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RAMOS, William Douglas	RAMOS, William Douglas	RAMOS, William Douglas		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?	Have you had a medical license or license to practice any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory?	Have you been denied a license, permission to practice medicine or any other healing art, or permission to take an examination to practice medicine or any other healing art in any state, country or U.S. territory?	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.	Have you been arrested, investigated for, charged with,
z	z	z		z
4/7/2011	4/7/2011	4/7/2011		4/7/2011
	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?	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? 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?	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? RAMOS, William Douglas 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? 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?	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), state or local law, or the laws of any foreign country, which is a misdemeanor, felony, violation of the Uniform Code of Military Justice), excluding any minor traffic offense (afrilying 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. 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 revoked, suspended, limited, or restricted in any state, country or U.S. territory? Have you voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory? Have you voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory?

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RAMOS, William Douglas	RAMOS, William Douglas		RAMOS, William Douglas	RAMOS, William Douglas		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.	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.	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.)	Have you had hospital staff privileges denied,	Have you surrendered your state or federal controlled substance registration or had it revoked or restricted in any way?	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?	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) convirted of any
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RAMOS, William Douglas	KAMOS, William Douglas	RAMOS, William Douglas	RAMOS, William Douglas		RAMOS, William Douglas	RAMOS, William Douglas	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 have a medical condition which in any way impairs or limits your ability to practice medicine, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice?	Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety?	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.	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.	of practice or specialty in the textbox directly below this question. I have completed the required amount of AMA	Do you want to change your scope of practice or specialty? If you answer "Yes" type your current scope	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?
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5/4/2009	5/4/2009	5/4/2009	4/7/2011		4/7/2011	4/7/2011	4/7/2011

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RAMOS, William Douglas		RAMOS, William Douglas	RAMOS, William Douglas	RAMOS, William Douglas	RAMOS, William Douglas	Market Company of the
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.	convicted of, or pled guilty or nolo contendere to any criminal offense related to the manufacture, distribution, prescribing, or dispensing of controlled substances? Please note that you MUST disclose ANY investigation or arrest, including those where the final disposition was dismissal, sealing of a record, or expungement.	Have you been arrested, investigated for, charged with,	where (provide state), and when in the textbox directly below this question. 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.	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 (mahractical) places includes the secondary of the seco	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.	
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RAMOS, William Douglas		RAMOS, William Douglas	RAMOS, William Douglas	RAMOS, William Douglas	RAMOS, William Douglas	RAMOS, William Douglas
Have you surrendered your state or federal controlled substance registration or had it revoked or restricted in any way?	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?	Regarding any medical licensing board, hospital medical society, or other governmental entity or agency (other	Have you been denied membership, been asked to resign or expelled from a medical society or other professional medical organization (including the ABMS)?	Have you voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory in lieu of any disciplinary action?	Have you had a medical license or license to practice any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory?	Have you been denied a license, permission to practice medicine or any other healing art, or permission to take an examination to practice medicine or any other healing art in any state, country or U.S. territory?
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RAMOS, William Douglas	RAMOS, William Douglas	RAMOS, William Douglas	RAMOS, William Douglas		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.	State of Nevada. 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.	I hereby request my license to be placed on Inactive status, which means I will not physically practice in the	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.	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.)	Have you had hospital staff privileges denied, suspended, limited, revoked or not renewed by the
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5/4/2009	5/4/2009	5/4/2009	5/4/2009		5/4/2009

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RAMOS, William Douglas	RAMOS, William Douglas	RAMOS, William Douglas	RAMOS, William Douglas		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.	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.	I hereby request my license to be placed on Inactive status, which means I will not physically practice in the	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.	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.)	Have you had hospital staff privileges denied,
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5/4/2009	5/4/2009	5/4/2009	5/4/2009		5/4/2009

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RAMOS, William Douglas	RAMOS, William Douglas	RAMOS, William Douglas	RAMOS, William Douglas		RAMOS, William Douglas
board? Have you been denied membership or expelled from a medical society or other professional medical organization?	Have you voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory by the direct request of a medical	Have you had a medical license or license to practice any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory?	Have you been denied a license, permission to practice medicine or any other healing art, or permission to take an examination to practice medicine or any other healing art in any state, country or U.S. territory?	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.	Have you been investigated for, arrested for, charged
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4/20/2007	4/20/2007	4/20/2007	4/20/2007		4/20/2007

4/20/2007	4/20/2007	4/20/2007	4/20/2007	4/20/2007	4/20/2007
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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?	Have you surrendered your state or federal controlled substance registration or had it revoked or restricted in any way?	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.)	Is your license currently contingent upon compliance with the Diversion program also known as the Nevada Health Professionals Assistance Foundation?	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?	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?
RAMOS, William Douglas	RAMOS, William Douglas	RAMOS, William Douglas	RAMOS, William Douglas	RAMOS, William Douglas	RAMOS, William Douglas
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RAMOS, William Douglas	RAMOS, William Douglas	RAMOS, William Douglas	RAMOS, William Douglas	RAMOS, William Douglas	RAMOS, William Douglas	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.	I hereby request my license to be placed on Inactive status. I will not physically practice in the state of Nevada.	I have actively practiced medicine in Nevada within the past 12 months.	I have completed the required amount of AMA Category 1 CME within the current biennial. (Review CME information online at www.medboard.nv.gov) I understand that I may be included in a random audit following July 1st 2007 renewal. I agree to retain CME's taken between July 1, 2005 and June 30, 2007.	Are you currently supervising a Physician Assistant or an Advanced Practitioner of Nursing? If you answer "Yes" please email a list of names of those you are supervising to elicensensbme@medboard.nv.gov	Do you want to change your scope of practice or specialty? If you answer "Yes" please email your request to elicensensbme@medboard.nv.gov	Are you out of compliance with court ordered child support? If this does not apply to you please answer "no".
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4/20/2007	4/20/2007	4/20/2007	4/20/2007	4/20/2007	4/20/2007	4/20/2007

PHYSICIAN Date Received by Board License No. 3597 APPLICATION FOR REGISTRATION RENEWAL FOR THE BIENNIAL REGISTRATION PERIOD 2005 - 2007 FEB 1 0 2005 **NEVADA STATE BOARD OF MEDICAL EXAMINERS** PAROLA (1905nly) Post Office Box 7238 Reno, Nevada 89510 Phone (775) 688-2559 Physical Address: 1105 Terminal Way, Suite 301 Reno, Nevada 89502 I hereby apply for renewal of biennial registration and enclose the appropriate fee(s) as indicated below: \$600.00 **ACTIVE STATUS INACTIVE STATUS** \$300.00.....(INACTIVE STATUS DOES NOT PERMIT I REQUEST NON-RENEWAL OF MY LICENSE* THE PRACTICE OF MEDICINE INCLUDING THE WRITING OF PRESCRIPTIONS IN NEVADA) (*IF YOU ARE REQUESTING NON-RENEWAL, SEE BELOW) 可以及 建筑之间 Make checks payable to: William Douglas RAMOS M.D. **NEVADA STATE BOARD OF MEDICAL EXAMINERS** 1670 E Flamingo Rd Suite C (Foreign checks must indicate "U.S. FUNDS") 89119-Las Vegas Request for NON-RENEWAL of License to Practice Medicine In Nevada I hereby represent that I am the person named in this APPLICATION FOR REGISTRATION RENEWAL of license to practice medicine in the state of Nevada. By signing on the signature line below, I am requesting that my license to practice medicine in Nevada NOT be renewed by the Nevada State Board of Medical Examiners. I will return this signed form to the Board office. 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 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

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	OLESCENT MEDICINE		44 N	EUROLOGY	86	PEDIATRIC	, UROLOGY
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	LERGY/IMMUNOLOGY			IEURORADIOLOGY IEUROTOLOGY		PSYCHIATI	
	MBULATORY MEDICINE MESTHESIOLOGY		40 N	ION-CONVENTIONAL MEDICINE		PSYCHOAN	
	OODBANKING			IUCLEAR MEDICINE	92	PSYCHOM	ATIC MEDICINE
	ONCO-ESOPHAGOLOGY			IUTRITION	93	PUBLIC HE	ALTH
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13 Ch	HILD PSYCHIATRY		56 (ONCOLOGY ONCOLOGY, GYNECOLOGICAL	97	RADIOLOG	Y, DIAGNOSTIC Y, INTERVENTIONAL
	INICAL PHARMACOLOGY		57 C	NCOLOGY, HEMATOLOGY			Y, NUCLEAR
	RMATOLOGY			NCOLOGY, RADIATION	100	RADIOLOG	Y, THERAPEUTIC
	RMATOPATHOLOGY			NCOLOGY, SURGICAL			Y, VASCULAR
	MERGENCY MEDICINE			PHTHALMOLOGY		RHEUMATO	
Service Control of the Control of th	IDOCRINOLOGY			TOLARYNGOLOGY		RHINOLOG	
	MILY PRACTICE			OTOLOGY PAIN MANAGEMENT		SLEEP DIS	
	RENSIC MEDICINE ASTROENTEROLOGY			ATHOLOGY			ABDOMINAL
	NERAL PRACTICE			ATHOLOGY, ANATOMIC			CARDIOTHORACIC
24 GE	RIATRIC PSYCHIATRY			ATHOLOGY, CLINICAL			CARDIOVASCULAR
	RIATRICS			ATHOLOGY, FORENSIC	109	SURGERY,	COLON/RECTAL
	NECOLOGY			EDIATRIC, ALLERGY			CRANIOFACIAL
	AIR TRANSPLANTATION			EDIATRIC, ANESTHESIOLOGY		SURGERY,	
T177 1554	MATOLOGY		70 P	PEDIATRIC, CARDIOLOGY PEDIATRIC, CRITICAL CARE		SURGERY,	
	OMEOPATHY PNOSIS		71 P	EDIATRIC, CRITICAL CARE PEDIATRIC, EMERGENCY MEDICINE			HEAD/NECK MAXILLOFACIAL
7.7	MUNOLOGY			EDIATRIC, ENDOCRINOLOGY			NEUROLOGICAL
	FECTIOUS DISEASES		74 P	EDIATRIC, GASTROENTEROLOGY			ORTHOPEDIC
33 INI	FERTILITY		75 P	EDIATRIC, HEMATOLOGY/ONCOLOGY		SURGERY,	
34 IN	TERNAL MEDICINE		76 P	EDIATRIC, INFECTIOUS DISEASES		SURGERY,	
	RYNGOLOGY		77 P	EDIATRIC, INTENSIVIST			TRANSPLANT
	GAL MEDICINE			EDIATRIC, NEPHROLOGY			TRAUMATIC UROLOGIC
750 6337	ATERNAL/FETAL MEDICINE			EDIATRIC, NEUROLOGY EDIATRIC, OPHTHALMOLOGY			VASCULAR
	EDICAL ACUPUNCTURE EDICAL ETHICS			EDIATRIC, PHYSIATRY		TOXICOLO	
	DICAL GENETICS			EDIATRIC, PULMONARY		TRANSPLA	
	O/PERINATAL MEDICINE			EDIATRIC, RADIOLOGY	125	URGENT C	ARE
42 NE	OPLASTIC DISEASES	0-4		EDIATRIC, RHEUMATOLOGY	126	UROLOGY	A CONTRACTOR OF THE PROPERTY O
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Prima	ry Scope of Practice _	26	_	Secondary Scop	e of F	Practice _	64,65,66,67
PLEAS			OF M	EDICAL SPECIALTIES BOARD C		FICATION	& RECERTIFICATION Date of Last Recertification
oard_	Am BL 08-67		• • •	/976 (Mo./Yr.)			(Mo.Yr.)
	Am BI PATROL		-	1990			(1102111)
ubboa	ard An Bd PATHOL	661 (FE	REMSI				(14- 5/-)
				stions refer to the tin			(Mo./Yr.)

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

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.

