S. territory? ☐ Yes ☒ No
16. Have you ever voluntarily surrendered a license to practice in the healing arts in any state, country or U.S. territory? ☐ Yes ☒ No
17. Have you ever been denied membership or expelled from a medical society or other professional medical organization? ☐ Yes ☒ No
18. List all hospitals where you have had staff privileges denied, suspended, limited, revoked or not renewed by the hospital. List any and all resignations from any medical staff in lieu of disciplinary or administrative action. (Please Note: Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance.)

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

19. 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
20. Have you ever surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? ☐ Yes ☒ No

I hereby certify that I am the person named in this Application for Initial Registration of license to practice medicine in the State of Nevada and that all statements I have made herein are true.

(718)549-8151 — Business Telephone #
5/2/95 — Date
X — Signature (SIGNATURE STAMP UNACCEPTABLE)
M.D.

STATE OF NEVADA BOARD OF MEDICAL EXAMINERS APPLICATION FOR LICENSURE

RECEIVED
MAR 14 1995
NEVADA STATE BOARD OF MEDICAL EXAMINERS

PERSONAL INFORMATION:

1. Present Legal Name RAMOS (Last) William (First) DOUGLAS (Middle) (Maiden)

   List any other name ever used _____

2. Business and/or Mailing Address 9 JENNIFER LN. (Street) WHITE RIVER JCT. (City) VT (State) 05001 (Zip)

   ~~9 JENNIFER LANE WHITE RIVER JCT. VT 05001-3304~~

3. Home Address 3205 ARLINGTON AVE (Street) BRONX (City) NY (State) 10463-3307 (Zip)

4. Telephone (718) 275-6020 (area code / Office) (___) _____ (area code / Home)

5. Date of Birth _____ Place of Birth NEW YORK, NY, USA (city, state, country)

6. Citizenship: U.S. Citizen X Alien Registration # _____ Other _____
   SUBMIT A CERTIFIED COPY OF BIRTH CERTIFICATE, AN ORIGINAL CERTIFICATE OF NATURALIZATION AND/OR A CERTIFIED COPY OF ALIEN REGISTRATION CARD.

7. Age 50 Height 5' 10" Weight _____ Color of Eyes BLUE

   Color of Hair BROWN Social Security # _____

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.

8. 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 X No N/A

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

10. Does your use of chemical substance(s) in any way impair or limit your ability to practice medicine with reasonable skill and safety? ___ Yes X No

JAN 10 1995

11. Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? ___ Yes X No

12. 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 X No

13. Have you ever been diagnosed as having, or have you ever been treated for pedophilia, exhibitionism, or voyeurism? ___ Yes X No

14. Are you currently engaged in the illegal use of controlled dangerous substances? ___ Yes X No

15. Are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? ___ Yes X No

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

17. Have you ever 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 X No

18. Have you ever been arrested, investigated for, charged with or convicted of, or pled nolo contendere to any offense, misdemeanor or felony in any state, the United States, or a foreign country? ___ Yes X No

19. Have you previously applied for medical licensure in Nevada (including a residency program)? X Yes ___ No

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

EDUCATION:

21. List name and address of all colleges or universities attended, other than schools where professional medical instruction was received.

Name	Address	Dates of Attendance From (Mo./Yr.)	To (Mo./Yr.)
DARTMOUTH COLLEGE	HANOVER, NH	9/62	6/66

22. List name and address of all schools where professional medical instruction was received. HAVE EACH SCHOOL SUBMIT AN OFFICIAL TRANSCRIPT DIRECTLY TO THE BOARD.

Name	Address	Place Where Instruction Received	Dates of Attendance From (Mo./Yr.)	To (Mo./Yr.)
STATE U. OF NEW YORK DOWNSTATE MED. CNTR.	350 CLARKSON AVE BROOKLYN, NY	SAME	9/66	6/70

23. Doctor of Medicine Degree granted by:

Medical School Name	Medical School Address	Exact Date of Issuance
STATE U. OF NEW YORK DOWNSTATE MED CNTR	350 CLARKSON AVE BROOKLYN, NY	6/3/70

GRADUATE MEDICAL EDUCATION:

24. List any and all ACGME* approved graduate medical education you have received as an intern or resident in the United States or Canada.

