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Before the Board of Medical Examiners
of the State of Nevada

* * * * *

In the Matter of the

License to Practice Medicine

In the State of Nevada, of:

File No.: License No.: 11150
Roy SILVER M.D.
8631 W. 3rd Street
Suite 1040E
Los Angeles CA 90048-

NOTICE OF AUTOMATIC SUSPENSION OF LICENSE TO PRACTICE MEDICINE

The above named physician, having failed to pay the fee for the biennial registration to the secretary-treasurer of the Board; and having been notified at least once that the fee for biennial registration was 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 Nevada, effective upon the date of this Order.

YOU ARE FURTHER ORDERED TO IMMEDIATELY CEASE THE PRACTICE OF MEDICINE IN THE STATE OF NEVADA

Your license may be reinstated to your previous status upon compliance with the provisions of NRS 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 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, 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 NRS 630.253 and NAC 630.153, and compliance with the provisions of Chapter 630 of the Nevada Revised Statutes. You may not be reinstated to a status other than the status you held prior to this order.

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.

DATED this 2nd day of July, 2009.

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

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

11159	SILVER, Roy	Have you been investigated for, arrested for, charged with, convicted of, or plead guilty or nolo contendere to any offense or violation of any federal (including the U.S. Military), state or local law, including any foreign country, which is in a foreign jurisdiction equivalent to, a misdemeanor, gross misdemeanor, court martial, or felony, excluding any minor traffic offense (driving or being in control of a motor vehicle while under the influence of any chemical substance and/or including alcohol, is not considered a minor traffic offense), or for any offense which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? Please note that you MUST disclose ANY investigation or arrest, even if the ultimate disposition was dismissal or expungement. If you answer "Yes" during the time period July 1, 2005 - June 30, 2007 email to elicensensbme@medboard.nv.gov	N	6/11/2007
11159	SILVER, Roy	Have you been denied a license, permission to practice medicine or any other healing art, or permission to take an examination to practice medicine or any other healing art in any state, country or U.S. territory? If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov.	N	6/11/2007
11159	SILVER, Roy	Have you had a medical license or license to practice any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory? If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov.	N	6/11/2007

11159	SILVER, Roy	Have you voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory by the direct request of a medical board? If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov.	N	6/11/2007
11159	SILVER, Roy	Have you been denied membership or expelled from a medical society or other professional medical organization? If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov.	N	6/11/2007
11159	SILVER, Roy	Have you been: a) notified that you were under investigation for; b) investigated for; c) charged with; or d) convicted of any violation of a statute, rule or regulation governing your practice as a physician by any medical licensing board, hospital, medical society, governmental entity or agency other than the Nevada State Board of Medical Examiners? If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov.	N	6/11/2007
11159	SILVER, Roy	Have you surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov.	N	6/11/2007

11159	SILVER, Roy	Have you had hospital staff privileges denied, suspended, limited, revoked or not renewed by the hospital? If you have answered "Yes" you will be required to submit a list of any and all resignations from any medical staff in lieu of disciplinary or administrative action via email to elicensensbme@medboard.nv.gov (Please Note: Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance.) If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov.	N	6/11/2007
11159	SILVER, Roy	Is your license currently contingent upon compliance with the Diversion program also known as the Nevada Health Professionals Assistance Foundation? If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov.	N	6/11/2007
11159	SILVER, Roy	Was your license issued contingent upon maintaining certification by the American Board of Medical Specialties in the specialty of Family Practice, Emergency Medicine or Preventative medicine? If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov.	N	6/11/2007
11159	SILVER, Roy	Are you a foreign medical doctor, who holds a Conditional Resident Alien Card, Employment Authorization Card, or Visa with the Department of Homeland Security, Immigration and Naturalization Services? If "yes" please fax a copy of proof to (775) 688-2551 ATTN:Online License Renewal.	N	6/11/2007

11159	SILVER, Roy	Are you out of compliance with court ordered child support? If this does not apply to you please answer "no". If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov.	N	6/11/2007
11159	SILVER, Roy	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	N	6/11/2007
11159	SILVER, Roy	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	N	6/11/2007
11159	SILVER, Roy	I have completed the required amount of AMA Category 1 CME within the current biennial. (Review CME information online at www.medboard.nv.gov) I understand that I may be included in a random audit following July 1st 2007 renewal. I agree to retain CME's taken between July 1, 2005 and June 30, 2007.	Y	6/11/2007
11159	SILVER, Roy	I have actively practiced medicine in Nevada within the past 24 months.	Y	6/11/2007
11159	SILVER, Roy	I hereby request my license to be placed on Inactive status. I will not physically practice in the state of Nevada.	N	6/11/2007
11159	SILVER, Roy	I HEREBY SWEAR OR AFFIRM UNDER THE PENALTIES OF PERJURY THAT I AM IN FULL COMPLIANCE WITH ANY AND ALL OBLIGATIONS, TERMS OR CONDITIONS OF MY NEVADA MEDICAL LICENSE SPECIFIED BY THE BOARD.	Y	6/11/2007

