Before the Board of Medical Examiners Summer of the State of Nevada 2 * * * * * 3 In the Matter of the 4 5 License to Practice Medicine 6 In the State of Nevada, of: 7 File No. 44450 Roy SILVER M.D. 8 8631 W. 3rd Street 9 Suite 1040E CA 90048-Los Angeles 10 NOTICE OF AUTOMATIC SUSPENSION OF mon LICENSE TO PRACTICE MEDICINE 12 The above named physician, having failed to pay the fee for the biennial registration to the secretarytreasurer of the Board; and having been notified at least once that the fee for biennial registration was 13 due on or before July 1, 2009, is, pursuant to the provisions of NRS 630.267, hereby ORDERED to be AUTOMATICALLY SUSPENDED FROM THE PRACTICE OF MEDICINE in the State of 14 Nevada, effective upon the date of this Order. 15 YOU ARE FURTHER ORDERED TO IMMEDIATELY CEASE THE PRACTICE OF 16 MEDICINE IN THE STATE OF NEVADA 17 Your license may be reinstated to your previous status upon compliance with the provisions of NRS 18 630.267(2), which requires, within two (2) years after the date of this Order, payment of the sum of SIXTEEN HUNDRED DOLLARS (\$1,600.00), if you were in ACTIVE status prior to this order, or 19 EIGHT HUNDRED DOLLARS (\$800), if you were in INACTIVE status prior to this order, these sums representing twice the amount of the current fees for biennial registration, to the secretary-treasurer, 20 submission of a completed renewal application, including the statement required pursuant to NRS 630.197 regarding child support, proof of continuing medical education requirements pursuant to 21 NRS 630.253 and NAC 630.153, and compliance with the provisions of Chapter 630 of the Nevada

A copy of this Notice of Automatic Suspension of License to Practice Medicine shall be sent to the Drug Enforcement Administration of the United States Department of Justice pursuant to the requirements of NRS 630.267. This notice will also be sent to the Nevada State Board of Pharmacy.

Revised Statutes. You may not be reinstated to a status other than the status you held prior to this

DATED this 2rd day of July, 2009.

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order.

CHARLES N. HELD, M.D., President Nevada State Board of Medical Examiners

Date Answered 6/11/2007	6/11/2007	6/11/2007	6/11/2007	6/11/2007
Answer N	2	2	2	Z
Question Text Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? If you answer "Yes" during the time period July	1, 2005 - June 30, 2007 email to elicensensbme@medboard.nv.gov If you have a medical condition which in any way impairs or limits your ability to practice medicine, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? If you answer "Yes" during the time period July 1, 2005 - June 30, 2007 email to	If you use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety? If you answer "Yes" during the	elicensensbme@medboard.nv.gov Have you failed to initiate the performance of public service within one year after the date the public service is required to begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local government for your medical education?	Have you been named as a defendant, or been requested to respond as a defendant, to a legal action involving professional liability (malpractice), or had a professional liability claim paid on your behalf, or paid such a claim yourself?
Licensee Name SILVER, Roy	SILVER, Roy	SILVER, Roy	SILVER, Roy	SILVER, Roy
License Number 11159	11159	11159	11159	4. 4. 50 0.