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N/A			
Hospital	Address	Action	From (Mo./Yr.) To (Mo./Yr.)
List any and all resignation suspensions or restriction maintain required malprace	ns from any medical sta is for failure to complete	ff in lieu of disciplinary or adm	limited, revoked or not renewed by the hospital. ninistrative action. (<u>Please Note</u> : Do not include ittend hospital department or staff meetings, or separate sheet) Dates of Action
			Yes <u>X</u> No
way?	.25.00 7001 01010 01 101	20. ar corni olioù dubatarioa re	
12. Have you ever surrer	ndered your state or fed	deral controlled substance re	egistration or had it revoked or restricted in any
medical society, governm	ental entity or other ag	ency other than the Nevada	State Board of Medical Examiners? Yes X No
any violation of a statute,	rule or regulation gove	ming your practice as a phys	vestigated for; c) charged with; or d) convicted of sician by any medical licensing board, hospital,
			YesXNo
	denied membershin or	expelled from a medical soci	iety or other professional medical organization?
Have you ever volunta territory?	rily surrendered a licen	se to practice medicine or ar	ny other healing art in any state, country or U.S. Yes X No
any state, country or U.S.		e to practice any other nealing	g art revoked, suspended, limited, or restricted inYesXNo
•	•	ealing art in any state, country	
			any other healing art, or permission to take an
dispensing of controlled s		mense) or which is related to	o the manufacture, distribution, prescribing, orYesXNo
violation of any federal, s felony, excluding any min	state or local law, inclu- nor traffic offense (drivin	ding any foreign country, wh ng or in control of a motor ve	and guilty or nolo contendere to any offense or nich is a misdemeanor, gross misdemeanor, or whicle while under the influence of any chemical
paid in your behalf or paid	d such a claim yourself	?	(malpractice) or had a professional liability claimNo
begin to satisfy a requir government for your med	ement of your receiving ical education?	ng a loan or scholarship fro	ar after the date the public service is required to me the federal government or a state or localYesNo _X_N/A
If you use chemical su skill and safety?	ibstances, does your u	se in any way impair or limit y	your ability to practice medicine with reasonableYesXNoN/A
If you have a medical limitation reduced or amountation?	condition which in any eliorated because of th	way impairs or limits your all e field of practice, the setting	bility to practice medicine, is that impairment or ng, or the manner in which you have chosen toYesNo _XN/A
Do you have a medical safety?	l condition which in any	way impairs or limits your ab	ility to practice medicine with reasonable skill andYes X No
		OR REGISTRATION R	

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).
3/6-
Date Signature (SIGNATURE STAMP LINACCEPTARI E)

PHYSICIAN Date Received by Board APPLICATION FOR REGISTRATION RENEWAL FOR THE BIENNIAL REGISTRATION PERIOD 2003-2005 FEB 1 1 2003 **NEVADA STATE BOARD OF MEDICAL EXAMINERS** Post Office Box 7238 Reno, Nevada 89510 Phone (775) 688-2559 (For Board Use Only) Physical Address: 1105 Terminal Way, Suite 301 Reno, Nevada 89502 I hereby apply for renewal of biennial registration and enclose the appropriate fee(s) as indicated below: \$400.00 4 **ACTIVE STATUS** \$200.00.....(INACTIVE STATUS DOES NOT PERMIT **INACTIVE STATUS** I REQUEST NON-RENEWAL OF MY LICENSE* THE PRACTICE OF MEDICINE INCLUDING THE WRITING OF PRESCRIPTIONS IN NEVADA) (*IF YOU ARE REQUESTING NON-RENEWAL, SEE BELOW) for go (steel) William D RAMOS M.D. Make checks payable to: 1670 E Flamingo Rd Suite C **NEVADA STATE BOARD OF MEDICAL EXAMINERS** Las Vegas, NV 89119 (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 County _____ State____ Zip____ City_ Phone Number___ Fax Number 3. IF YOU HAVE RETIRED OR MOVED YOUR PRACTICE, indicate the location of patient records below: Name Street County____State City____ _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 NEPHROLOGY NEUROLOGY NEURO-OPHTHALMOLOGY NEUROPATHOLOGY	81	PEDIATRIC, RHEUMATCLOGY
2	ADOLESCENT MEDICINE	42	NEPHROLOGY	82	PEDIATRIC, SURGERY
3	AEROSPACE MEDICINE	43	NEUROLOGY 83 PEDIATRIC, U		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		NUCLEAR MEDICINE	88	PSYCHOANALYSIS
9	BRONCO-ESOPHAGOLOGY		NUTRITION	89	PUBLIC HEALTH
10	CARDIOVASCULAR DISEASES		OBSTETRICS	90	PSYCHOMATIC MEDICINE
11	CATSCAN/ULTRASOUND		OBSTETRICS/GYNECOLOGY		PULMONARY DISEASES
12	CHILD NEUROLOGY		OCCUPATIONAL MEDICINE	92	RADIOLOGY
13	CHILD PSYCHIATRY	53			RADIOLOGY, DIAGNOSTIC
14	CLINICAL PHARMACOLOGY		ONCOLOGY, GYNECOLOGICAL		RADIOLOGY, INTERVENTIONAL
15	CRITICAL CARE		ONCOLOGY, HEMATOLOGY		RADIOLOGY, NUCLEAR
16	DERMATOLOGY		ONCOLOGY, RADIATION		RADIOLOGY, THERAPEUTIC
17	DERMATOPATHOLOGY		ONCOLOGY, SURGICAL		RADIOLOGY, VASCULAR
18	EMERGENCY MEDICINE		OPHTHALMOLOGY		RHEUMATOLOGY
19	ENDOCRINOLOGY		OTOLARYNGOLOGY		RHINOLOGY
20	FAMILY PRACTICE		OTOLOGY		SLEEP DISORDERS
	GASTROENTEROLOGY		PAIN MANAGEMENT		SPORTS MEDICINE
21	GENERAL PRACTICE		PATHOLOGY		SURGERY, ABDOMINAL
23	GERIATRIC PSYCHIATRY		PATHOLOGY, ANATOMIC		SURGERY, CARDIOTHORACIC
24	GERIATRICS		PATHOLOGY, CLINICAL		SURGERY, CARDIOVASCULAR
-	GYNECOLOGY		PATHOLOGY, FORENSIC		SURGERY, COLON/RECTAL
25 26	HAIR TRANSPLANTATION		PEDIATRIC, ALLERGY		SURGERY, GENERAL
27	HEMATOLOGY		PEDIATRIC, CARDIOLOGY		SURGERY, HAND
28	HOMEOPATHY		PEDIATRIC, CRITICAL CARE		SURGERY, HEAD/NECK
	HYPNOSIS		PEDIATRIC, EMERGENCY MEDICINE		SURGERY, MAXILLOFACIAL
29	IMMUNOLOGY		PEDIATRIC, ENDOCRINOLOGY		SURGERY, NEUROLOGICAL
30	INFECTIOUS DISEASES		PEDIATRIC, GASTROENTEROLOGY		SURGERY, ORTHOPEDIC
31	INFECTIOUS DISEASES		PEDIATRIC, HEMATOLOGY/ONCOLOGY		SURGERY, PLASTIC
100000000000000000000000000000000000000	INTERNAL MEDICINE		PEDIATRIC, INFECTIOUS DISEASES		SURGERY, THORACIC
33			PEDIATRIC, INTENSIVIST		SURGERY, TRANSPLANT
34	LARYNGOLOGY LEGAL MEDICINE		PEDIATRIC, NEPHROLOGY		SURGERY, TRAUMATIC
35			PEDIATRIC, NEUROLOGY		SURGERY, UROLOGIC
36	MATERNAL/FETAL MEDICINE		PEDIATRIC, NECHOLOGY		SURGERY, VASCULAR
37	MEDICAL ACUPUNCTURE		PEDIATRIC, PHYSIATRY		TOXICOLOGY
38	MEDICAL ETHICS				URGENT CARE
39	MEDICAL GENETICS		PEDIATRIC, PULMONARY		UROLOGY
40	NEO/PERINATAL MEDICINE	80	PEDIATRIC, RADIOLOGY	120	UNULUGI

	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:

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

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

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

"Medical condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to, orthopedic, vision, speech, hearing, cerebral palsy, 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.

 Do you have a medic safety? 	al condition which in any w	ay impairs or limits your abilit	ty to practice medicine with reasonableYes			
			lity to practice medicine, is that impai , or the manner in which you have cl YesNo	hosen to		
3. If you use chemical s skill and safety?	substances, does your use	in any way impair or limit yo	our ability to practice medicine with rea			
	irement of your receiving		r after the date the public service is remarked the federal government or a state	or local		
	endant in a legal action inv aid such a claim yourself?		nalpractice) or had a professional liabi	lity claim No		
violation of any federal, felony, excluding any m	state or local law, including traffic offense (driving dered a minor traffic off	ing any foreign country, whic g or in control of a motor veh	d guilty or nolo contendere to any of ch is a misdemeanor, gross misdemeaticle while under the influence of any of the manufacture, distribution, prescribeYes	eanor, or chemical ribing, or		
			any other healing art, or permission to or U.S. territory?			
8. Have you ever had a any state, country or U.	art revoked, suspended, limited, or res	spended, limited, or restricted inYesNo				
Have you ever volun territory?	tarily surrendered a licens	e to practice medicine or any	y other healing art in any state, country	any state, country or U.S. YesNo		
10. Have you ever been	n denied membership or e	xpelled from a medical socie	ty or other professional medical organ			
any violation of a statute	e, rule or regulation govern	ning your practice as a physi	estigated for; c) charged with; or d) concician by any medical licensing board, listate Board of Medical Examiners?Yes			
12. Have you ever surr way?	endered your state or fed	eral controlled substance reg	gistration or had it revoked or restricte			
List any and all resignati	ons from any medical staff ons for failure to complete ractice insurance).	f in lieu of disciplinary or admi hospital medical records, att	mited, revoked or not renewed by the linistrative action. (<u>Please Note</u> : Do no tend hospital department or staff mee	t include tings, or		
Hospital	Mailing Address	Type of Action	Dates of Action From (Mo./Yr.) To (M			
NONE						
	-0					
	(If more eng	co is needed attach a sensi	rate shoot \			

CHILD SUPPORT STATEMENT

Pleas	place a check mark next to one of the following statements:
V	(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 iance with a plan approved by the district attorney or other public agency enforcing the order for the repayment of the nt 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 approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed ant to the order.
CONT	INUING MEDICAL EDUCATION (CME) STATEMENT
Pleas	e place a check mark next to one of the following statements:
were i	(a) I completed a minimum of 40 hours of AMA Category 1 continuing medical education (CME), 2 hours of which n medical ethics and 20 hours of which were in my scope of practice or specialty, during the past biennial period of July 1 through June 30, 2003;
month (CME	(b) I was initially licensed in Nevada during the time period January 1, 2002 through June 30, 2002, the second six s of the past biennial period, and completed a minimum of 30 hours of AMA Category I continuing medical education b, 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 s of the past biennial period, and completed a minimum of 20 hours of AMA Category I continuing medical education , 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 s of the past biennial period, and completed a minimum of 10 hours of AMA Category I continuing medical education , 2 hours of which were in medical ethics and 8 hours of which were in my scope of practice or specialty; OR
a full y	(e) I am exempt from submitting proof of completion of continuing medical education (CME) because I have completed ear of residency or fellowship training during the biennial period July 1, 2001 through June 30, 2003.
⇒ IF	TTACH COPIES OF PROOF OF YOUR COMPLETION OF CONTINUING MEDICAL EDUCATION (CME) HOURS. YOU COMPLETED A FULL YEAR OF RESIDENCY OR FELLOWSHIP TRAINING DURING THE BIENNIAL PERIOD JLY 1, 2001 THROUGH JUNE 30, 2003, ATTACH A COPY OF PROOF OF COMPLETION OF YOUR TRAINING. DUR COPIES OF PROOF OF CME OR TRAINING COMPLETION WILL NOT BE RETURNED TO YOU.
I HAV	
BY S	IGNING ON THE SIGNATURE LINE BELOW:
01	EREBY REPRESENT THAT I AM THE PERSON NAMED IN THIS APPLICATION FOR REGISTRATION RENEWAL FLICENSE TO PRACTICE MEDICINE IN THE STATE OF NEVADA AND THAT ALL STATEMENTS I HAVE MADE
2) IL PL 3) IL	REIN ARE TRUE; INDERSTAND THAT THIS APPLICATION FOR REGISTRATION RENEWAL WILL BE DENIED IF I HAVE NOT ACED A CHECK MARK NEXT TO (a), (b), OR (c) UNDER THE CHILD SUPPORT STATEMENT SECTION; AND INDERSTAND THAT THIS APPLICATION FOR REGISTRATION RENEWAL WILL BE DENIED IF I HAVE NOT ISWERED ALL QUESTIONS THEREON AND/OR ATTACHED THERETO: (a) THE APPROPRIATE COPIES OF
	NOOF OF CONTINUING MEDICAL EDUCATION (CME), OR RESIDENCY OR FELLOWSHIP TRAINING

COMPLETION; (b) PAYMENT OF THE APPROPRIATE REGISTRATION RENEWAL FEE; AND (c) WRITTEN

2/7/2003
Signature (SIGNATIBE STAMP LINACCEPTARIE)

EXPLANATION(S) TO ANY "YES" ANSWER(S).