*Accreditation Council for Graduate Medical Education

Hospital/ Institution	Mailing Address	Type of Service or Specialty	Dates of Attendance From (Mo./Yr.)	To (Mo./Yr.)
KINGS CO. HOSP.	451 CLARKSON AVE. BROOKLYN, NY 11203	INT. INTERN	7/90	6/91
KINGS CO. HOSP.	451 CLARKSON AVE BROOKLYN, NY 11203	RES. OB/GYN	7/91	12/94
DARTMOUTH-HITCHCOCK MED CNTR	LEBANON, NH 03766	RES. PATHOLOGY	7/94	6/90

25. List any and all Fellowship training programs attended in the United States or Canada.

Institution	Mailing Address	Type of Fellowship	Dates of Attendance From (Mo./Yr.)	To (Mo./Yr.)
OFFICE OF CHIEF MEDICAL EXAMINER	520 FIRST AVE NEW YORK, NY 10019	FORENSIC PATHOLOGY	7/90	6/91

26. Have any actions, restrictions, limitations, or probations ever been imposed on you while participating in any type of training program? ___ Yes X No

27. List any other postgraduate medical education not accounted for in questions 24 and 25 above.

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

LICENSING EXAMINATIONS:

28. Have you ever failed a state licensure examination, any part of FLEX, any part of National Boards, or any part of ECFMG, FMGEMS, USMLE or SPEX, even if subsequently passed? ___ Yes X No

29. For each of the following licensing examinations list the location, parts and dates taken, and scores obtained. For each exam taken, have certificate of scores submitted from the testing entity directly to the Board.

a. NATIONAL BOARDS:

Location	Part Taken	Date	Result (Scores)
NY, NY	I	1969	PASSED
NY, NY	II	1970	PASSED
NY, NY	III	1971	PASSED

b. FLEX (Federation Licensing Examination):

Location	Part Taken	Date	Result (Scores)
N/A			

c. State Written Examination:

Location	Part Taken	Date	Result (Scores)

d. USMLE (United States Medical Licensing Examination):

Location	Part Taken	Date	Result (Scores)
N/A			

e. SPEX (Special Purpose Examination):

Location	Part Taken	Date	Result (Scores)
N/A			

f. ECFMG (Educational Commission for Foreign Medical Graduates) Examination:

Location	Part Taken	Date	Result (Scores)
N/A			

LIST ECFMG # _____

g. FMGEMS (Foreign Medical Graduates Examination in the Medical Sciences):

Location	Part Taken	Date	Result (Scores)
N/A			

AREA OF SPECIALTY:

30. State your area of specialty: OB-GYN & PATHOLOGY (AP, CP, FP)

31. List any and all certifications by a board recognized by the American Board of Medical Specialties.

Specialty Board	Certification #	Dates of Certification/Recertification
OB/GYN		
PATHOLOGY		

MEDICAL PRACTICE HISTORY:

32. Account for all periods of time since graduation from medical school (include military service). **All periods of time must be accounted for.**

City/State	From (Mo./Yr.)	To (Mo./Yr.)
NEW YORK	7/70	6/75
VANDENBERG AFB, CA	7/75	7/77
RENO, NV	8/77	6/86
HANOVER, NH	7/86	6/90
NEW YORK, NY	7/90	PRESENT

33. List below the requested information for all hospitals in which you are, or have ever been a staff member at any level during the last ten years. If none, please indicate. Do not list internship, residency or fellowship affiliation.