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Have you been investigated for, arrested for, charged with, convicted of, or plead guilty or nolo contendere to any offense or violation of any federal (including the U.S. Military), state or local law, including any foreign country, which is in a foreign jurisdiction equivalent to, a misdemeanor, gross misdemeanor, court martial, or felony, excluding any minor traffic offense (driving or being in control of a motor vehicle while under the influence of any chemical substance and/or including alcohol, is not considered a minor traffic offense), or for any offense which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? Please note that you MUST disclose ANY investigation or arrest, even if the ultimate disposition was dismissal or expungement. If you answer "Yes" during the time period July 1, 2005 - June 30, 2007 email to elicensensbrue@medboard.nv.gov	Have you been denied a license, permission to practice medicine or any other healing art, or permission to take an examination to practice medicine or any other healing art in any state, country or U.S. territory? If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov.	Have you had a medical license or license to practice any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory? If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov.
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6/11/2007	6/11/2007	6/11/2007	6/11/2007
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Have you voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory by the direct request of a medical board? If "Yes" during the time period July 1, 2005-June 30-2007 e-	mail explanation to email to elicensensbme@medboard.nv.gov. Have you been denied membership or expelled from a medical society or other professional medical organization?	elicensensbme@medboard.nv.gov. 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,	
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Have you had hospital staff privileges denied, suspended, limited, revoked or not renewed by the hospital? If you have answered "Yes" you will be required to submit a list of any and all resignations from any medical staff in lieu of disciplinary or administrative action via email to elicensensbme@medboard.nv.gov (Please Note: Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance.) If "Yes" during the time period July 1, 2005-June 30-2007 e-	elicensensbme@medboard.nv.gov.	Is your license currently contingent upon compliance with the Diversion program also known as the Nevada Health Professionals Assistance Foundation? If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov.	Was your license issued contingent upon maintaining certification by the American Board of Medical Specialties in the specialty of Family Practice, Emergency Medicine or Preventative medicine? If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov.	Are you a foreign medical doctor, who holds a Conditional Resident Alien Card, Employment Authorization Card, or Visa with the Department of Homeland Security, Immigration and Naturalization Services? If "yes" please fax a copy of proof to (775) 688-2551 ATTN:Online License Renewal.
SILVER, Roy		SILVER, Roy	SILVER, Roy	SILVER, Roy
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Are you out of compliance with court ordered child support? If this does not apply to you please answer "no". If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov.	Do you want to change your scope of practice or specialty? If you answer "Yes" during the time period July 1, 2005 - June	30, 2007 email your request to elicensensbme@medboard.nv.gov elicensensbme@medboard.nv.gov Are you currently supervising a Physician Assistant or an Advanced Practitioner of Nursing? If you answer "Yes" please answer of those you are supervising to	elicensensbme@medboard.nv.gov 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	30, 2007. I have actively practiced medicine in Nevada within the past		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.
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7/1/18	Date Received by Board License No. 1/15 9
PHYSICIAN APPLICATION FOR REGISTRATION RENEWAL APPLICATION FOR REGISTRATION REPROD 2005 - 2007	NTK U B CUUJ K X
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NEVADA STATE BUARU VI CINO (1775) 688-2559	(For Board Use Chry)
Post Office Box 7238 Reno, Nevada 89510 Phone (775) 688-2559 Physical Address: 1105 Terminal Way, Suite 301 Reno, Nevada 89502 Physical Address: 1105 Terminal Way Suite 301 Reno, Nevada 89502 Thereby apply for renewal of biennial registration and enclose \$	reprinte fee(s) as indicated below:
Physical Address: 1109 remains 397	the appropriate rector as
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Roy SILVER	(Foreign checks must indicate "U.S. FUNDS")
10525 Courtney Cove	
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Request for NON-RENEWAL U. LIV	211322
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Date Signature (SIGNATURE S	STAMP UNACCEPTABLE)
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1. Active status registration renewal requires the submission redical education (CME), which includes 2 hours of CME specialty completed during the period July 1, 2003 the Statutes (NRS) 630.253(2)(b), an applicant must complete act of terrorism that involves the use of a weapon of mass of that includes instruction in the following subjects: (1) And Personal protective equipment required for acts of terrorism exposure to, or injuries caused by, chemical, biological, reporting procedures for acts of terrorism that involve biol and the use of, the Health Alert Network." Submit your	R PRINT LEGIBLY on of proof of completion of 44 hours of AMA Category 1 continuing in medical ethics and 20 hours of CME in your scope of practice or rough June 30, 2005. Additionally, pursuant to Nevada Revised a course of instruction relating to the medical consequences of an destruction. "The course must provide at least 4 hours of instruction overview of acts of terrorism and weapons of mass destruction; (2 poverview of acts of terrorism and methods of treatment associated with a radioactive and nuclear agents; (4) Syndromic surveillance and logical agents; and (5) An overview of the information available on proof of completion of CME with your completed Application for CME statement.)
 If your name and/or address has changed from that p space provided below. Also, please indicate your current copy of the document authorizing your name change (ma 	printed on the label on this form, clearly indicate in the label or certifie it telephone and fax numbers. [Please note: a notarized or certifie arriage license, divorce decree, etc.) must be included.]
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County CN	NK State State
City (as Vegas County C	ax Number 70a) 438 - 4693
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July 1, 2003, through the present date only.

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

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

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

or medical developments.

The ability to communicate those judgments and medical information to patients and other health care providers, with or without abreast of medical developments;

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, "Medical condition" includes physiological, mental or psychological conditions, cancer, heart disease, diabetes, emotional or vision, speech, hearing, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes

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

FOR ALL "YES" RESPONSES TO THE FOLLOWING QUESTIONS, YOU MUST SUBMIT YOUR

WRITTEN EXPLANATION(S) ON A SEPARATE SHEET ATTACHED TO YOUR COMPLETED APPLICATION FOR REGISTRATION RENEWAL FORM. 1. Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and 2. If you have a medical condition which in any way impairs or limits your ability to practice medicine, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to 3. If you use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable 4. Have you failed to initiate the performance of public service within one year after the date the public service is required to begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local government for your medical education? 5. Have you been a defendant in a legal action involving professional liability (malpractice) or had a professional liability claim paid in your behalf or paid such a claim yourself? 6. Have you ever been investigated for, charged with, convicted of, or plead guilty or nolo contendere to any offense or violation of any federal, state or local law, including any foreign country, which is a misdemeanor, gross misdemeanor, or felony, excluding any minor traffic offense (driving or in control of a motor vehicle while under the influence of any chemical substance is not considered a minor traffic offense) or which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? 7. Have you ever been denied a license, permission to practice medicine or any other healing art, or permission to jake an examination to practice medicine or any other healing art in any state, country or U.S. territory? any state, country or U.S. territory? 9. Have you ever voluntarily surrendered a license to practice medicine or any other healing art in any state, country of U.S. 10. Have you ever been denied membership or expelled from a medical society or other professional medical organization? 11. Have you ever been: a) notified that you were under investigation for; b) investigated for; c) charged with; or d) convicted of any violation of a statute, rule or regulation governing your practice as a physician by any medical licensing board, hospital, medical society, governmental entity or other agency other than the Nevada State Board of Medical Examiners? 12. Have you ever surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? 13. List all hospitals where you have had staff privileges denied, suspended, limited, revoked or not renewed by the hospital. List any and all resignations from any medical staff in lieu of disciplinary or administrative action. (Please Note: Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance.) (If more space is needed, attach a separate sheet) Dates of Action From (Mo./Yr.) To (Mo./Yr.) Mailing Action Address Hospital

CHILD SUPPORT STATEMENT
The same state a check mark next to one of the following statements:
t and a for the sunnort of a CNIO;
(b) I am subject to a court order for the support of one or more children and 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 aim No i in comparing the amount owed 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 AMA were in medical ethics and 20 hours of which were in my scope of practice or specialty, and an additional 4 hours of AMA were in medical ethics and 20 hours of which were in my scope of practice or specialty, and an additional 4 hours of AMA were in medical ethics and 20 hours of which were in my scope of practice or specialty, and an additional 4 hours of AMA were in medical ethics.
(b) I was initially licensed in Nevada during the time period January 1, 2004 through 1 continuing medical education months of the past biennial period, and completed a minimum of 34 hours of AMA Category 1 continuing medical education months of the past biennial period, and completed a minimum of 34 hours of AMA Category 1 continuing medical education 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 medical education in acts of terrorism;
additional 4 hours of AlviA Category (c) I was initially licensed in Nevada during the time period July 1, 2004 through December 31, 2004, the third size the past biennial period, and completed a minimum of 24 hours of AMA Category 1 continuing medical education months of the past biennial period, and completed a minimum of 24 hours of which were in my scope of practice or specialty, and an (CME), 2 hours of which were in medical ethics and 18 hours of which were in my scope of practice or specialty, and an individual education in acts of terrorism;
(d) I was initially licensed in Nevada during the time period January 1, 2005 through static formula (d) I was initially licensed in Nevada during the time period January 1, 2005 through static formula (d) I was initially licensed in Nevada during the time period January 1, 2005 through static formula (e) I was initially licensed in Nevada during the time period January 1, 2005 through static formula (e) I was initially licensed in Nevada during the time period January 1, 2005 through static formula (e) I was initially licensed in Nevada during the time period January 1, 2005 through static formula (e) I was initially licensed in Nevada during the time period January 1, 2005 through static formula (e) I was initially licensed in Nevada during the time period January 1, 2005 through static formula (e) I was initially licensed in Nevada during the time period January 1, 2005 through static formula (e) I was initially licensed in Nevada during the time period January 1, 2005 through static formula (e) I was initially licensed in Nevada during the time period January 1, 2005 through static formula (e) I was initially licensed in Nevada during the time period January 1, 2005 through static formula (e) I was initially licensed in Nevada during the time period January 1, 2005 through static formula (e) I was initially licensed in Nevada during the time period January 1, 2005 through static formula (e) I was initially licensed in Nevada during the time period January 1, 2005 through static formula (e) I was initially licensed in Nevada during the time period January 1, 2005 through static formula (e) I was initially licensed in Nevada during the time period January 1, 2005 through static formula (e) I was initially licensed in Nevada during the time period (e) I was initially licensed in Nevada during the time period (e) I was initially licensed in Nevada during the time period (e) I was initially licensed in Nevada during the time period (e) I was initially licensed in Nevada during the time period (e) I was initially
(e) I am exempt from submitting proof of completion of continuing medical education (OME) 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. JULY 1, 2003 THROUGH JUNE 30, 2005, ATTACH A COPY OF PROOF OF COMPLETION FOR TRAINING.
_ YOUR COPIES OF PROOF OF CINE OR TRAINING OUT. 1 HAVE HAVE NOT (CHECK ONE) ACTIVELY PRACTICED MEDICINE IN NEVADA WITHIN THE PAST 12 MONTHS.
BY SIGNING ON THE SIGNATURE LINE BELOW: 1) I HEREBY REPRESENT THAT I AM THE PERSON NAMED IN THIS APPLICATION FOR REGISTRATION RENEWAL OF LICENSE TO PRACTICE MEDICINE IN THE STATE OF NEVADA AND THAT ALL STATEMENTS I HAVE MAI
HEREIN ARE TRUE; 1 UNDERSTAND THAT THIS APPLICATION FOR REGISTRATION RENEWAL WILL BE DENIED IF I HAVE NOT 2) LUNDERSTAND THAT THIS APPLICATION FOR REGISTRATION RENEWAL WILL BE DENIED IF I HAVE NOT 2) LUNDERSTAND THAT THIS APPLICATION FOR REGISTRATION RENEWAL WILL BE DENIED IF I HAVE NOT 2) LUNDERSTAND THAT THIS APPLICATION FOR REGISTRATION RENEWAL WILL BE DENIED IF I HAVE NOT 3) LUNDERSTAND 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