		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 AY 1 8 2001 (For Board Use Only)	License No. 3597 File No. 5299
I hereby apply for renewal of biennial registration and enclose t ACTIVE STATUS INACTIVE STATUS RETIRED STATUS SUPERVISING/COLLABORATING PHYSICIAN	he appropriate fee(s) as indica \$600.00/ \$200.00 (RETIRED STA	ated below: TUS REQUIRES THAT THE OT PRACTICE MEDICINE
William D RAMOS 1670 E Flamingo Rd Suite C Las Vegas, NV 89119	NEVADA STATE BOA	hecks payable to: ARD OF MEDICAL EXAMINERS must indicate *U.S. FUNDS*)
 YOUR CURRENT M.D. LICENSE EXPIRES ON JUNE 30, RENEWAL FORMS NOT RECEIVED AT THE BOARD OF SUSPENDED FOR NON-PAYMENT. EXTENSIONS OF THAS NO GRACE PERIOD. (USE THE ENCLOSED ENVEREGISTRATION RENEWAL FORM.) YOUR LICENSE WILL NOT BE RENEWED UNLESS YOUR REGISTRATION RENEWAL FORM. YOU MUST PROVID ANSWERED "YES." ALL INFORMATION YOU PROVIDE ON THIS APPLICATION FORMATION. 	FICE BY JULY 1, 2001 AT 5:0 TIME ARE NOT ALLOWED FO ELOPE TO MAIL YOUR COME J ANSWER ALL QUESTIONS DE WRITTEN EXPLANATION TON FOR REGISTRATION RE	20 P.M. ARE AUTOMATICALLY DR ANY REASON, AS NEVADA PLETED APPLICATION FOR SON THIS APPLICATION FOR S FOR ALL QUESTIONS ENEWAL FORM IS PUBLIC
PLEASE TYPE OF	R PRINT LEGIBLY	•
 To be eligible to act as a SUPERVISING PHYSICIAN FOR PHYSICIAN FOR AN ADVANCED PRACTITIONER OF NURSI you must complete the enclosed Application for Approval as payment in the amount of \$200.00 in the enclosed envelope. 	NG for the biennial period of Ju	ly 1, 2001 through June 30, 2003
 Active status registration renewal requires the submission of medical education (CME), which includes 2 hours of CME in m specialty completed during the period July 1, 1999 through your completed Application for Registration Renewal form. (See 	edical ethics and 20 hours of C June 30, 2001. Submit your p	CME in your scope of practice or proof of completion of CME with
if your name and/or address has changed from that printed o provided below. Also, please indicate your current telephone ar document authorizing your name change (marriage license, di	nd fax numbers. [Please note:	a notarized or certified copy of the
Name		

Name				
Street				
City	County		_ State	Zip
Phone Number	Fa	x Number		
4. IF YOU HAVE RETIF	RED OR MOVED YOUR PRACTIC	CE, indicate the loc	cation of patier	nt records below:
Name				
Street				
City	County	State		Zip
Phone Number				
5. Indicate below the EX of graduation:	KACT NAME AND LOCATION of the	ne Medical School	from which you	graduated and your EXACT DATE
STate U	1 New York, Oversto	T	hu	ne 3 /970
Medical School Name a	and Location		Date of G	raduation (Month / Day / Year)