PHYSICIAN
APPLICATION FOR REGISTRATION RENEWAL
FOR THE BIENNIAL REGISTRATION PERIOD 2005 - 2007
NEVADA STATE BOARD OF MEDICAL EXAMINERS

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

Date Received by Board
APR 0 8 2005
APR 2 8 2005
(For Board Use Only)

License No. 11159

File No. 2/17/04

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

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

File No. **License No. 11159**

Roy SILVER M.D.
10525 Courtney Cove
Las Vegas NV 89144-

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

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

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

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

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

PLEASE NOTE:

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

PLEASE TYPE OR PRINT LEGIBLY

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

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

Name Roy Silver M.D.
Street 517 Rose St.
City Las Vegas County Clark State NV Zip 89106
Phone Number 702) 438-4692 Fax Number 702) 438-4693

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

Name ______________________________

Street ______________________________ Zip __________

City __________ County __________ State __________

Phone Number __________

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

SCOPES OF PRACTICE CODES

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

Primary Scope of Practice <u>Code</u> 53

Secondary Scope of Practice <u>Code</u> __________

PLEASE INDICATE AMERICAN BOARD OF MEDICAL SPECIALTIES BOARD CERTIFICATION & RECERTIFICATION

	Date of Initial Certification	Date of Last Recertification
Board __________	(Mo./Yr.)	(Mo./Yr.)
Subboard __________	(Mo./Yr.)	(Mo./Yr.)

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

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

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

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments;
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without

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

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

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

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

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

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

3. If you use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety? ______Yes __X__No __6__N/A

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

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

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

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

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

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

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

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

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

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

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

CHILD SUPPORT STATEMENT

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

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

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

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

CONTINUING MEDICAL EDUCATION (CME) STATEMENT

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

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

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

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

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

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

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

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

BY SIGNING ON THE SIGNATURE LINE BELOW:

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

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

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

2/2/05

____
(... STAMP UNACCEPTABLE)

RECEIVED
Date Received by Board
SEP 1 3 2004
NEVADA STATE BOARD OF MEDICAL EXAMINERS
(For Board Use Only)

License No. ____________
File No. ____________

PHYSICIAN APPLICATION FOR INITIAL REGISTRATION

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

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

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

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.]

Name Roy Silver
Street ____________ State ____________ Zip ____________
City ____________ County Clark
Phone Number 702-838-2728 Fax Number 702-671-2300

Indicate below your primary and secondary practice specialties using the following codes:

SCOPES OF PRACTICE CODES

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

Primary Scope of Practice **Code** 53

Secondary Scope of Practice **Code** ____________

For the purposes of the f( )owing questions, these phr( )es or words have these meanings:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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.

BY SIGNING ON THE SIGNATURE LINE BELOW:

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

2) **I UNDERSTAND THAT THIS *APPLICATION FOR INITIAL REGISTRATION* 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 WRITTEN EXPLANATION(S) TO ANY "YES" ANSWER(S).**

9/10/04
Date

Signature (SIGNATURE STAMP UNACCEPTABLE)

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PHYSICIAN
APPLICATION FOR LICENSURE
NEVADA STATE BOARD OF
MEDICAL EXAMINERS

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

Date Received by Board RECEIVED AUG 17 2004 NEVADA STATE BOARD OF MEDICAL EXAMINERS

License No. ________

File No. ________

(For Board Use Only)

1. Present Legal Name SILVER (Last) Roy (First) ________ (Middle) ________ (Maiden)

List any other name(s) ever used ________

2. Business and/or Mailing Address 10525 Courtney Cove (Street) LV (City) Clark (County) NV (State) 89144 (Zip)

3. Home Address 10525 Courtney Cove (Street) Las Vegas (City) Clark County (County) NV (State) 89144 (Zip)

4. Telephone Number (702) 671-2300 (Office) ( ) ________ (Home) Fax Number (702) 671-2333

5. Date of Birth 07- 73 Place of Birth ISRAEL

6. Citizenship: U.S. Citizen ✓ Alien Registration # ________ Employment Authorization # ________
Submit a certified copy of birth certificate or original Certificate of Naturalization or current U.S. passport or copy of the front and back of your alien registration card, Employment Authorization or Visa. __Please note__: Copy of document authorizing a name change (marriage license, divorce decree, etc) must be included.