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).

ands

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

ROY SILVER, M.D. 10525 COURTNEY COVE LAS VEGAS, NV 89144

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License No. File No.

NEVADA STANBOARMAN BEYN

MYOUR COMPSETED APPLICATION FOR INITIAL REGISTRATION MUST BE RETURNED TO THE BOARD OFFICE WITHIN THIRTY (30) DAYS OF RECEIPT.

PLEASE TYPE OR PRINT LEGIBLY PLEASE PROVIDE ALL INFORMATION AS REQUESTED

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.]

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Name Roy SILVER		
Name		
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Indicate below your primar	y 20	s using the following codes:
1 ADDICTION MEDICINE	SCOPES OF PRACTICE CODES 43 NEPHROLOGY 44 NEUROLOGY	85 PEDIATRIC, SURGERY 86 PEDIATRIC, UROLOGY 87 PEDIATRICS

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		344	verusou ocy	85	PEDIATRIC, SURGERY
	ADDICTION MEDICINE	43	NEPHROLOGY	86	PEDIATRIC, UROLOGY
4	ADDIESCENT MEDICINE	44	NEUROLOGY	87	PEDIATRICS
2	ADOLESCENT MEDICINE	45	NEURO-OPHTHALMOLOGY	88	PHYSICAL MEDICINE/REHABILIT
3	AEROSPACE MEDICINE	46	NEUROPATHOLOGY	89	PREVENTIVE MEDICINE
4	ALLERGY	47	NEURORADIOLOGY	90	PSYCHIATRY
5	ALLERGY/IMMUNOLOGY	48	NEUROTOLOGY	91	PSYCHOANALYSIS
6	AMBULATORY MEDICINE	40	MUN-CONVENTIONAL MEDIA	92	PSYCHOMATIC MEDICINE
7	ANESTHESIOLOGY	50	NUCLEAR MEDICINE	93	PLIALIC HEALTH
8	ai aanaakikiNG	51	NUTRITION	94	DI II MONARY DISEASES
9	ANAMAN CSOPHAGULUUT			9 5	OCCUPATIONAL MEDICINE
10	CADDIOVASCULAR DISEASES	276	ABSTETRICS/GYNECULUGI		RADIOLOGY
11	CATSCAN/ULTRASOUND	CA.	OCCUPATIONAL MEDICINE	96	RADIOLOGY, DIAGNOSTIC
12		U** EE	ANCALOGY	97	RADIOLOGY, INTERVENTIONAL
12	. AURO DOVCHIATRY	56	ANCOLOGY GYNEUULUGIUM	98	RADIOLOGY, NUCLEAR
			ONCOLOGY, HEMATOLOGY	99	RADIOLOGY, THERAPEUTIC
14	CRITICAL CARE	57	ONCOLOGY, RADIATION	100	HADIOLOGI, INCIONA CONTRA
		58		101	RADIOLOGY, VASCULAR
		59		102	RHEUMATOLOGY
1		60	OLH LUVENOCA OCA	103	RHINOLOGY
1	FINEWOCIAN UCA	61	OTOLARYNGOLOGY	104	SLEEP DISORDERS
1	ENDOCRINOLOGY	62	OTOLOGY	105	SPORTS MEDICINE
	FAMILY PRACTICE	63	PAIN MANAGEMENT	106	SURGERY, ABDOMINAL
2	1 FORENSIC MEDICINE	64	PATHOLOGY	107	SURGERY, CARDIOTHORACIC
2	2 GASTROENTEROLOGY	6 5	PATHOLOGY, ANATOMIC	400	CHROSERY CARDIOVASCULAR
2	3 GENERAL PRACTICE	മർ	DATHOLOGY, CLINICAL	400	CHROPERY COLONINELIAL
2	4 GERIATRIC PSYCHIATRY	67	PATHOLOGY, FORENSIC	440	SURGERY, CRANIUPACIAL
4	5 GERIATRICS	68	PEDIATRIC, ALLERGY	411	SURGERY, GENERAL
ě	6 GYNECOLOGY	69	PEDIATRIC, ANESTHESIOLOGY	440	I SHRGERY, HAND
6	HAIR TRANSPLANTATION	****	DENIATRIC CARDIOLOGI	445	I SURGERY HEAD/NEUX
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<u>Code</u>