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

SCOPE OF PRACTICE SPECIALTY CODES

1 ADDICTION MEDICINE 2 ADOLESCENT MEDICINE 3 AEROSPACE MEDICINE 4 ALLERGY 5 ALLERGY/IMMUNOLOGY 6 ANESTHESIOLOGY 7 BLOODBANKING 8 BRONCO-ESOPHAGOLOGY 9 CARDIOVASCULAR DISEASES 10 CATSCAN/ULTRASOUND 11 CHILD NEUROLOGY 12 CHILD PSYCHIATRY 13 CLINICAL PHARMACOLOGY 14 CRITICAL CARE 15 DERMATOLOGY 16 DERMATOPATHOLOGY 17 EMERGENCY MEDICINE 18 ENDOCRINOLOGY 19 FAMILY PRACTICE 20 GASTROENTEROLOGY 21 GENERAL PRACTICE 22 GERIATRICS 23 GYNECOLOGY 24 HEMATOLOGY 25 HOMEOPATHY 26 HYPNOSIS 27 IMMUNOLOGY 28 INFECTIOUS DISEASES	42 43 44 45 48 49 50 51 52 53 54 55 56 57 58	NEURO-OPHTHALMOLOGY NEUROPATHOLOGY	93 94	PEDIATRICS PHYSICAL MEDICINE/REHABILITATION PREVENTIVE MEDICINE PSYCHIATRY PSYCHOANALYSIS PSYCHOMATIC MEDICINE PUBLIC HEALTH PULMONARY DISEASES RADIOLOGY RADIOLOGY, DIAGNOSTIC RADIOLOGY, INTERVENTIONAL RADIOLOGY, THERAPEUTIC RADIOLOGY, VASCULAR
AEROSPACE MEDICINE ALLERGY ALLERGY ALLERGY/IMMUNOLOGY ANESTHESIOLOGY BLOODBANKING BRONCO-ESOPHAGOLOGY CARDIOVASCULAR DISEASES CATSCAN/ULTRASOUND CHILD NEUROLOGY CHILD PSYCHIATRY CHILD PSYCHIATRY CHICAL CARE DERMATOLOGY DERMATOLOGY FAMILY PRACTICE GASTROENTEROLOGY GENERAL PRACTICE GERIATRICS GYNECOLOGY HOMEOPATHY SHIPMONOSIS IMMUNOLOGY	42 43 44 45 48 49 50 51 52 53 54 55 56 57 58	NEUROPATHOLOGY NEURORADIOLOGY NON-CONVENTIONAL MEDICINE NUCLEAR MEDICINE NUTRITION OBSTETRICS OBSTETRICS/GYNECOLOGY OCCUPATIONAL MEDICINE ONCOLOGY ONCOLOGY, GYNECOLOGICAL ONCOLOGY, HEMATOLOGY ONCOLOGY, RADIATION ONCOLOGY, SURGICAL OPHTHALMOLOGY OTOLARYNGOLOGY	81 82 83 84 85 86 87 88 89 90 91 92 93 94	PHYSICAL MEDICINE/REHABILITATION PREVENTIVE MEDICINE PSYCHIATRY PSYCHOANALYSIS PSYCHOMATIC MEDICINE PUBLIC HEALTH PULMONARY DISEASES RADIOLOGY RADIOLOGY, DIAGNOSTIC RADIOLOGY, INTERVENTIONAL RADIOLOGY, THERAPEUTIC RADIOLOGY, VASCULAR
AEROSPACE MEDICINE ALLERGY ALLERGY ALLERGY/IMMUNOLOGY ANESTHESIOLOGY BLOODBANKING BRONCO-ESOPHAGOLOGY CARDIOVASCULAR DISEASES CATSCAN/ULTRASOUND CHILD NEUROLOGY CHILD PSYCHIATRY CHILD PSYCHIATRY CHICAL CARE DERMATOLOGY DERMATOLOGY FAMILY PRACTICE GASTROENTEROLOGY GENERAL PRACTICE GERIATRICS GYNECOLOGY HOMEOPATHY SHIPMONOSIS IMMUNOLOGY	43 44 45 48 49 50 51 52 53 54 55 56 57 58	NEURORADIOLOGY NON-CONVENTIONAL MEDICINE NUCLEAR MEDICINE NUTRITION OBSTETRICS OBSTETRICS/GYNECOLOGY OCCUPATIONAL MEDICINE ONCOLOGY ONCOLOGY, GYNECOLOGICAL ONCOLOGY, HEMATOLOGY ONCOLOGY, RADIATION ONCOLOGY, SURGICAL OPHTHALMOLOGY OTOLARYNGOLOGY	82 83 84 85 86 87 88 89 90 91 92 93 94	PREVENTIVE MEDICINE PSYCHIATRY PSYCHOANALYSIS PSYCHOMATIC MEDICINE PUBLIC HEALTH PULMONARY DISEASES RADIOLOGY RADIOLOGY, DIAGNOSTIC RADIOLOGY, INTERVENTIONAL RADIOLOGY, NUCLEAR RADIOLOGY, THERAPEUTIC RADIOLOGY, VASCULAR
4 ALLERGY 5 ALLERGY/IMMUNOLOGY 6 ANESTHESIOLOGY 7 BLOODBANKING 8 BRONCO-ESOPHAGOLOGY 9 CARDIOVASCULAR DISEASES 10 CATSCAN/ULTRASOUND 11 CHILD NEUROLOGY 12 CHILD PSYCHIATRY 13 CLINICAL PHARMACOLOGY 14 CRITICAL CARE 15 DERMATOLOGY 16 DERMATOLOGY 17 EMERGENCY MEDICINE 18 ENDOCRINOLOGY 19 FAMILY PRACTICE 20 GASTROENTEROLOGY 21 GENERAL PRACTICE 22 GERIATRICS 23 GYNECOLOGY 24 HEMATOLOGY 25 HOMEOPATHY 26 HYPNOSIS 27 IMMUNOLOGY 28 INFECTIOUS DISEASES	44 45 48 47 48 49 50 51 52 53 54 55 56 57 58	NON-CONVENTIONAL MEDICINE NUCLEAR MEDICINE NUTRITION OBSTETRICS OBSTETRICS/GYNECOLOGY OCCUPATIONAL MEDICINE ONCOLOGY ONCOLOGY, GYNECOLOGICAL ONCOLOGY, HEMATOLOGY ONCOLOGY, RADIATION ONCOLOGY, SURGICAL OPHTHALMOLOGY OTOLARYNGOLOGY	83 84 85 86 87 88 89 90 91 92 93 94	PSYCHIATRY PSYCHOANALYSIS PSYCHOMATIC MEDICINE PUBLIC HEALTH PULMONARY DISEASES RADIOLOGY RADIOLOGY, DIAGNOSTIC RADIOLOGY, INTERVENTIONAL RADIOLOGY, NUCLEAR RADIOLOGY, THERAPEUTIC RADIOLOGY, VASCULAR
5 ALLERGY/IMMUNOLOGY 6 ANESTHESIOLOGY 7 BLOODBANKING 8 BRONCO-ESOPHAGOLOGY 9 CARDIOVASCULAR DISEASES 10 CATSCAN/ULTRASOUND 11 CHILD NEUROLOGY 12 CHILD PSYCHIATRY 13 CLINICAL PHARMACOLOGY 14 CRITICAL CARE 15 DERMATOLOGY 16 DERMATOLOGY 17 EMERGENCY MEDICINE 18 ENDOCRINOLOGY 19 FAMILY PRACTICE 20 GASTROENTEROLOGY 21 GENERAL PRACTICE 22 GERIATRICS 23 GYNECOLOGY 24 HEMATOLOGY 25 HOMEOPATHY 26 HYPNOSIS 27 IMMUNOLOGY 28 INFECTIOUS DISEASES	45 48 47 48 49 50 51 52 53 54 55 56 57 58	NUCLEAR MEDICINE NUTRITION OBSTETRICS OBSTETRICS/GYNECOLOGY OCCUPATIONAL MEDICINE ONCOLOGY ONCOLOGY, GYNECOLOGICAL ONCOLOGY, HEMATOLOGY ONCOLOGY, RADIATION ONCOLOGY, SURGICAL OPHTHALMOLOGY OTOLARYNGOLOGY	84 85 86 87 88 89 90 91 92 93 94	PSYCHOANALYSIS PSYCHOMATIC MEDICINE PUBLIC HEALTH PULMONARY DISEASES RADIOLOGY RADIOLOGY, DIAGNOSTIC RADIOLOGY, INTERVENTIONAL RADIOLOGY, THERAPEUTIC RADIOLOGY, VASCULAR
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15 DERMATOLOGY 16 DERMATOPATHOLOGY 17 EMERGENCY MEDICINE 18 ENDOCRINOLOGY 19 FAMILY PRACTICE 20 GASTROENTEROLOGY 21 GENERAL PRACTICE 22 GERIATRICS 23 GYNECOLOGY 24 HEMATOLOGY 25 HOMEOPATHY 26 HYPNOSIS 27 IMMUNOLOGY 28 INFECTIOUS DISEASES	54 55 56 57 58	ONCOLOGY, SURGICAL OPHTHALMOLOGY OTOLARYNGOLOGY	94	
16 DERMATOPATHOLOGY 17 EMERGENCY MEDICINE 18 ENDOCRINOLOGY 19 FAMILY PRACTICE 20 GASTROENTEROLOGY 21 GENERAL PRACTICE 22 GERIATRICS 23 GYNECOLOGY 24 HEMATOLOGY 25 HOMEOPATHY 26 HYPNOSIS 27 IMMUNOLOGY 28 INFECTIOUS DISEASES	55 56 57 58	OPHTHALMOLOGY OTOLARYNGOLOGY		
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18 ENDOCRINOLOGY 19 FAMILY PRACTICE 20 GASTROENTEROLOGY 21 GENERAL PRACTICE 22 GERIATRICS 23 GYNECOLOGY 24 HEMATOLOGY 25 HOMEOPATHY 26 HYPNOSIS 27 IMMUNOLOGY 28 INFECTIOUS DISEASES	57 58		95	RHINOLOGY
19 FAMILY PRACTICE 20 GASTROENTEROLOGY 21 GENERAL PRACTICE 22 GERIATRICS 23 GYNECOLOGY 24 HEMATOLOGY 25 HOMEOPATHY 26 HYPNOSIS 27 IMMUNOLOGY 28 INFECTIOUS DISEASES	58		96	SLEEP DISORDERS
20 GASTROENTEROLOGY 21 GENERAL PRACTICE 22 GERIATRICS 23 GYNECOLOGY 24 HEMATOLOGY 25 HOMEOPATHY 26 HYPNOSIS 27 IMMUNOLOGY 28 INFECTIOUS DISEASES		PAIN MANAGEMENT	97	SPORTS MEDICINE
21 GENERAL PRACTICE 22 GERIATRICS 23 GYNECOLOGY 24 HEMATOLOGY 25 HOMEOPATHY 26 HYPNOSIS 27 IMMUNOLOGY 28 INFECTIOUS DISEASES	59	PATHOLOGY	98	
22 GERIATRICS 23 GYNECOLOGY 24 HEMATOLOGY 25 HOMEOPATHY 26 HYPNOSIS 27 IMMUNOLOGY 28 INFECTIOUS DISEASES	60	PATHOLOGY, ANATOMIC	99	SURGERY, CARDIOTHORACIC
23 GYNECOLOGY 24 HEMATOLOGY 25 HOMEOPATHY 26 HYPNOSIS 27 IMMUNOLOGY 28 INFECTIOUS DISEASES		PATHOLOGY, CLINICAL	100	SURGERY, CARDIOVASCULAR
24 HEMATOLOGY 25 HOMEOPATHY 26 HYPNOSIS 27 IMMUNOLOGY 28 INFECTIOUS DISEASES		PATHOLOGY, FORENSIC	101	SURGERY, COLON/RECTAL
25 HOMEOPATHY 26 HYPNOSIS 27 IMMUNOLOGY 28 INFECTIOUS DISEASES		PEDIATRIC, ALLERGY		SURGERY, GENERAL
26 HYPNOSIS 27 IMMUNOLOGY 28 INFECTIOUS DISEASES	64	PEDIATRIC, CARDIOLOGY	103	SURGERY, HAND
27 IMMUNOLOGY 28 INFECTIOUS DISEASES		PEDIATRIC, CRITICAL CARE	104	SURGERY, HEAD/NECK
28 INFECTIOUS DISEASES		PEDIATRIC, EMERGENCY MEDICINE	105	SURGERY, MAXILLOFACIAL
A-THE - (4.1.14 TO TO TO THE THE THE STATE OF THE STATE O	67	PEDIATRIC, ENDOCRINOLOGY	106	SURGERY, NEUROLOGICAL
29 INFERTILITY	68		107	SURGERY, ORTHOPEDIC
30 INTERNAL MEDICINE		PEDIATRIC, HEMATOLOGY/ONCOLOGY	108	SURGERY, PLASTIC
31 LARYNGOLOGY	70	PEDIATRIC, INFECTIOUS DISEASES	109	SURGERY, THORACIC
32 LEGAL MEDICINE		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	0	ondary Specialty 5-9	-	ertiary 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;
- 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 me safety?	edical condition which	n in any way impairs or limits you	ur ability to practice medicine with reasonable skill andYesNo
			our ability to practice medicine, is that impairment or setting, or the manner in which you have chosen toYesNoN/A
3. If you use chemica and safety?	al substances, does y	your use in any way impair or lin	nit your ability to practice medicine with reasonable skill YesNoN/A
	uirement of your rece		ne year after the date the public service is required to n the federal government or a state or local government YesNoN/A
5. Have you been a paid in your behalf o	defendant in a legal r paid such a claim y	action involving professional lia	bility (malpractice) or had a professional liability claim YesNo
of any federal, state excluding any minor	or local law, includ traffic offense (driving inor traffic offense	ling any foreign country, which g or in control of a motor vehicle	ead guilty or nolo contendere to any offense or violation is a misdemeanor, gross misdemeanor, or felony, while under the influence of any chemical substance is anufacture, distribution, prescribing, or dispensing of
			ine or any other healing art, or permission to take an ountry or U.S. territory?YesNo
8. Have you ever had any state, country or		r license to practice any other h	ealing art revoked, suspended, limited, or restricted inYesNo
9. Have you ever vo territory?	luntarily surrendered	a license to practice medicine	or any other healing art in any state, country or U.S. YesNo
10. Have you ever b	een denied member	ship or expelled from a medica	al society or other professional medical organization?YesNo
any violation of a sta	itute, rule or regulati	on governing your practice as	; b) investigated for; c) charged with; or d) convicted of a physician by any medical licensing board, hospital, yada State Board of Medical Examiners? Yes
12. Have you ever su	urrendered your state	or federal controlled substanc	e registration or had it revoked or restricted in any way?YesNo
any and all resignati	ons from any medic ictions for failure to o	al staff in lieu of disciplinary or complete hospital medical reco	ded, limited, revoked or not renewed by the hospital. List administrative action. (Please Note: Do not include ords, attend hospital department or staff meetings, or
	Mailing	Type of	Dates of Action
Hospital	Address	Action	From (Mo./Yr.) To (Mo./Yr.)
NONE	Ε		
	(If m	nore space is needed, attach a	separate sheet.)

CHILD SUPPL	DRISIAIEME	41						
Please place	a check mark r	ext to one of the	following stater	nents:				
(a) I	am not subject	to a court order for	the support of a	child;				
compliance wi	am subject to a ith a plan appro pursuant to the	court order for the ved by the district a	support of one or attorney or other	more children public agency	and am in co enforcing the	mpliance w order for t	vith the o	rder or am in yment of the
plan approved	am subject to a by the district at	court order for the torney or other pub	support of one or lic agency enforc	more children ing the order f	and am NOT or the repaym	in complia ent of the a	nce with mount o	the order or a wed pursuan
to the order.		1. 2.		2 3 32 5				
CONTINUING	MEDICAL EDU	CATION (CME) S	TATEMENT.					
	21 181	ext to one of the		nents:			***	
, / (a) Ic	ompleted a minics and 20 hours	mum of 40 hours o of which were in m	f AMA Category	1 continuing m	edical educat during the pa	ion (CME), st biennial	2 hours period o	of which were f July 1, 1999
months of the (CME), 2 hour (c) I wo of the past bie	past blennial post of which were vas initially licens nnial period, and	sed in Nevada dur eriod, and complet in medical ethics a sed in Nevada durin a completed a min	ed a minimum of and 20 hours of w ag the time period imum of 20 hours	f 30 hours of A which were in n July 1, 2000 to s of AMA Cate	MA Category ny scope of pi nrough Decen gory I continu	continuin ractice or s nber 31, 200 ing medica	ng medic pecialty; 00, the that educat	cal education ird six months
(d) I w	vas initially licens	ed in Nevada during d completed a min d ethics and 8 hou	ng the time period imum of 10 hours	January 1, 20 s of AMA Cate	01 through Ju	ne 30, 2001 ing medica	, the fou	rth six months tion (CME), 2
(e) la a full year of re	m exempt from esidency or fello	submitting proof of wship training duri	completion of co	ntinuing medic eriod July 1, 19	al education (199 through J	(CME) becaune 30, 20	ause I ha 01.	ve completed
⇒ IF YOU C JULY 1, 1	OMPLETED A F	OOF OF YOUR C FULL YEAR OF RE JUNE 30, 2001, A OF OF CME OR TI	SIDENCY OR F	ELLOWSHIP T	TRAINING DU	IRING THE	BIENN OUR T	IAL PERIOD RAINING.
I HAVE MONTHS.	HAVE NOT_	(CHECK ON	E) ACTIVELY PR	ACTICED ME	DICINE IN N	EVADA WI	ITHIN TI	HE PAST 12
BY SIGNIN	G ON THE S	IGNATURE LIN	E BELOW:					
1) IHEREBY	REPRESENT	THAT I AM THE PE	RSON NAMED I	N THIS APPLICATION	CATION FOR	REGISTRA EMENTS I	ATION R	ENEWAL OF

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).