Hospital	Complete Mailing Address	Dates of Appointment From (Mo./Yr.)	To (Mo./Yr.)
LA GUARDIA HOSP	102-01 66TH AVE. FOREST HILLS, NY 11374	1993	PRESENT
ROOSEVELT HOSP	1000 TENTH AVE NEW YORK, NY 10019	1/94	PRESENT
ELMHURST HOSP.	79-01 BROADWAY ELMHURST, NY	1/95	PRESENT

34. List any and all licenses you hold or have held to practice medicine in any state or country.

State or Country	License #	Date of Issuance	Dates of Practice From (Mo./Yr.)	To (Mo./Yr.)
NEW YORK	109886	7/1/71	7/71 - 6/75	
			7/90 -	PRESENT
CALIFORNIA	G-28860	1975	7/75 -	8/78
NEVADA	3597	6/3/78	9/78 -	6/86
NEW HAMPSHIRE	7527	3/4/87	RESIDENCY 7/86 -	6/90
VERMONT	42-0007546	5/20/87	7/87 -	1989

35. 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 X No

36. Have you ever had a medical license revoked, suspended, limited, or restricted in any state, country or U.S. territory?
___ Yes X No

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

38. Have you ever been denied membership or expelled from a medical society or other professional medical organization?
___ Yes X No

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

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

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

41. Have you ever surrendered your state or federal controlled substance registration or had it revoked or restricted in any way?
___ Yes X No

33. List below the requested information for all hospitals in which you are, or have ever been a staff member at any level during the last ten years. If none, please indicate. Do not list internship, residency or fellowship affiliation.

Hospital	Complete Mailing Address	Dates of Appointment From (Mo./Yr.)	To (Mo./Yr.)
ST. MARY'S HOSP.	RENO, NV	9/78	12/85
SPARKS FAMILY	SPARKS, NV	?	6/86
LaGUARDIA HOSP	102-01 66TH RD. FOREST HILLS, NY 11375	10/92	PRESENT
ST. LUKES/ROOSEVELT	1000 TENTH AVE NY, NY 10019	1/94	PRESENT
ELMHURST HOSP	7901 BROADWAY ELMHURST, NY 11373	1/95	PRESENT

34. List any and all licenses you hold or have held to practice medicine in any state or country.

State or Country	License #	Date of Issuance	Dates of Practice From (Mo./Yr.)	To (Mo./Yr.)
NEW YORK	108916	1971	?/78 2/90	6/85 PRESENT
CALIFORNIA	G028960	1975	7/75	8/78
NEVADA	3957	1978	8/78	6/86
NEW HAMPSHIRE	7527	1987	?/87	6/90
VERMONT	92-0007546	1987	?/87	6/90

35. 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 X No

36. Have you ever had your ... ked, suspended, limited, or restricted in any state, country or U.S. territory?
___ Yes X No

37. Have you ever ... a se ... ndered a license to practice in the healing arts in any state, country or U.S. territory?
___ Yes X ... or Sr ...

38. Have you ever be... ...ership or expelled from a medical society or other professional medical organization?
___ Yes X No

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

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

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

41. Have you ever surrendered your state or federal controlled substance registration or had it revoked or restricted in any way?
___ Yes X No

I, William Douglas Rand, being duly sworn, depose and say: That the answers to the foregoing questions and statements made in the above application are true and correct; that I am the person named in the credentials to be submitted; and that the same were procured in the regular course of instruction and examination without fraud or misrepresentation. I understand that if any of my responses on this application are false, fraudulent, misleading, inaccurate, or incomplete, my application for licensure will be denied.

W. D. R.
Signature of Applicant

Subscribed and sworn to before me this 24 day of January, 1995

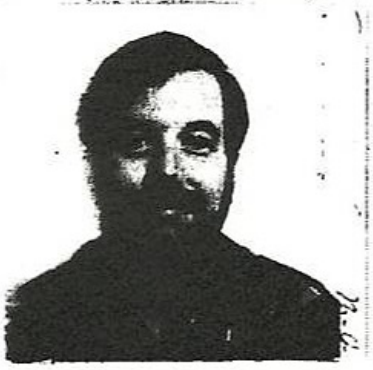
(Notary Seal)

Notary Public for State of J. MICHAEL GAUDREAU Notary Public, New Hampshire My Commission Expires June 25, 1998.

My Commission Expires .

Residing at Enfield, New Hampshire.

J. Michael Gaudreau
Signature of Notary



Attach a finished photograph of passport quality of your head and shoulders only.

Photo must have been taken within the last 60 days and be at least 2" x 2" in size. Sign the photo in ink across the lower portion of its front side.

Proof photos and negatives are not acceptable.