Code

125 URGENT CARE

126 UROLOGY

PEDIATRIC, RHEUMATOLOGY

PEDIATRIC, PULMONARY

PEDIATRIC, RADIOLOGY

NEO/PERINATAL MEDICINE

NEOPLASTIC DISEASES

MEDICAL ETHICS

MEDICAL GENETICS

39

40

For the purposes of the f owing questions, these phrtos 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

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

3. The physical capability to perform medical tasks such as physician examination and surgical procedures, with or without the use the use of aids or devices, such as voice amplifiers; and 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 OUR COMPLETED APPLICATION FOR INITIAL REGISTRATION FORM.

TO YOUR COMPLETED AP	PLICATION FOR INITIAL REGISTION With reasonable skill and
and condition which in a	ny way impairs or limits your ability to practice medicine with reasonable skill and YesNo
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ilmitation reduced of attractive	ny way impairs or limits your ability to practice medicine, is that impairment or the field of practice, the setting, or the manner in which you have chosen to
practice?	in any way impair or limit your ability to practice medicine with reasonable
3. If you use chemical substances, does you	r use in any way impair or limit your ability to practice medicine with reasonable Yes Vo No N/A
ekill and safety?	to be a second of the second o
havin to satisfy a requirement of the	of public service within one year after the date the public service is required to siving a loan or scholarship from the federal government or a state or local Yes No N/A
government for your medical education?	the appropriate and a professional liability (malpractice) or had a professional liability claim
Have you been a defendant in a legal action paid in your behalf or paid such a claim your	on involving professional liability (malpractice) or had a professional liability claim
 Have you ever been investigated for, cheviolation of any federal (including the U.S. Magross misdemeanor, court martial or felony, under the influence of any chemical substantial. 	narged with, convicted of, or plead guity of mode and the same and a misdemeanor, alitary), state or local law, including any foreign country, which is a misdemeanor, alitary), state or local law, including any foreign country, which is a misdemeanor, excluding any minor traffic offense or which is related to the manufacture, compared to the manufacture, and the substances?
7 Have you ever been denied a license, pe	ermission to practice medicine or any other recting any YesNo
a House you ever had a medical license or li	cense to practice any other healing art revoked, suspended, limited, or restricted inYesNo
any state, country or U.S. territory?	the a basiling art in any state, country or U.S.
 Have you ever voluntarily surrendered a 	license to practice medicine or any other healing art in any state, country or U.S.
territory?	ip or expelled from a medical society or other professional medical organization?
11. Have you ever been: a) notified that you any violation of a statute, rule or regulation	were under investigation for; b) investigated for; c) charged with; or d) convicted of a governing your practice as a physician by any medical licensing board, hospital, ner agency other than the Neyada State Board of Medical Examiners? Yes
a three you over surrendered your state	or federal controllar substander registration or had it revoked or restricted in any
way?	NEVADA STATE ECAT

rist aut au reaa.	e for failure to complete	vileges denied, suspended, limit if in lieu of disciplinary or adminis hospital medical records, atten		hates of Action
suspensions of restitution maintain required malprai Hospital	ctice insurance). Mailing Address	Type of Action	From (Mo./Yr.) To (Mo./Yr.)
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Please place a check	mark next to one of th	ne following statements:		
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(c) I am subja plan approved by the pursuant to the order.	ect to a court order for the district attorney or other the di	ne support of one or more childre her public agency enforcing the	en and am NOT in con corder for the repayn	nent of the amount owed
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9/10/94 Date/ 19/94	- Signature	(SIGNATURE STAMP UNACC	EPTABLE)	RECEIVED
				SZP 132004

NEVADA STATE BOARD OF MEDICAL EXAMINERS





PHYSICIAN

Date Received by Bodral TV E. D.