	e -	
PHYSICIAN	Date Received',	
APPLICATION FOR RENEWAL REGISTRATION NEVADA STATE BOARD OF	APR 2 2 1999	License No
MEDICAL EXAMINERS	• 22	File No.
Post Office Box 7238 Reno, Nevada 89516 Phone (775) 688-2559	(Board Use Only)	
I hereby apply for renewal of biennial registration and en	close the appropriate fee(s) as	indicated below:
X_ACTIVE STATUS V	\$600.00	
INACTIVE STATUS	\$200.00	
RETIRED STATUS X SUPERVISING/COLLABORATING PHYSICIA	\$ 50.00 \$200.00	
SUPERVISING/COLLABORATING PHYSICIA	147 \$200.00	
100000000000000000000000000000000000000		
William D. Ramos, MD		checks payable to:
2550 F Desert Inn Rd Box # 263		DARD OF MEDICAL EXAMINERS s must indicate "U.S. FUNDS")
Las Vegas NV 89121	(Foreign check	stitust indicate 0.5. PONDS /
0005299		
PLE	ASE NOTE	
NEVADA HAS NO GRACE PERIOD		
ARE AUTOMATICALLY S		
EXTENSIONS OF TIME ARE		
YOUR LICENSE WILL NOT BE RENEWE		
	RS MUST BE EXPLAINE	
YOU MUST INCLUDE PROOF OF 40 HOU		
2 HOURS IN MEDICAL ETHICS AND 20 HOU	RS IN YOUR SCOPE OF	PRACTICE OR SPECIALTY
ALL FEES MUST BE PA		
- "구역구대 (FOR) 가는 사람이 이번 시간 전쟁이 있다면 되었다고 있다고 있다면 이번 시간	ASH THROUGH THE MA	
PLEASE ALLOW SIXTY (60) DAYS		
	E OR PRINT LEGII	
1. YOUR CURRENT M.D. LICENSE EXPIRES ON .	JUNE 30, 1999. THIS IS TH	E NOTICE TO RENEW YOUR M.D
LICENSE.		
2. To be eligible to act as a supervising physician for a particle.	hveician's assistant or as a co	Illaborating physician for an advance
practitioner of nursing, complete the enclosed Application	n for Approval as Supervising/	Collaborating Physician.
3. ACTIVE STATUS REGISTRATION RENEWAL RE	QUIRES THE SUBMISSION (OF PROOF OF 40 HOURS OF AMA
CATEGORY 1 CONTINUING MEDICAL EDUCATION V	which includes 2 hours of med	cal ethics and 20 hours in your scop
of practice or specialty completed during the period July	1, 1997 through June 30, 1998	. Submit your proof of CME with you
completed Application for Registration Renewal form.		
4. In order to provide sufficient time for processing, please	complete and return your App	lication for Registration Renewal forn
and Application for Approval as Supervising/Collabora	ting Physician form (if applical	ble) with your proof of 40 hours AM
Category I CME and the correct fee(s) BY JUNE 30,	1999. Use the enclosed se	lf-addressed envelope to return you
completed form(s) and fee(s).		
5. If your name and/or address has changed from that pr	inted on this form clearly indic	ate the change in the space provider
 If your name and/or address has changed from that pi A notarized or certified copy of the document authorizing 	i vour name change (marriage	license, divorce decree, etc.) must b
included.	, , - a on ang , (manuage	,,,
Name VIIIIA D. KAMOS	m.D.	
Street 1670 E. ELAMINGO	ROAD SYITE	c
Name Villiam D. RAMOS Street 1670 E. STEPROS City LAS VEGAS County CLARI	State NV	ZipZip
6. IF YOU HAVE RETIRED OR MOVED YOUR PRACTIC	E. INDICATE THE LOCATIO	N OF PATIENT RECORDS BELOW
Name		
Street		
City County	State	Zip

7. Are you currently active in me a. [] YES, in training c. [] YES, working [e. [] NO, other (spe	g. part-time	b.[X] d.[YES, working fu NO, retired.	ıll-time		_)
Please indicate your primar following codes:	y, secondary	SCOP	E OF PRACTICE	percent of p	ractice time sper	nt in each, using the
102 ADDICTION MEDICINE 1 ADOLESCENT MEDICINE 2 AEROSPACE MEDICINE 3 ALLERGY/IMMUNOLOGY 104 ALTERNATIVE MEDICINE 4 ANESTHESIOLOGY 5 BLOODBANKING 6 BRONCO-ESOPHAGOLOGY 7 CARDIOVASCULAR DISEASES 8 CATSCAN/ULTRASOUND 9 CHILD NEUROLOGY 10 CHILD PSYCHIATRY 11 CLINICAL PHARMACOLOGY 12 CRITICAL CARE 13 DERMATOLOGY 14 EMERGENCY MEDICINE 15 ENDOCRINOLOGY 16 FAMILY PRACTICE 17 GASTROENTEROLOGY 18 GENERAL PRACTICE 19 GERIATRICS 20 GYNECOLOGY 21 HEMATOLOGY 21 HEMATOLOGY 22 HYPNOSIS 23 IMMUNOLOGY 24 INFECTIOUS DISEASES 25 INFERTILITY 26 INTERNAL MEDICINE 27 LARYNGOLOGY 28 LEGAL MEDICINE 29 MATERNAL/FETAL MEDICINE 106 MEDICAL ACUPUNCTURE 107 MEDICAL ETHICS	32 33 34 35 36 37 38 39 40 41 45 42 43 44 46 47 48 49 50 51 52 53 54 55 59 99 97 56 57 58 59 59 59 59 59 59 59 59 59 59 59 59 59	NEOPLASTIC I NEPHROLOGY NEUROLOGY NEUROPATHO NEURORADIO NUCLEAR MEI NUTRITION OBSTETRICS OCCUPATION. ONCOLOGY ONCOLOGY, G ONCOLOGY, G ONCOLOGY, S OPHTHALMOL OTOLARYNGO OTOLOGY PAIN MANAGE PATHOLOGY, PATHOLOGY, PATHOLOGY, PATHOLOGY, PEDIATRIC, C PEDIATRIC, C PEDIATRIC, E PEDIATRIC, E PEDIATRIC, I PEDIATRIC, II PEDIATRIC, I PEDIATRIC, I PEDIATRIC, I PEDIATRIC, I I I I I I I I I I I I I I I I I I I	DLOGY LOGY LOGY LOGY LOGY LOGY LOGY LOGY	63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 100 80 103 81 91 82 83 84 NE 92 93 84 NE 92 93 85 ES 86 87 88	PEDIATRIC, RADIOI PEDIATRIC, SURGE PEDIATRIC, UROLO PEDIATRICS PHYSICAL MEDICIN PREVENTIVE MEDIC PSYCHOANALYSIS PSYCHOANALYSIS PSYCHOMATIC MEI PUBLIC HEALTH PULMONARY DISEA RADIOLOGY, DIAGN RADIOLOGY, NUCL. RADIOLOGY, NUCL. RADIOLOGY, SURGERY, ABDOMI SURGERY, ABDOMI SURGERY, CARDIO SURGERY, CARDIO SURGERY, CARDIO SURGERY, HEAD/N SURGERY, HOLOG SURGERY, TRAUM/SURGERY, UROLOG SURGERY, VASCUL SURGERY, VASCUL	E/REHABILITATION CINE DICINE SES NOSTIC EAR APEUTIC NAL THORACIC VASCULAR RECTAL AL ECK DFACIAL LOGICAL PEDIC CIC CATIC GIC
20 NEO/PERINATAL MEDICINE Primary		PEDIATRIC, PE PEDIATRIC, PE Percent	JLMONARY		rd Certified (Indic	ate Yes/No)
Secondary Tertiary	53		7		Y 65	_
PLEASE INDICATE ALL AMER Board OBSTRTRIC				Dat	OR SUBBOARD e of rtification	CERTIFICATIONS: Date of Last Certification
	2 4 ///			(Mo	(Yr.)	(Mo.Yr.)
Board PATHO LOGY	, ANATOM	110 + 62	NICAL	(Mo.	(Yr.) 90	(Mo/Yr.)
	,			(Mo.	Yr.)	(Mo./Yr.)
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9. Form of employment is	BY: of Practitione	rs		D, EMPLOYI on-Government covernment vernment overnment	(armed services	spital, school, etc.) personnel only)
1012	Other (specifi	y)				

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

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

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

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

2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without

the use of aids or devices, such as voice amplifiers; and

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

000	COMPLETED REGISTRATIO	N APPLICATION FORM
1. Do you and safety?		limits your ability to practice medicine with reasonable skillYesXNo
		mits your ability to practice medicine, is that impairment or e, the setting, or the manner in which you have chosen toYesNoXN/A
3. If you us skill and saf		pair or limit your ability to practice medicine with reasonableYesXNoN/A
begin to sa		thin one year after the date the public service is required to clarship from the federal government or a state or localNoX_N/A
5. Have you paid in your	been a defendant in a legal action involving profession behalf or paid such a claim yourself?	nal liability (malpractice) or had a professional liability claim
violation of felony, excl substance i	any federal, state or local law, including any foreign uding any minor traffic offense (driving or in control of	d of, or plead guilty or nolo contendere to any offense or country, which is a misdemeanor, gross misdemeanor, or a motor vehicle while under the influence of any chemical is related to the manufacture, distribution, prescribing, orYesXNo
		edicine or any other healing art(s), or permission to take an sy state, country or U.S. territory?YesXNo
	ever had a medical license or license to practice any country or U.S. territory?	other healing art revoked, suspended, limited, or restrictedYesXNo
9. Have you territory?	u ever voluntarily surrendered a license to practice me	edicine or any other healing art in any state, country or U.SYesXNo
10. Have yo	ou ever been denied membership or expelled from a n	nedical society or other professional medical organization?YesXNo

11. Have you ever bee the practice of medicin	n investigated for, charged e by any medical licensing	d with, or convicted of any board, hospital, medical	violation of a statute, rule or regulation governing society, governmental entity or other agency? YesNo
12. Have you ever su way?	rrendered your state or fed	deral controlled substance	e registration or had it revoked or restricted in any YesXNo
Liet any and all regionation	ons from any medical staff ions for failure to complete	in lieu of disciplinary or ac	d, limited, revoked or not renewed by the hospital. dministrative action. (Please Note: Do not include a, attend hospital department or staff meetings, or
maintain roquiro minip	Mailing	Type of	Dates of Action
Hospital	Address	Action	From (Mo./Yr.) To (Mo./Yr.)
	ONE Address		
(16 ma)	re space is needed, attach	a congrate cheet)	
(if moi	e space is needed, attach	a separate sileet.)	
PLEASE CHECK ONE	OF THE FOLLOWING:		
I am not subje	et to a court order for the s	upport of a child.	
V I am subject	o a court order for the sup	port of one or more child	ren and am in compliance with the order or am in
compliance with a plan	approved by the district a	ttorney or other public ag	ency enforcing the order for the repayment of the
amount owed pursuan	to the order: or		
I am subject to	a court order for the supr	ort of one or more childre	en and am NOT in compliance with the order or a
	district attorney or other p	oublic agency enforcing t	he order for the repayment of the amount owed
pursuant to the order.			
		TURE STAMP UNACCES	
Signature	101016	THE STAND UNACCED	TARIE)
	(SIGNA	TURE STAMP UNACCE	INDLE
DI EASE CHECK ONE	OF THE FOLLOWING:		
V 1 I have ear	ned a minimum of 40 hou	rs approved AMA Categor	ry 1 continuing medical education (CME), 2 hours
of which were in medi	cal ethics, and 20 hours of	which were in my scope	of practice or specialty during the biennial period
Viely 1 1997 through .	June 30, 1999.		
2 I was initia	Ilv licensed in Nevada duri	ng the second six months	of the biennial period July 1, 1997, through June
30 1000 and have ea	med a minimum of 30 hou	irs approved AMA Catego	ory I continuing medical education (CME).
3 I was initial	v licensed in Nevada durir	na the third six months of t	the biennial period July 1, 1997, through June 30,
1999, and have earned	l a minimum of 20 hours a	approved AMA Category I	continuing medical education (CME).
4. I was initiall	y licensed in Nevada durin	g the fourth six months of	the biennial period July 1, 1997, through June 30,
1999, and have earned	I a minimum of 10 hours	approved AWA Category I	continuing medical education (CME). ation (CME) because I have completed a full year
5. I am exem	hip training during the bien	nial period luby 1 1997 th	rough June 30, 1999
of residency of fellows	inp training during the bien		nough dans os, 1000.
		IMPORTANT	OF ALL ADDRESS AND LAKE DE DETINIES
ATTACH COPIES OF	PROOF OF DECLARED	CME CREDITS - PROOF	OF CME CREDITS WILL NOT BE RETURNED.
		n 12.0	/
Signature	~ (OIONA	TURE STAMP UNACCER	
	(SIGNA	TURE STAMP UNACCE	PIABLE)
IUME X UMEN	OT ACTIVELY PR	ACTICED IN NEVADA WI	THIN THE PAST 12 MONTHS. (CHECK ONE)
THAVE_/ HAVE	OI AOTIVEETTIO	NOTICED IN THE VIOLET	mint me
I HEDERY CERTIF	V THAT I AM THE PE	RSON NAMED IN TH	IIS APPLICATION FOR REGISTRATION
DEVICENT OF L	CENCE TO DEACTIC	E MEDICINE IN THE	E STATE OF NEVADA AND THAT ALL
			STATE OF MENADA WAD THAT WEE
STATEMENTS I H	AVE MADE HEREIN	ARE TRUE.	
(262) 800 100	1/2/00		VI. 11
(764) 892-0660		01	TURE STAMP UNACCEPTABLE)
Business Telephone #	Date	Signature (SIGNA)	URE STAMP UNACCEPTABLE)