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

W. D. R.
Signature of Applicant

3/11/95
Date

NEVADA STATE BOARD OF MEDICAL EXAMINERS

OF THE STATE OF NEVADA

IN THE MATTER OF THE LICENSE
TO PRACTICE MEDICINE IN THE
STATE OF NEVADA,

OF

WILLIAM D. RAMOS, M.D.

_____/

No. _____

Filed: JUL 13 1987

Kathleen Lewis
Executive Director

ORDER FOR SUSPENSION OF LICENSE
TO PRACTICE MEDICINE IN THE STATE OF NEVADA

Pursuant to the provisions of NRS 630.288 (2), the license to practice medicine in the State of Nevada of WILLIAM D. RAMOS, M.D. is hereby suspended for failure to pay the required fee for biennial registration to practice in the State of Nevada.

DATED: This 10 day of July, 1987.

NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: M. Ronald Avery, M.D.
M. RONALD AVERY, M.D.
Secretary-Treasurer

APPLICATION FOR REGISTRATION
NEVADA STATE BOARD OF MEDICAL EXAMINERS

t 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)

JUL 08 1985

Delinquent after September 15, 1985.

5299

William D RAMOS
975 Ryland St

Reno NV 89502

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

TYPE OR PRINT LEGIBLY

NAME RAMOS (Last) WILLIAM (First) DOUGLAS (Middle)

Social Security # _____

Business Phone # 702 323-7060

BUSINESS OR MAILING ADDRESS 975 RYLAND (Street Address or P. O. Box) _____ (Suite No.) RENO (City) NV. (State) 89502 (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 1976

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

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. ST. MARY'S
2. SPARKS FAMILY
3. RENO MEDICAL PLAZA
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

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

DEC 20 1984

Delinquent after March 2, 1985

Nevada License No. _____ 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

5299 3597

RAMOS WILLIAM D MD
850 MILL ST #302
RENO, NV 89502

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

TYPE OR PRINT LEGIBLY

NAME Ramos (Last) William (First) Douglas (Middle)

Social Security # _____

Business Phone ( ) 702-323-7060

BUSINESS OR MAILING ADDRESS 850 Mill (Street Address or P. O. Box) Suite 302 (Suite No.) Reno (City) NV. (State) 89502 (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.)

DDRESS 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 OB/GYN

Date of Certification or Recertification 1976

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. St Mary's Hosp, Reno, Nv
2. Sparks Family Hosp, Sparks, Nv
3. Mt Grant Hosp, Hawthorne, 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

FEB 23 1984

Delinquent after March 1, 1984

Nevada License No. 3597 Date of License 6/3/78

File No. 3299 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.

3597
RAMOS WILLIAM D MD
850 MILL ST #302
RENO, NV 89502

TYPE OR PRINT LEGIBLY

NAME RAMOS (Last) WILLIAM (First) DOUGLAS (Middle)

Social Security #

Business Phone ( ) 323-7060

BUSINESS ADDRESS 850 Mill St. Reno (City) Nevada (State) 89502 (Zip Code)

MAILING ADDRESS as above (City) (State) (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 yes No _____

AM. Bd. of OB/GYN

Date of Certification or Recertification Nov. 1976

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

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. Washoe Medical Center, Reno
2. Saint Mary's Hospital, Reno
3. Sparks Family Hospital, Sparks
4. Mount Grant Hospital, Hawthorne

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

STATE OF NEVADA
BOARD OF MEDICAL EXAMINERS

1281 Terminal Way, Suite 211, Reno, Nevada, (702) 329-2559

MAY 22 1978

APPLICATION FOR LICENSURE

1. Name RAMOS (Last) WILLIAM (First) DOUGLAS (Middle)

2. Address 4961 La Gama Way (Street No.) Santa Barbara (City) Calif. (State) 93111 (Zip)

3. Date of Birth _____ Place of Birth New York, New York

I hereby make application for a license to practice medicine in Nevada on the basis of:

- ☐ Endorsement of the written examination given by the State of _____
- ☐ Endorsement by the Medical Council of Canada _____
- ☐ Certificate of American Specialty Board, No. _____
- ☒ Certificate of the National Board of Medical Examiners No. _____
- ☐ Admission to the written examination of this Board _____

4. Citizenship Status: U. S. Citizen Yes Declaration of Intention _____

Alien Registration Card _____ Temporary Work Visa _____

5. Medical School and Date of Graduation State U. of New York, Downstate, June 3, 1970

Medical School attended from September 1966 to June 3, 1970

Location 450 Clarkson Ave., Brooklyn, N. Y. 11203

* If you are a foreign graduate, do you hold a permanent ECFMG certificate?