License No._____

APPLICATION FOR LICENSURE	AUG 1 7 2004
NEVADA STATE BOARD OF	File No. (For Board USECO DE TATE BOARD OF
MEDICAL EXAMINERS	(For Board User Day Art E DOWN DO
Ost Office Box 7238 Reno, Nevada 89510 Phone (775) 688-2559	28/3 Sign 6-8 1 State Com SST
1. Present Legal Name <u>S/4VER</u> <u>Roy</u> Last First	
List any other name(s) ever used	01 1 36111
2. Business and/or Mailing Address 10525 Courthly Col	Clark NV 89144 City County State Zip
3. Home Address 10525 Courtney Con Las	SVEGAS County (State Zip
4. Telephone Number (202) 671-230e ()	Fax Number (702) 671-2333
5. Date of Birth 07- 73 Place	
and back of your allers a factors, atc) must be included.	Employment Authorization # te of Naturalization or current U.S. passport or copy of the front attion or Visa. Please note: Copy of document authorizing a name change
For the purposes of the following questions,	these phrases or words have these meanings:
developments; 2. The ability to communicate those judgments and medical inform devices, such as voice amplifiers; and devices, such as voice amplifiers and devices, such as voice amplifiers and devices.	e following: nd exercise reasoned medical judgments and to learn and keep abreast of medical nd exercise reasoned medical judgments and to learn and keep abreast of medical nation to patients and other health care providers, with or without the use of aids or sician examination and surgical procedures, with or without the use of aids or
"Medical condition" includes physiological, mental or psychological chearing, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cand	conditions or disorders, such as, but not limited to, orthopedic, vision, speech per, heart disease, diabetes, emotional or mental illness, HIV disease, tuberculosis
"Chemical substances" is to be construed to include alcohol, drugs of	r medications, including those taken pursuant to a valid prescription for legitimate
YOUR WRITTEN EXPLANATION(3) C	LLOWING QUESTIONS, YOU MUST SUBMIT ON A SEPARATE SHEET ATTACHED TO ATION FOR LICENSURE FORM.
8 Do you have a medical condition which in any way impairs or limits your	ability to practice medicine with reasonable skill and safety? Yes Yes Yes
because of the field of practice, are sources	bility to practice medicine, is that impairment or limitation reduced or ameliorate ve chosen to practice? Yes No No
10. If you use chemical substances, does your use in any way impair	ir or limit your ability to practice medicine with reasonable skill and safety
11. Have you failed to initiate the performance of public service within one y your receiving a loan or scholarship from the federal government or a state	to satisfy a required to begin to satisfy a required to

Have you been a defendant in a	tanal act involving professiona	ni liability (maipractice	or had a see Application Chec	dalm paid in your behalf or paid klist.) Yes No
this daim yoursaire to constitute			ntendere to any offense or vio	lation of any teneral increases traffic
litary), state or local law, income lense (driving or in control of a mote lense (driving or in control of a manu	or vehicle while under the influence facture, distribution, prescribing, (or glabenaing of coup e or any crientings and	olled substances?	or traffic offense) or for any offense YesNo YesNo
				Portage Parties
I. Have you previously applied to	And onbode altended, HAVE	EACH MEDICAL SCH	OOL SUBMIT AN OFFICIAL	TRANSCRIPT <u>DIRECTLY</u> TO THE
i, List names and addresses of all f OARD.	Hedical schools amount		Place Where	Dates of Attendance
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(All infor	nation must begin on the applica	gori, a more operation		NEVADA STATE BOARD OF MEDICAL EXAMINERS
16. Doctor of Medicine Degree gr	73131			Exact Date of Issuance
Medical School Name 57. George's Viz	iversity Ge	uda/uz		06/16/2000
17. List all ACGME* approved gr	LELECT / Laducation you ha	ve received as an inte	om or resident in the United S	tates or Canada.
 List all ACGME* approved gr *Accreditation Council for Grant 	Hilliam Innounce		Type of	Cates of Attendance
Posidianness	sprav ihution	City/State	Specialty	From (Mo./Yr.) To (Mo./Yr.)
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2-4 Univ. 11	intown Hosp. A led Center Ca	15 Yegas /NV	Us/ by.r	1/2/10/31/04
	ormation must begin on the applic			rate sheet.)
(All info	amanon inust begin on a serviced S	tates or Canada.		
18. List all Fellowship training pa Institution	ograms attended in the United S City/State		Type of Fellowship	Dates of Attendance From (Mo./Yr.) To (Mo./Yr.)
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was matricular	ns limitations, or probations ever	been imposed on yo	a while participating in any type	Yes / No
		Lind States of Amer	ica or Canada, list your ECFN	1G#: 0-514-503-2
21. For each of the following its	HAVE CERTIFICATE OF SCOR	LES SUBMITTED FR	OW THE JESTIMO ENTITY A	also include any failed examinations). RECTLY TO THE BOARD OFFICE.
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77 Have will ever been denied a license	, permission to practice med	dicine or any outer /if "Yes." attac	h explanation on separa	te sheet .)	Y95£	edicir ^
27. Have you ever been denied a license or any other healing art in any state, cou28. Have you ever had a medical licens territory? This does not include lapsed	a or license to practice any	other healing art ro (If "Yes," altac	evoked, suspended, limit th explanation on separa	ed, or restricted te sheet.)	in any state, country Yes	or U.
territory? This does not include appose	red a license to practice me					
29. Have you ever voluntarily surrence.This does not include lapsed or non-ren30. Have you ever been denied member	ewed licenses.	if "Yes," altai) In no vietv or ott	zn explanialich un separe ner professional medical	organization?	was a second sec	
					ny violation of a statut	e, rule
31. Have you ever been: a) notified that regulation governing your practice as a Nevada State Board of Medical Examin			od for; c) changed with, ovi ital, medical society, gov ch explanation on sepan		or other agency <u>other</u>	
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	controlled	stricter stricter (if "Yes," attach explanation on separate st	d in any way? YesNo
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33. List all hospi any medical staff	tals where you have had start privileges fin lieu of disciplinary or administrative action. hospital department or staff meetings, or maint Mailing	l, suspended, limited, revoked or not renewed by the t (<u>Please Note</u> : Do not include suspensions or restrictic tain required malpractice insurance). Type of	I DIES DI PONT
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aut n SID	DORT STATEMENT		a manister that
The law of the support of a challenger fraudule	state of Nevada requires that all applicants for hild. You are advised that this questions is par nt, misleading, inaccurate or incomplete, may i one of the responses may result in denial of y	r issuance of a license be required to provide the foll t of your application, your response is given under or result in your application being denied. You must m your application.	lowing information concerning the ath, and any response hereto which is ark one of the following responses, and
Diassa nia	ce a check mark next to one of the	following statements:	
			to popularion with a plan
/ ba 3	am subject to a court order for the support	of one or more children and am in compliance	the order or am in compliance many and pursuant to the order; OR
approved by t	he district attorney or other public agont, see	with sometimes with	the order or a plan approved by the district
attorney or of	her public againty amoromy and a		
			heing duly sworn, depose and say.
CONTRACTOR CONTRACTOR	wers to the foregoing questions and statemer iched pages are true and correct, that I am the truction and examination without fraud or mismaccurate, or incomplete, my application for lice	nts made in the above application as well as any an person named in the credentials to be submitted, and representation. I understand that if any of my respon- censure will be denied.	id all further explanations contained on any distributed that the same were procured in the regular ses on this application are false, fraudulent,
			3/22/08
			3/20/01 (data)
	-upgaphodelelelel	(signature of applicant)	
		State of <u>NV</u> Cour	nty of Clark
	and the second section and the second second second section and the second seco	THE SECOND SECON	
	(NOTARY SEAL)	Subscribed and swom to b	2 4
		8y: CAROC	J. A. T. J.
	Many Was Store of Navada	Notary Public for the State	of VENAUF
	W 422 No. 3, 2006	My Commission Expires:	AJUH
		Residing at: 42	LIGOLALL
			and the same of th
		Signature of Notary:	Cust A New