	50		Date received by B	Soard
APPLICATION FOR RENEW		TION	APR -3 1997	License No
NEVADA STATE I MEDICAL EXA		242	Mrk - 3 1997	APR 1, 041997File No.
Post Office Box 7238 Reno, Nevad		2) 688-2559	(Board Use Only)	** ** ** ** ** ** ** ** ** ** ** ** **
hereby apply for renewal of the	biennial registrati	\$600.00	e the appropriate fee PLEASE NOTE:	
ACTIVE STATUS INACTIVE STATUS	•	\$150.00 \$150.00	PLEASE NOTE:	NEVADA HAS NO GRACE PERIOD. LICENSES NOT RENEWED BY
RETIRED STATUS		\$ 50.00		JULY 1, 1997 ARE AUTOMATICALLY
P.A. SUPERVISING		\$200.00		SUSPENDED FOR NON-PAYMENT
I.A. OOI ERVIOUR		4200.00		OGO, ENDED I ON NON-I ATMENT
William D. Romos A.	4D			
William D. Ramos, N				Make checks payable to:
2550 E Desert Inn R	d #263			TE BOARD OF MEDICAL EXAMINERS
Las Vegas, NV	89121		(Foreign	checks must indicate "U.S. FUNDS")
			-	
LICENSE.				
LICENSE. 2. To be eligible to act as a st as Supervising Physician form 3. ACTIVE STATUS REGIST CATEGORY I, CONTINUING Submit your proof of CME with 4. In order to provide sufficient And Application for Approval a and the correct fee(s) PRIOR 1 and fee(s). 5. If your name and/or address	upervising physican. TRATION RENE MEDICAL EDI h your completed t time for process as Supervising Pl TO JULY 1, 1997 s has changed fro	EWAL REQUIR JCATION com d Application for ing, please con hysician form (7. Use the encl om that printed	RES THE SUBMISS pleted during the per Registration Rener plete and return you if applicable) with you osed self-addressed on this form, clearly	Diete the enclosed Application for Approva
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YOUR LICENSE REGISTRATION WILL NOT BE RENEWED WITHOUT SUBMISSION OF THE CORRECT FEE(S),

___State__

__County__

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

		c. []	YES, in training. YES, working part-ti		YES, working full- NO, retired.	ume	20		
		e. []	NO, other (specify_						
	2. Please	indicate	your primary, second	ary and tertiary spe	ecialties and percen	t of time	spent in each, using the	following codes.	
				SP	ECIALTY CODE:				
	CENT MEDICINE	1		35 NEURORADIOLOGY			UROLOGY		
3 ALLERG	PACE MEDICINE Y/MMUNOLOGY			36 NUCLEAR MEDICINE 37 NUTRITION		68 PHY	IATRICS SICAL MEDIREHAB		
5 BLOODS	ESIOLOGY BANKING			38 OBSTETRIC/GYNECO 39 OBSTETRICS		67 PRE	SICIAN ASSISTANT VENTIVE MED		
	O-ESOPHAGOLO WASC DISEASES			40 OCCUPATIONAL MED 41 ONCOLOGY	1	68 PSY 69 PSY	CHIATRY CHOANALYSIS		
8 CATSCA	NAULTRASOUND EUROLOGY			45 ONCOLOGY, GYNECO 42 ONCOLOGY, HEMATO		70 PSY	CHOMATIC MEDICINE LIC HEALTH		
10 CHILDP	SYCHIATRY L PHARMACOL			43 ONCOLOGY, RADIATE 44 ONCOLOGY, SURGICE	ON		MONARY DISEASES		
12 CRITICA	L CARE			48 OPHTHALMOLOGY	~	74 RAD	HOLOGY, DIAGNOSTIC		
13 DERMAT	ENCY MEDICINE			47 OTOLARYNGOLOGY 48 OTOLOGY		76 RAD	IOLOGY, NUCLEAR IOLOGY, THERAPEUT		
18 FAMILY	PRACTICE			48 PAIN MANAGEMENT 50 PATHOLOGY		78 RHII			
	DENTEROLOGY AL PRACTICE			51 PATHOLOGY, ANATO: 52 PATHOLOGY, CLINICA		79 SLE 100 SPC	EP DISORDERS RTS MEDICINE		
19 GERIATI	RICS			53 PATHOLOGY, FOREN 54 PED. ALLERGY		80 SUR	GERY, ABDOMINAL GERY, CARDIOVASC		
21 HEMATO	OLOGY			55 PED. CARDIOLOGY 99 PED. CRITICAL CARE		91 SUR	GERY, COLON/RECTAL GERY, GENERAL		
22 HYPNOS 23 IMMUNO	DLOGY			97 PED. EMERGENCY M	ED .	63 SUR	GERY, HAND		
25 INFERT				58 PED. ENDOCRINOLOG 57 PED. HEMAT/ONCOLO	DGY	92 SUR	GERY, HEADNECK GERY, MAXILLOFAC		
27 LARYNG	AL MEDICINE SOLOGY			58 PED. INFECTIOUS DIS 59 PED. INTENSIVIST		85 SUR	GERY, NEUROLOGICAL GERY, ORTHOPEDIC		
	MEDICINE NAL/FETAL MED			98 PED. NEPHROLOGY		87 SUR	GERY, PLASTIC GERY, THORACIC		
30 NEO/PE	RINATAL MED ASTIC DISEASES			01 PED. OPHTHALMOLO 61 PED. PHYSIATRY	GY		GERY, TRAUMATIC GERY, UROLOGIC		
32 NEPHRO	DLOGY			95 PED. PULMONARY 62 PED. RADIOLOGY		90 SUR	GERY, VASCULAR LOGY		
	PATHOLOGY			63 PED. SURGERY					
				Code	Percent of Time		Board Certified (Ind		
Primary				20	- 98		ye.		
Seconda	ry			50				<u> </u>	
Tertlary				-			-		
PLEASE	INDICATE	AMERI	CAN BOARD OF MEI	HCAL SPECIALTI	ES BOARD CERTI		N: f Initial Certification	Data of Last Contilla	-41
Board	AAIR	De	CO/EYN			Date	11/76	Date of Last Certific	auon
Subboam	AABR	80	PATHOLEGY	rele	,	0	(Mo./Yr.)	(Mo./Yr.)	
Outboard	7,			FORRA	VSIC PATH.	6	(Mo.Yr.)	(Mo./Yr.)	
3. Form	of employm		/012	(Use the following	codes)		//		
4004	SELF-EM		1		ALARIED, EMPLO		the state of the s	4-1	
1001	Solo Prac	Charles and Committee of the Committee o	oup Practitioners			Commence of the second	oyer (hospital, school, e services personnel only		
1002			OYED BY:		ederal Government			,	
1003	Individual				State Government				
1004			oup of Practitioners		County Government				
1005	Group He	alth Plar	n Facility (such as H.M 1012 Ot	l.O.) 1011 I her (specify)	Local Government				
	All of t						i, through the pre		
							PARATE QUEET		

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.

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"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.

If you use chemical substances, does your use of chemical substance(s) in any way impair or limit your ability to practice medicine with and safety? 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 sat of your receiving a loan or scholarship from the federal government or a state or local government for your medical education? 5. Have you been a defendant in a legal action involving professional liability (malpractice) or had a professional liability claim paid in y such a claim yourself? 6. Have you ever been investigated for, charged with, convicted of, or plead guilty or noto contendere to, any offense or violation of ar local law, including any foreign country, which is a misdemeanor, gross misdemeanor, or felony, excluding any minor traffic offense (D of a motor vehicle while under the influence of any substance is not considered a minor traffic offense) or which is related to the manufal prescribing, or dispensing of controlled substances? 7. Have you ever been denied a license, permission to practice medicine or any other healing arts, or permission to take an examination to or any other healing arts in any state, country or U.S. territory? 8. Have you ever had a medical license revoked, suspended, limited, or restricted in any state, country or U.S. territory? 9. Have you ever been denied membership or expelled from a medical society or other professional medical organization? 11. Have you ever been investigated for, charged with, or convicted of any violation of a statute, rule or regulation governing the practice.	1. D						
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APPLICATION FOR INITIAL REGISTRATION NEVADA STATE BOARD OF MEDICAL EXAMINERS

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

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	SELF-EMPLOYED	. (USC LIC TOHOWI	1006	Other Non-Government Employer (hos	oital, so	choo
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FOR	ALL YES RESPONSES, I	Tease explain on a separ	ATE SHEET A	ND RETURN WITH THIS REGISTRATION APPLICA	TON.	
or the purpose	of the following question	is, these phrases or words have	these meaning	igs:		
bility to prac	ctice medicine" is to be o	onstrued to include all of the f	ollowing:			
	nitive capacity to make ap ments; and	propriate clinical diagnoses as	nd exercise re	asoned medical judgments and to learn and keep ab	reast of i	medi
2. The abili	ty to communicate those		ation to patier	ts and other health care providers, with or without t	he use of	aids
	such as voice amplifiers;		ian examination	on and surgical procedures, with or without the use o	side or o	lavio
	corrective lenses or heari					
				isorder, such as, but not limited to, orthopedic, vis		
		ies, HIV disease, tuberculosis,		 s, cancer, heart disease, diabetes, mental retardation, and alcoholism. 	n, emoti	onal
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		the prescriber's direction, as				
currently" do	es not mean on the day of	or even in the weeks or month ig impact on one's functioning	s preceding the	e completion of this application. Rather, it means reco	ently end	ough
				us substances obtained illegally (e.g. heroin or cocair	e) as wel	last
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				ny part of your medical education?	Q Yes	M
				to practice medicine with reasonable skill and safety		A
				practice medicine with reasonable skill and safety? ameliorated because you receive ongoing treatment	☐ Yes	24
(with or w	thout medications) or par	ticipate in a monitoring progra	m?	ameliorated because of the field of practice, the	Q Yes	01
setting, or	the manner in which you	have chosen to practice?		M/A	Q Yes	0
. Have you	ver been diagnosed as ha	ving, or have you ever been tree egal use of controlled dangerou	ated for pedop	hilis, exhibitionism, or voyeurism?	☐ Yes ☐ Yes	
. Are you cu	rrently participating in a	supervised rehabilitation progr	am or profess	onal assistance program which monitors you in orde	T Les	
		in the illegal use of controlled			☐ Yes	20
	f or paid such a claim you		natimity (marp)	actice) or had a professional liability claim paid in	Z Yes	0
				ntendere to a violation of any federal, state or local	☐ Yes	701
		tribution, prescribing, or disper gated for, charged with or conv		d nolo contendere to any offense, misdemeanor or		
	ny state, the United State			,	Yes Yes	ख
Have you i	ailed to initiate the perfor	ical licensure in Nevada (include mance of public service within	one year after	the date the public service is required to begin to	A Yes	4
satisfy a re	equirement of your receive			ernment or a state or local government for your	D.,	d.
medical ed		, permission to practice medici	ine or any othe	er healing arts, or permission to take an	Q Yes	
		any other healing arts in any			Q Yes	됨:
				any state, country or U.S. territory? any state, country or U.S. territory?	Q Yes	
				er professional medical organization?	☐ Yes	
				revoked or not tenewed by the hospital. List any and tion. (Please Note: Do not include suspensions or		
restriction	s for failure to complete h	ospital medical records, attend	hospital depar	tment or staff meetings, or maintain required malprac	tice insu	ranc
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. Have you e	ver been investigated for.	charged with, or convicted of a	ny violation of	a statute, rule or regulation governing the practice o	r	
medicine t Have you e	y any medical licensing b ver surrendered your stat	oard, hospital, medical society, e or federal controlled substan	governmental ce registration	entity or other agency? or had it revoked or restricted in any way?	Yes Yes	A S
	that I am the person name we made herein are true.	ned in this Application for Initi	al Registration	of license to practice medicine in the State of Nevi	da and t	hat
	-/	/)_		
8)548-8	151 .5/1	195 X		n 1		