Yes _____ No _____ Number _____

6. List Internship and Residency training, chronologically, and give addresses:

Kings County Hospital, 451 Clarkson Ave, Brooklyn, N. Y.

Intern July 1970 - June 1971,

Resident Obstetrics & Gynecology July 1971 - Dec 1974

7. Type of Practice Obstetrics & Gynecology

8. Are you Board certified? Yes If so, by what Board? American Board of OBS/GYN

Certificate No. and Date Nov. 5, 1976 (unnumbered)

9. Where have you practiced medicine since graduation, including military service? List month and year.

At Brooklyn (City) New York (State), from Jan 1975 to June 1975

At Vandenberg AFB (City) Calif. (State), from July 1975 to June 1978

At _____ (City) _____ (State), from _____ to _____

At _____ (City) _____ (State), from _____ to _____

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

Tri-Counties OB/GYN Society	Santa Barbara, Calif.
American College of OB/GYN	Chicago, Ill.

11. List name and address of all hospitals of which you are, or have been a Staff member. (Do not include hospitals where internship or residency served)

USAF Hospital, Vandenberg AFB, Calif.

12. In what states do you hold a license? Give license numbers and date of issue:

New York State, # 108816, July 1, 1971.

California, # G 28860, Feb. 7, 1975

13. Have you ever been charged or convicted of a felony or an offense involving moral turpitude? No

14. Have you ever been addicted to the use of narcotics, controlled substances or alcohol? No

15. Have you ever been charged, convicted or investigated for use or illegal sale or dispensing of controlled substances? No

16. Have you ever been charged or convicted of unprofessional conduct by any medical licensing board or other agency? No

17. Have you ever received psychiatric treatment or received treatment for a mental illness? ___ ___

18. Have you ever been expelled from a medical society or other medical professional organization?

No.

If yes, give details on separate sheet.

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

M.D., FACOG
Signature of Applicant

Subscribed and sworn to before me this 18th day of May, 19 78

Betty L. Butler

(Seal)

Notary Public for State of California

My Commission Expires July 22, 1979

Residing at Vandenberg AFB Ca

Place photograph taken within the year application is made within the space provided.

Date May 17, 1978 Age 33

Height 5' 10" Weight ____ lbs

Color of Eyes Blue Color of Hair Brown

Social Security No. ___ - ___ - ____

I hereby certify that the attached photograph is a true likeness of myself taken within the last year and that the description given above is true and correct.

R. S. Falco

Signature of Applicant

INSTRUCTIONS

This application consists of two sections.

Section One, the Application, and Form 4 of Section Two, are to be completed by the applicant, notarized as indicated, and returned to the Nevada State Board of Medical Examiners.

Section Two, Forms 1, 2, 3, 5, 6 and 7, are to be completed by the agencies or individuals indicated. It is the responsibility of the applicant to see that these are promptly returned. Application must be in 60 days before the meeting. The forms may be separated and mailed individually, then returned directly to the Nevada State Board of Medical Examiners by the agencies or individuals concerned.

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

The fee for licensure by endorsement or by written examination is $200.00 and must accompany the application.

Nevada State Board of Medical Examiners
Airport Center Building
1281 Terminal Way, Suite 211
Reno, Nevada
MAILING ADDRESS:
Post Office Box 7238, Reno, Nevada 89510

ORIGINAL

BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

* * * * *

In The Matter of Charges and Complaint Against WILLIAM RAMOS, M.D., Respondent.	Case No. 07-5299-1

ORDER OF DISMISSAL WITHOUT PREJUDICE

The above-entitled matter came on regularly for decision before the Nevada State Board of Medical Examiners, hereinafter "Board," on November 6, 2009, at the Board's offices, located at 1105 Terminal Way, Suite 301, Reno, Nevada, on the complaint filed herein pursuant to Nevada's Open Meeting Laws, NRS and NAC chapters 630, and NRS Chapter 233B.