APPLICANT PHOTOGRAPH:

ATTACH A FINISHED PHOTOGRAPH OF PASSPORT QUALITY OF YOUR HEAD AND SHOULDERS ONLY.

PHOTOGRAPH MUST HAVE BEEN TAKEN WITHIN THE LAST SIXTY (60) DAYS AND BE AT LEAST 2" x 2" IN SIZE.

SIGN THE PHOTOGRAPH IN INK ACROSS THE LOWER PORTION OF ITS FRONT SIDE.

PROOF PHOTOS, NEGATIVES AND DIGITAL PHOTOS ARE NOT ACCEPTABLE



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

(signature of applicant)

Roy Silven Milly

RESIDENT	Date Receiver Sterred V E Picense No.
THE REPORT OF THE PROPERTY OF	
	APR 2 0 2004 File No
NEVADA STATE BOARD OF MEDICAL CAMBINATION	(La Brang Areauth Board Ol
NEVADA STATE BOARD OF INC. DOOR (775) 688-2559 St Office Box 7238 Reno, Nevada 89510 Phone (775) 688-2559	MEDICAL EXAMINERS MEDICAL EXAMINERS MEDICAL EXAMINERS MEDICAL EXAMINERS
YOUR LICENSE WILL NOT BE RENEWED THIS APPLICATION FOR REGISTRATION YOU MUST PROVIDE WRITTEN EXPLANA	UNLESS YOU ANSWER ALL QUESTIONS ON RENEWAL FORM. ATIONS FOR ALL QUESTIONS ANSWERED "YES."
expires: 06/30/2004	
Roy SILVER 10525 Courtney Cove NV 89144-	M.D.
Las Vegas	
PLEASE TYPE	OR PRINT LEGIBLY
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rovided below. Also, production and change (marriage he document authorizing your name change (marriage	ted on the label on this form, clearly indicate the change in the space hone and fax numbers. [Please note: a notarized or certified copy of license, divorce decree, etc.) must be included.]
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THIS PORTION OF THE APPLICATION FOR REGISTRATION RENEWAL IS TO BE COMPLETED BY THE RESIDENT

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

abreast of medical developments;

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 scierosis, 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

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9. Have you ever voluntarily surrende	ered a license to practice medicine or any other healing art in any state, country or U.S. YesNo
10. Have you ever been denied mem	bership or expelled from a medical society or other professional medical organization?
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Signature (SIGNATURE STAMP UNACCEPTABLE)

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APPLICATION FOR REGISTRATION RENEWAL

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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."