STATE OF NEVADA BOARD OF MEDICAL EXAMINERS APPLICATION FOR TEENEURED D PERSONAL INFORMATION: MAR 1 4 1995 William First **NEVADA STATE BOARD OF** 1. Present Legal Name MEDICALEXAMINERS List any other name ever used Business and/or Mailing Address 9 JE4WiFER 26. 3. Home Address 3205 Telephone (7/9) 275 - 602 6 Office Place of Birth NEW YORK 5. Date of Birth 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. Weight ____ Color of Eves Black 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 __ No 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

JAN 1 0 1995

and safety? Yes X No

22.	List name and address of all schools what AN OFFICIAL TRANSCRIPT DIRECT Name TATE U. OF NEU YEAR OUNSTATE AED. CHTR. Doctor of Medicine Degree granted by Medical School Name TATE U. OF NEU YOAR	here professional medical instruction was place with the second s	Vhere Dates Received From (Mo.	H SCHOOL SUBMIT of Attendance //r.) To (Mo./yr.)
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	was received.	Address	Dates of Atte	
21.	OUCATION: List name and address of all colleges	or universities attended, other than so	chools where professions	al medical instruction
	government for your medical education	on? Yes X No N/A	•	
20.	. Have you failed to initiate the performa begin to satisfy a requirement of you	ance of public service within one year ir receiving a loan or scholarship from	after the date the public and the federal government	service is required to
19.	. Have you previously applied for medi-	cal licensure in Nevada (including a	residency program)?	Yes No
18.	. Have you ever been arrested, investi misdemeanor or felony in any state, t	igated for, charged with or convicted the United States, or a foreign country	of, or pled nolo contend y? Yes X N	dere to any offense o
	state or local law relating to the manu Yes No	facture, distribution, prescribing, or o	lispensing of controlled s	substances?
17.	. Have you ever been investigated for,		nolo contendere to a vio	lation of any federal
16	Have you been a defendant in a legal a paid in your behalf or paid such a clai	action involving professional liability (m	nalpractice) or had a profe	essional liability clain
15.	Are you currently participating in a sup you in order to assure that you are not	pervised rehabilitation program or pro engaging in the illegal use of controll	fessional assistance prog ed dangerous substance	gram which monitors s?Yes _ X_ No
14.	Are you currently engaged in the illeg	al use of controlled dangerous subst	ances?Yes X_N	0
	Have you ever been diagnosed as ha	aving, or have you ever been treated	for pedophilia, exhibition	ism, or voyeurism?
13.	and country or and manner in miner y	ou have chosen to practice?Ye	s X No	of the field of practice
	Are the limitations or impairments caus the setting, or the manner in which yo	sed by your medical condition reduced	or ameliorated because o	

*Accre		da. Council for Gra	duate Medical Ed	lucation			NEV/	DA STATE BO.
	Hospital		Mailing		1	Type of Service	Dates of A	ttendance
1	nstitutio	n	Address			or Specialty	From (Mo./Yr.)	To (Mo./Yr.)
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KINGS	C 0.	Mosp.	BROOMETO	BY I	9203	08/6700	7/7/	13/19
		Mo Tenewa				AES.	7/90	1100
ARD	CM	TR	LEBROW	, NA	13766	PATRULLY	// //	1/10
25. List an	y and al	Fellowship tra		tended in	the Unite	ed States or Canada	ı.	
2			Mailing			Type of	Dates of At	
Free	nstitutio		Address 520 FIRE			Fellowship	From (Mo./Yr.)	10 (MO./Yr.)
		2.025	NEU TORK			PAT No LO 67	2/00	1/11
RFAR	MEM		IV IS V FOR A	, ~ / /	, , , , , , , , , , , , , , , , , , ,	1 MI PULL	.,,,,	.,,,,
6. Have a	ny action	ns, restrictions, Yes X N	limitations, or prot o	oations ev	er been in	nposed on you while	participating in any	type of trainir
7. List an	y other p	oostgraduate m		not accou		n questions 24 and	25 above.	
12			Mailing		1	Type of Service	Dates of A	
1	nstitutio	n	Address			or Specialty	From (Mo./Yr.)	10 (IVIO./11.)
ICENSIN	G EYAN	PANOITANII			•			
8. Have y	ou ever	IINATIONS: failed a state lic	ensure examinati	on, any pa	art of FLE	X, any part of Nation Yes <u>¥</u> No	nal Boards, or any p	part of ECFMC
28. Have y FMGE 29. For ea	ou ever MS, USI ch of the	failed a state lic MLE or SPEX, o following licen	even if subsequents	ntly passe s list the k	ocation, p	Yes <u>X</u> No parts and dates take	n, and scores obta	
28. Have y FMGE 29. For ea exam t	ou ever MS, USI ch of the aken, ha	failed a state lic MLE or SPEX, of ollowing licentage certificate of	even if subsequents	ntly passe s list the k	ocation, p	Yes <u>X</u> No	n, and scores obta	
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28. Have y FMGE 29. For ea exam to NATIO	ou ever MS, USI ch of the aken, ha	failed a state lic MLE or SPEX, of ollowing licentary ave certificate of ARDS:	even if subsequents	ntly passe s list the lo	ocation, p	Yes <u>Y</u> No parts and dates take entity directly to the Date	n, and scores obta	ined. For eac
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28. Have y FMGE 29. For ea exam to NATIO	ch of the aken, ha NAL BO Location	failed a state lic MLE or SPEX, of following licentave certificate of ARDS:	even if subsequentsing examination of scores submitted Part Taken Taken Examination): Part Taken	ntly passe s list the lo	od?	Yes Y No parts and dates take entity directly to the Date //// //// //// Date	n, and scores obta Board. Result (Scores)

d. USMLE (United States M Location	edical Licensing Examination): Part Taken	Date	Result (Scores)
N/A	3		
6		1.4	
e. SPEX (Special Purpose E Location	Part Taken	Date	Result (Scores)
N/A	*		*
. ECFMG (Educational Cor Location	nmission for Foreign Medical Gr Part Taken	Date	Result (Scores)
IST ECFMG #	al Graduates Examination in the Part Taken	Medical Sciences): Date	•
REA OF SPECIALTY: 0. State your area of specialt	y: 08-64× }	PAT NOC. 67 (A.	P, CP, FP)
1. List any and all certificatio	ns by a board recognized by the	American Board of Medical	Specialties. Dates of
Specialty Board	Certifica	tion # Ce	ertification/Recertification
PATHOLOGY			
EDICAL PRACTICE HISTO	RY:		
 Account for all periods of ti be accounted for. City/State 	me since graduation from medica	al school (include military ser	vice). All periods of time mu From (Mo./Yr.) To (Mo./Yr.
NEW YORK	¥.,	*	1/20 6/25
VANDERBEAR AFO.	CA		7/15 8/18
RENO, NV			9/74 6/16
HANOVER, NH	.5		7/86 6/90
NEU YORK , NO		y R	7/90 PARSEN

	11		Complete N	Acilian Address Er	Dates of Appoi	DATATE BOAR
	Hospita	1500		Mailing Address Fr	om (Mo./Yr.) ME	ECHNEXALIN"
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een n	4RST	Hosp.		ROBBYAT IT , NY	1/95	PRUENT
	and all lice	nses <u>you hol</u>		ce medicine in any state or	Dates of	of Practice
C	Country		License #	Date of Issuance	From (Mo./Yr.)	To (Mo./Yr.)
NEU	YORK		107786	1/1/1/	7/90 -	PRESENT
CAL	FORW/4		6-28860	1975	1/15	8/18
NEV	ADA		-	(/3/18	7/78 -	c/8c
PEU	ROMPSH	DIAE	1527	3/4/87	7/26	E/90
VER	RAONT		42-0007546	5/20/17	2/87	1189
examina	ation to prac	ctice medicine	e or any other healing a	ctice medicine or any other harts in any state, country or l	U.S. territory? Y	es 🗶 No
examina Have yo Yes	ation to prac ou ever had sNo	a medical lic	e or any other healing a	arts in any state, country or led, limited, or restricted in a	U.S. territory? Y	es <u>X</u> No
examina . Have yo Yes	ation to prac ou ever had sNo	a medical lic	e or any other healing a	arts in any state, country or	U.S. territory? Y	es <u>X</u> No
examina Have you Yes Have you Yes	ou ever had bu ever had No ou ever volu s No ou ever beer	a medical lic	e or any other healing a ense revoked, suspend ndered a license to prac	arts in any state, country or led, limited, or restricted in a	U.S. territory? Yearny state, country or ly state, country or l	r U.S. territory?
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Have you Have you Have you Yes Have you Yes List all h List any include meeting	ou ever had No ou ever volu s No No ospitals who and all resistances, or maintal	a medical lice ntarily surrent denied men ere you have gnations from s or restriction	e or any other healing a sense revoked, suspend ndered a license to prace abership or expelled from had staff privileges den any medical staff in licens for failure to comple nalpractice insurance.)	arts in any state, country or led, limited, or restricted in a stice in the healing arts in an a medical society or other ied, suspended, limited, reveau of disciplinary or administe hospital medical records,	U.S. territory? Yearny state, country or large state state action. (Plea attend hospital deponants)	Yes No TU.S. territory? J.S. territory? al organization by the hospital se Note: Do no partment or state of Action

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ng arts in any state,	, country or U.S. ter	ritory?
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or administrative a	not renewed by the action. (Please Note hospital department)	e: Do r
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olation of a statute, Il society, governme	rule or regulation gental entity or other	overnir agency
i	iolation of a statute, al society, governme	

VilliAA DOUGLAS , 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. Signature of Applicant Subscribed and sworn to before me this (Notary Seal) J. MICHAEL GAUDREAU Notary Public for State of _ Notary Public, New Hampshire My Commission Expires Octavidation Expires June 25, 1998 Attach a finished photograph I hereby certify that the attached of passport quality of your photograph is a true likeness of head and shoulders only. myself taken within the last 60 days. 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 Signature of Applicant the lower portion of its front side. Proof photos and negatives

are not acceptable.

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		
	JUL 13 1987	
Filed:		
Kathloon	Lowie	

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. P.