The members of the Board participating in the decision were Charles N. Held, M.D., Renee West, Javaid Anwar, M.D., Benjamin Rodriguez, M.D., Beverly Neyland, M.D., Michael Fisher, M.D. and Theodore Berndt, M.D. 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 received and reviewed the Recommendation of the Investigative Committee to Dismiss the Complaint against the Respondent. The Board, after due consideration, and being fully advised in the premises, hereby dismisses the formal complaint filed against respondent in the above entitled case without prejudice.

IT IS HEREBY ORDERED that the complaint against William Ramos, M.D., is hereby dismissed without prejudice.

Done in open session this 6th day of November 2009.

Charles N. Held, M.D., President
Nevada State Board of Medical Examiners

BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

* * * * *

In The Matter of Charges and Complaint Against WILLIAM RAMOS, M.D. Respondent.

Case No. 07-5299-1

FILED 10 January 2008

For EXECUTIVE DIRECTOR

COMPLAINT

The Investigative Committee of the Board of Medical Examiners of the state of Nevada, composed of Sohail U. Anjum, M.D., S. Daniel McBride, M.D, and Donald H. Baepler, Ph.D., D.Sc. by and through Edward O. Cousineau, Deputy General Counsel for the Nevada State Board of Medical Examiners, having a reasonable basis to believe that William Ramos, 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 licensed in active status to practice medicine in the state of Nevada, 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 twenty-three-year-old-year-old female at the time of events at issue. Her true identity is not disclosed herein to protect her privacy, but is disclosed in the Patient Designation served on Respondent along with a copy of this Complaint.

3. Patient A was pregnant when she presented to Respondent on March 8, 2005, for an elective abortion. Patient A's last menstrual period was documented to be in the first week of January. Patient A underwent an ultrasound procedure which was performed by Dr. Ramos. An "empty" uterus was noted in the medical records. There is no indication in the medical records that Respondent performed a pelvic examination of Patient A.

4. The following day, Patient A presented to a different practitioner who ordered various diagnostic tests based upon Patient A's lower quadrant tenderness. An ultrasound was accomplished on Patient A and showed approximate eight-week ectopic pregnancy. Patient A was advised that she would need immediate surgical intervention and underwent a partial salpingectomy surgical procedure that same day.

5. Based upon the foregoing, Respondent failed to use the reasonable knowledge, skill and expertise ordinarily used in similar circumstances in his treatment of Patient A, as Respondent should have preformed a more through history and physical of the patient based upon the patient's presentment circumstance, including a pelvic examination, and further diagnostic evaluation, including obtaining a beta h-CG value to rule out the possibility that Patient A was suffering an ectopic pregnancy.

6. Section 630.301(4) of the Nevada Revised Statutes provides that malpractice, defined as the failure to use the reasonable knowledge, skill and expertise ordinarily used in similar circumstances, is grounds for discipline.

7. Respondent committed malpractice in the course of providing care and treatment to Patient A and is subject to discipline by the Nevada State Board of Medical Examiners as provided in NRS 630.352.

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 notice Respondent of the charges herein against her, the time and place set for the hearing, and the possible sanctions against her;

3. That the Board determine what sanctions it deems appropriate to impose for the violation committed by Respondent; and

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

DATED this 10th day of January, 2008.

By: _____
Edward O. Cousineau
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 10TH day of January, 2008.

Sohail U. Anjum, M.D.

CERTIFICATE OF MAILING

I hereby certify that I am employed by Nevada State Board of Medical Examiners and that on the 10th day of January 2008, I served a file copy of the COMPLAINT, NOTICE OF PRE-HEARING CONFERENCE & HEARING and PATIENT DESIGNATION, along with appointment letter, by mailing via USPS certified return receipt mail to the following:

William Ramos, M.D.
1670 E. Flamingo Rd., Ste. C
Las Vegas, NV 89119

Dated this 10th day of January 2008.