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ROY SILVER 10525 Courtney Cove Las Vegas NV 89144

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MAY 3.0 2003

NEVADA STATE BOARD OF HEDICAL EXAMINERS

PLEASE TYPE OR PRINT LEGIBLY PLEASE PROVIDE ALL INFORMATION AS REQUESTED

If your name and/or address has changed from that printed or provided below. Also, please indicate your current telephone the document authorizing your name change (marriage lice)	on the label on this form, clearly a and fax numbers. (Please non the divorce decree, etc.) must	rindicate the change in te: a notarized or certife t be included.]	the space lied copy of
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THIS PORTION OF THE APPLICATION FOR REGISTRATION RENEWAL IS TO BE COMPLETED BY THE DIRECTOR OF MEDICAL EDUCATION FOR THE RESIDENCY PROGRAM 1/2010

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(IF ANSWERING "YES," PLEASE ATTACH EXPLANATION ON A SEPARATE SHEET.)

I hereby certify that the information I have provided hereto for the above-named resident is accurate. I, as Director of Medical Education for the Maridanay Program, recommend this resident to continue in the above-named residency program.

Signature of Director of Medical Education to the Above-Named Residency Program (SIGNATURE STAMP UNACCEPTABLE)

THIS PURTION OF THE MELLIOMINIA FOR REGISTRATION RESERVAL IS TO BE COMPLETED BY THE RESIDENT

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

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

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

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6. Have you ever been investigated for, charged with, convicted of, or plead guilty or note of violation of any federal, state or local law, including any foreign country, which is a misdement felony, excluding any minor traffic offense (driving or in control of a motor vehicle while under substance is not considered a minor traffic offense) or which is related to the manufacture of	
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9. Have you ever voluntarily surrendered a license to practice medicine or any other healing a	rt in any state, country or U.S. YesNo
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territory? 10. Have you ever been denied membership or expelled from a medical society or other profe	YesNo

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*	any violation of a statute, rule or regulation governing your practice as a physician by any medical licensing board, hospital, medical society, governmental entity other agency other than the Nevada State pard of Medical Examiners? YesNo
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	BY SIGNING ON THE SIGNATURE LINE BELOW: 1) I HEREBY REPRESENT THAT I AM THE PERSON NAMED IN THIS APPLICATION FOR REGISTRATION RENEWAL OF LIMITED LICENSE TO PRACTICE MEDICINE AS A RESIDENT IN THE STATE OF NEVADA AND THAT ALL STATEMENTS I HAVE MADE HEREIN ARE TRUE; 1 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 PLACED A CHECK MARK NEXT TO (a), (b), OR REGISTRATION RENEWAL WILL BE DENIED IF I HAVE NOT 1 UNDERSTAND THAT THIS APPLICATION FOR REGISTRATION RENEWAL WILL BE DENIED IF I HAVE NOT ANSWERED ALL QUESTIONS THEREON AND/OR ATTACHED THERETO WRITTEN EXPLANATION(S) TO ANY "YES" ANSWER(S).
	Signature (SIGNATURE STAMP UNACCEPTABLE)

Date

RESIDEN

Date

APPLICATION FOR REGISTATION RENEWAL FOR A LIMITED LICENSE

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YOU MUST PROVIDE WRITTEN EXPLANATIONS FOR ALL QUESTIONS ANSWERED "YES."

PLEASE TYPE OR PRINT LEGIBLY PLEASE PROVIDE ALL INFORMATION AS REQUESTED

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.]

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Signature of Director of Medical Education of the Above Named Residency Program

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THIS PORTION OF THE APPLICATION FOR REGISTRATION RENEWAL IS TO BE COMPLETED BY THE RESIDENT

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17. List all ACGME* approved g United States or Canada. *Accreditation Council for Gra Hospital/ Institution NYU Downtown Hosp.	raduate medical eduate Medical Edi Mailing Type of S	ducation you have ucation Service or Specialty	Dates of Attenda	ince (r.) To (Mo./Yr.)
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explanations contained on any support and that the	being duly sworn, depose and say: That the answers to ade in the above application as well as any and all further ched pages are true and correct, that I am the person named in a same were procured in the regular course of instruction and ion. I understand that if any of my responses on this application, or incomplete, my application for licensure will be denied.		
	Signature of Applicant		
(Notary Seal)	Subscribed and sworn to before me thisday of		
EDWINA A. JOHNSON Clotary Public, State of New York No. 91.J05029156 Ocalified in Clucens County Commission Expires June 13, 200.	Notary Public for State of		
Attach a finished photograph of passport quality of your head and shoulders only. Photo must have been taken within the last 60 days and be at least 2" x 2" in size. Sign the photo in ink across the lower portion of its front side.			
Proof photos and negatives are not acceptable	I hereby certify that the attached photograph is a true likeness of myself taken within the last 60 days. Signature of Applicant		