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

			TIVE STATUS	\$250.00 \$100.00			IUL 08 1985
			TIRED (NO FEE		ED FOR 1985-	87)	UZ U8 1900
I	Delinquent after Septem						,005
			5299				
Г	William D F	RAMOS				PRACTICE	: (Check One Only)
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		9000				☐ Adminis ☐ Medical	
7	Reno	NA			J	Li Medicai	Teaching Retired
L			89502				
			TYPE OR PRINT	LEGIBL		Social Security #	
AME	RAMOS	WILLIAM	DOUGLA	AS		Social Security -	
	Last	First	Middle			Business Phone 7	2 323-7060
		975 RYLAND		73'	ENO	>177	00000
USINESS	OR MAILING ADDRESS	Street Address or F	O. Box Suite N		ENO	NV . State	89502 Zip Code
vou have	retired or moved your	practice, please indicate	the location B	OARD CE	RTIFICATION:		
	patient's records below:						
AME				es	X	No	
DDRESS_						S & GYNECOLCO	¥
HONE # (1		D	ate of Certif	ication or Rece	rtification 1976	
rimary Sp	oecialty (List only one)	OB/GYN	Sul	b-Specialti	es: _INFER	TILITY	
SINCE YO	OUR LAST REGISTRATION	ON:					+
1. Have yo	ou been investigated, cha	arged or convicted of unp	rofessional	3. Have you	ı surrendered	your license to prac	tice medicine in anothe
tice by	ct, professional incomper any medical licensing	tence or gross or repeate board or other agency, l	d maiprac- hospital or	jurisdict		16"" -14b - d	
	al society?					If "yes" attach a de	restricted and a risk of advantage of the set
medica				4 Have and	y malpractice	settlements, awards	or judgment been mad
medica	과어가는 이번 얼마가 하면서요 그라고 없었다.	attach a detailed explana		against	vou in any fur	1SCHOTH Y	or juagiment occir maa
medica 2. Have yo	ou been investigated, cha	attach a detailed explana arged or convicted for the p sing of controlled substan	possession,	against	you in any jur		
medica 2. Have you use of,	ou been investigated, cha or illegal sale or dispens	arged or convicted for the p	possession, ces?	against	you in any jur	If "yes" attach a de	
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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	n for BOARD USE ONLY	
hereby apply for a 1985 certificate of ann	nual registration AND ENCL	OSE the fee for \$100.00	
F 5299 RAMOS WILLIA 850 MILL ST	# 30 2		PRACTICE: (Check One Only) Direct Patient Care Resident Administration Military
RENO, NV	8950	٦	☐ Medical Teaching ☐ Retired
	TYPE OR F	RINT LEGIBLY	
NAME Ramos Wil	liam Dou First Mid	9/05	cial Security * usiness Phone () - 323 - 7060
BUSINESS OR MAILING ADDRESS 850	Street Address or P. O. Box	e 302 Reno	NU. 89502 State Zip Code
USINESS OR MAILING ADDRESS f you have retired or moved your practice former patient's records below:		Suite No. City BOARD CERTIFICATION:	State Zip Code
AME		Yes	
DDRESS		AM. Bd. of 00/474	
		Date of Certification or Recertificat	ion / 976
Primary Specialty (List only one)	08/614		7.7.1
SINCE YOUR LAST REGISTRATION: 1. Have you been investigated, charged or conduct, professional incompetence or tice by any medical licensing board or medical society? Yes \Boxedown No \Boxedown If "yes" attach a 2. Have you been investigated, charged or use of, or illegal sale or dispensing of conversion of the profession of the prof	gross or repeated malprac- or other agency, hospital or a detailed explanation convicted for the possession, ontrolled substances? a detailed explanation	Yes No X If "ye 4. Have any malpractice settler against you in any jurisdicti Yes No If "ye	es" attach a detailed explanation
1. ST Many boys, 3. Mr hant boys,	pens, as	2. Sperts Finity	May, Sperke, Mr
fake checks payable to: BOARD OF MEDI Foreign checks must indicate "U.S. FUNDS")	CAL EXAMINERS	I certify that all the above statements Signature	gre true M.I

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20	/
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APPLICATION FOR REGISTRATION NEVADA STATE BOARD OF MEDICAL EXAMINERS

Post Office Box 7238 Reno, Nevada 89510			FC	18 23 1984	70. mar. (1.
Delinquent after March 1, 1984	Nevada License No	3597	Date of	License 6/3/78	
	File No.	3299	New □	Renewal	
*	This shaded secti	on for BOARD USE ON	ILY .		
I hereby apply for a 1984 certificate of annu	al registration AND ENC	LOSE the fee for \$75.0	0.		
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850 MILL ST #3					
KENO, NV	89502	: 	Ī		
	TYPE OR	PRINT LEGIBLY			
RAMOS		OUGLAS	So	ocial Security *	
NAME		iddle	Bu	isiness Phone () 323-700	50
BUSINESS ADDRESS 850 Mill St.	Reno		Nevada	89502	
	City		State	Zip Code	
MAILING ADDRESS as above	City		State	Zip Code	
NOTE: Business Address will be used as dir		masted otherwise IN		2.p code	
NEW ADDRESS: If your address will change (If longer than two months, notify this office by let	tter just prior to changing lo	cation.)	s below.		
ADDRESS WILL CHANGE ON:	19_				
BUSINESS ADDRESS					
MAILING ADDRESS	City		State	Zip Code	
	City		State	Zip Code	
If you have retired or moved your practice, p of former patient's records below:	lease indicate the location	on BOARD CERTIFIC	CATION:		
NAME		Yes yes		No	
ADDRESS	•	AM. Bd. of OB/	GYN .		
PHONE * ()		Date of Certification	or Recertificati	Nov. 1976	
	B/GYN				
Primary Specialty (List only one)	2, 433.	Sub-Specialties:			
Has any disciplinary action been	taken	Yes No		PRACTICE:	(Check One Only
against you in any jurisdiction since your last registration?	If "ves" att	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	tion	Direct Patient Care	X
•				Administration	
Has any malpractice action been t	aken	Yes No		Medical Teaching	
against you in any jurisdiction since your last registration?		Yes No □ □ ach a detailed explanat	don	Military	
,				Retired	
STAFF PRIVILEGES: List all Nevada Hospital	ls in which you have any	staff privileges: (Name	and Location)	
1. Washoe Medical Center, 1	Reno	2. Saint Mar	y's Hospi	tal, Reno	
3. Sparks Family Hospital,	Sparks	Mount Gra	nt Hospit	al, Hawthorne	
		Tel man an action			
Make checks psyable to: BOARD OF MEDIC / (Foreign checks must indicate "U.S. FUNDS")	al examiners	I certify that all the ab	ove statements	2.0	,
		Signature		12 //	#M.D.

STATE OF NEVADA BOARD OF MEDICAL EXAMINERS 1281 Terminal Way, Suite 211, Reno, Nevada, (702) 329-2559

MAY 22 1978

APPLICATION FOR LICENSURE

	Nama RAMOS				
	NameLast	First		Middle	
	Address 4961 La Gama Way	Santa B	arbara C	alif.	93111 zip
	Date of Birth	PI	lace of Birth New	York, Ne	w York
er	reby make application for a license to pra	stice medicine	e in Nevada on th	e basis of:	560
	Endorsement of the written examination	given by the	State of		
	Endorsement by the Medical Council of	f Canada			
	Certificate of American Specialty Board	, No			
	Certificate of the National Board of Me	dical Examine	rs No		
	Admission to the written examination of	this Board			
	Citizenship Status: U. S. Citizen Yes	3	Declaration of	f Intention	
	Alien Registration Card	14			
	Medical School and Date of Graduation	State U.	of New Yor	k, Downst	ate, June 3,
	Medical School attended from Septe	ember 19	66	to June 3	, 1970
				207	
	Location 450 Clarkson Ave.	Brookly	n. N. Y. 11	203	
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*	Location 450 Clarkson Ave. If you are a foreign graduate, do you ho		ent ECFMG certifi	cate?	
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	Tri-Counties OB/GYN Society	<u>5a</u>	nta Barbara, Calif.
	American College of OB/GYN	<u>Ch</u>	icago, Ill.
		:_	J
	List name and address of all hospitals of v (Do not include hospitals where internship		
	USAF Hospital, Vandenberg A	FB, Calif	•
	V 1		
	*		
	In what states do you hold a license? Give	license numb	ers and date of issue.
	New York State, # 108816.		
	1 194		
	Have you ever been charged or convicted	of a felony or	an offense involving moral turpitude? NO
	Have you ever been addicted to the use of	narcotics, con	rolled substances or alcohol?No
	Have you ever been charged, convicted or substances? No	nvestigated fo	ruse or illegal sale or dispensing of controlled
	Have you ever been charged or convicted or other agency? No	of unprofessio	nal conduct by any medical licensing board
	Have you ever received psychiatric treatme	nt or received	treatment for a mental illness?
	Have you ever been expelled from a med	lical society	or other medical professional organization?
	Have you ever been expelled from a med	lical society	or other medical professional organization?
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4 30 U	If yes, give details on separate sheet. (1) (1) AM D. RAMOS, M. Poing questions and the statements made in named in the credentials to be submitted action and examination without fraud or mapplication is found to be false or fraudulent	being duly sy the above ap and that the srepresentation that I forfeit to Subscribe day of	orn, depose and say: That the answers to the plication are true and correct; that I am the same were procured in the regular course of the right to a license. Signature of Applicant and Signature of Applicant
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Place photograph taken within the year application is made within the space provided.

300 E W SW	Date <u>May 17, 1978</u> Age <u>35</u>
	Height 5' 10" Weight 1bs
	Color of Eyes Blue Color of Hair Brown
SIS .	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.
	Signature of Applicant A.S. FACO 6
	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

BEFORE THE BOARD OF MEDICAL EXAMINERS

OF THE STATE OF NEVADA 2 * * * * * 3 In The Matter of Charges and 4 Case No. 07-5299-1 Complaint Against 5 FILED 6 WILLIAM RAMOS, M.D., NOV 8 6 2009 7 Respondent. NEVADA STATE BOARD OF 8 9 ORDER OF DISMISSAL WITHOUT PREJUDICE The above-entitled matter came on regularly for decision before the Nevada State Board of 10 Medical Examiners, hereinafter "Board," on November 6, 2009, at the Board's offices, located at 11 1105 Terminal Way, Suite 301, Reno, Nevada, on the complaint filed herein pursuant to Nevada's 12 Open Meeting Laws, NRS and NAC chapters 630, and NRS Chapter 233B. 13 The members of the Board participating in the decision were Charles N. Held, M.D., Renee 14 West, Javaid Anwar, M.D., Benjamin Rodriguez, M.D., Beverly Neyland, M.D., Michael Fisher, 15 M.D. and Theodore Berndt, M.D. All other remaining members of the Board, being members of the 16 Investigative Committee that issued the complaint in this matter, were excused from participating 17 and took no part in the proceedings of the Board. - 18 The Board received and reviewed the Recommendation of the Investigative Committee to 19 Dismiss the Complaint against the Respondent. The Board, after due consideration, and being fully 20 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

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For Public

BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

* * * * *

In The Matter of Charges and

WILLIAM RAMOS, M.D.

Respondent.

Complaint Against

Case No. 07-5299-1

FILED 10 JANUARY 2008

6 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:

- 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.
- 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.
- 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.
- 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:

- That the Nevada State Board of Medical Examiners fix a time and place for a formal hearing;
- 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;
- That the Board determine what sanctions it deems appropriate to impose for the violation committed by Respondent; and
- 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 10 day of January, 2008

By: Edward O. Cousineau

Attorney for the Investigative Committee of the Nevada State Board of Medical Examiners

VERIFICATION

SS.

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 10⁷¹ day of January, 2008.

Sohail U. Anjum, M.

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

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

AMOUNT OF SETTLEMENT: \$97,500.00

SETTLEMENT DATE:

March 8, 1984

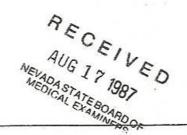
DATE REPORT REC'D BY BOARD

REVIEWED BY BD. SECY

ACTION TAKEN



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:
Claimant:
Occurrence Date:
Closed Date:
Settlement Amt.:

Nilliam Ramos, M.D. Rosy Rose April 19, 1983 August 13, 1987 \$100000.00

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 Vice-President/Claims

CL: jh



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:
Claimant:
Occurrence Date:
Closed Date:
Settlement:

William Ramos, M.D.
Ralph O. and Sally G. Lehn
March 25, 1983
May 23, 1988
\$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 Vice President/Claims

CL:pac

3597		3597	3597	3597	3597	License Number
RAMOS, William Douglas		RAMOS, William Douglas	RAMOS, William Douglas	RAMOS, William Douglas	RAMOS, William Douglas	Licensee Name
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.	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.	with reasonable skill and safety?If you do not use chemical substances, select No. Have you been named as a defendant, or been	If you use chemical substances, does your use in any	medical condition, select No. 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.	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	Question Text
z		z	z	z	Z	Answer
4/7/2011		4/7/2011	4/7/2011	4/7/2011	4/7/2011	Date Answered