Angelia Donohoe
Legal Assistant

DEFENDENT LICENSE NO. 3597 FILE NUMBER 5299

SUMMARY OF MEDICAL LIABILITY CLAIM

DEFENDENT/INSURED: RAMOS, William D.

PATIENT/CLAIMANT: Melissa Bickel

INSURER: The Doctor's Company

ALLEGATION: Mismanagement of patient during labor on 5/8/81 ultimately resulting in patient's death

(Infante)

AMOUNT OF SETTLEMENT: $97,500.00

SETTLEMENT DATE: March 8, 1984

DATE REPORT REC'D BY BOARD _____ REVIEWED BY BD. SECY. _____

ACTION TAKEN Set records

- Peer review obtained
- No basis for complaint
- No action taken

1/9/85

NEVADA MEDICAL LIABILITY INSURANCE COMPANY

August 14, 1987

Nevada State Board of Medical Examiners
Post Office Box 7238
Reno, Nevada 89510

Re: Nevada Revised Statutes
Chapter 690.B, Section 1

Gentlemen:

In accordance with NRS 690.B, wherein it is mandated that insurers who issue "a policy of insurance covering the liability of a practitioner licensed pursuant to chapters 630 and 640 inclusive of NRS for a breach of his professional duty toward a patient shall report to the board which licensed the practitioner..." we submit the following information.

Insured:	[redacted]
Claimant:	Rosy Rose
Occurrence Date:	April 19, 1983
Closed Date:	[redacted]
Settlement Amt.:	[redacted]

Recap: Claimant underwent laparoscopy, right salpingectomy and a dilation and curettage for right ectopic pregnancy. She had subsequent laparoscopy and drainage of pelvic abscess.

If you should require any additional information, please do not hesitate to contact our office.

Very truly yours,

Carolyn Littlewood

Carolyn Littlewood
Vice-President/Claims

CL:jh

1245 South Wells Avenue • P.O. Box 7456 Reno, Nevada 89510 • (702) 329-2246

NEVADA MEDICAL LIABILITY INSURANCE COMPANY

May 23, 1988

Nevada State Board of Medical Examiners
Post Office Box 7238
Reno, Nevada 89510

Re: Nevada Revised Statutes
Chapter 690.B, Section 1

Gentlemen:

In accordance with NRS 690.B, wherein it is mandated that insurers who issue "a policy of insurance covering the liability of a practitioner licensed pursuant to chapters 630 and 640 inclusive of NRS for a breach of his professional duty toward a patient shall report to the board which licensed the practitioner..." we submit the following information.

Insured:	William Ramos, M.D.
Claimant:	Ralph O. and Sally G. Lehn
Occurrence Date:	March 25, 1983
Closed Date:	May 23, 1988
Settlement:	$5,499.00

Recap: This incident involves a 23 year old female who underwent a postpartum tubal ligation. Subsequently, she became pregnant.

If you should require additional information, please do not hesitate to contact our office.

Very truly yours,

Carolyn Littlewood

Carolyn Littlewood
Vice President/Claims

CL:pac

1245 South Wells Avenue • P.O. Box 7456 Reno, Nevada 89510 • (702) 329-2246

License Number	Licensee Name	Question Text	Answer	Date Answered
3597	RAMOS, William Douglas	Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? If you do not have a medical condition, select No.	N	4/7/2011
3597	RAMOS, William Douglas	If you have a medical condition which in any way impairs or limits your ability to practice medicine, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? If you do not have a medical condition, select No.	N	4/7/2011
3597	RAMOS, William Douglas	If you use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety?If you do not use chemical substances, select No.	N	4/7/2011
3597	RAMOS, William Douglas	Have you been named as a defendant, or been requested to respond as a defendant, to a legal action involving professional liability, malpractice, including any military tort claims if applicable? Please include: who, what, where (provide state), and when in the textbox directly below this question.	N	4/7/2011
3597	RAMOS, William Douglas	Have you had a professional liability, malpractice, claim paid on your behalf or paid such a claim yourself including any military tort claims if applicable? If "Yes" during the time period July 1, 2009 - June 30, 2011 type an explanation in the textbox directly below this question.	N	4/7/2011