7. Social Security Number ________ Height 5'7" Weight 165 Color of Eyes Blue Color of Hair Brown

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

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

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

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

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

FOR ALL "YES" RESPONSES TO THE FOLLOWING QUESTIONS, YOU MUST SUBMIT YOUR WRITTEN EXPLANATION(S) ON A SEPARATE SHEET ATTACHED TO YOUR COMPLETED *APPLICATION FOR 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 ✓ No

9. If you have a medical condition which in any way impairs or limits your ability to practice medicine, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? ____Yes ✓ No ____N/A

10. If you use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety? ____Yes ✓ No ____N/A

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

12. 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? (IF ANSWER IS "YES", YOU MUST COMPLETE FORM B AND FORM 6 – see Application Checklist.) ____ Yes ✓ No

13. Have you ever been investigated for, charged with, convicted of, or plead guilty or nolo contendere to any offense or violation of any federal (including U.S. Military), state or local law, including any foreign country, which is a misdemeanor, gross misdemeanor, court-martial, 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 for any offense **which is related to the** to the manufacture, distribution, prescribing, or dispensing of controlled substances? ____ Yes ✓ No

14. Have you previously applied for medical licensure in Nevada (including a residency program)? ____ Yes ✓ No

15. List names and addresses of all medical schools attended. **HAVE EACH MEDICAL SCHOOL SUBMIT AN OFFICIAL TRANSCRIPT DIRECTLY TO THE BOARD.**

Name	City/State	Place Where Instruction Received	Dates of Attendance From (Mo./Yr.) To (Mo./Yr.)
St. George's University	Grenada/W.I.	Grenada, W.I.	8/96 to 6/00

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(All information must begin on the application, if more space is needed, please attach separate sheet.)

16. Doctor of Medicine Degree granted by:

Medical School Name	City/State	Exact Date of Issuance
St. George's University	Grenada/W.I.	06/16/2000

17. List all ACGME* approved graduate medical education you have received as an intern or resident in the United States or Canada.
*Accreditation Council for Graduate Medical Education

Postgraduate Year	Hospital/ Institution	City/State	Type of Specialty	Dates of Attendance From (Mo./Yr.) To (Mo./Yr.)
1	NYU Downtown Hosp.	NY/NY	OB/Gyn	11/00 to 7/01
2-4	Univ. Med Center	Las Vegas/NV	OB/Gyn	7/01 to ~~current~~ 10/31/04

(All information must begin on the application, if more space is needed, please attach separate sheet.)

18. List all Fellowship training programs attended in the United States or Canada.

Institution	City/State	Type of Fellowship	Dates of Attendance From (Mo./Yr.) To (Mo./Yr.)

(All information must begin on the application, if more space is needed, please attach separate sheet.)

19. Have any actions, restrictions, limitations, or probations ever been imposed on you while participating in any type of training program? (If "Yes," attach explanation on separate sheet.) ____ Yes ✓ No

20. If you graduated from a medical school located outside the United States of America or Canada, list your ECFMG#: 0-594-585-2

21. For each of the following licensing examinations, list the location, parts and dates taken, and scores obtained, (also include any failed examinations). **HAVE CERTIFICATE OF SCORES SUBMITTED FROM THE TESTING ENTITY DIRECTLY TO THE BOARD OFFICE. FOR EACH EXAM TAKEN, HAVE CERTIFICATE OF SCORES SUBMITTED FROM THE TESTING ENTITY DIRECTLY TO THE BOARD OFFICE.**

a. NATIONAL BOARDS: (ALSO INCLUDE ALL INFORMATION PERTAINING TO ANY AND ALL FAILED EXAMINATIONS.)

Location	Part Taken	Date (Mo/Yr)	Results (Scores)

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R. Silva M.D.

b. FLEX (Federation Licensing Examination): (ALSO INCLUDE ALL INFORMATION PERTAINING TO ANY AND ALL FAILED EXAMINATIONS.)

Location	Part Taken	Date (Mo/Yr)	Results (Scores)

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c. USMLE (United States Medical Licensing Examination): (ALSO INCLUDE ALL INFORMATION PERTAINING TO ANY AND ALL FAILED EXAMINATIONS.)

Location	Part Taken	Date (Mo/Yr)	Results (Scores)
Florida	I	6/98	161
California	I	10/98	176
London	I	7/99	178
Palm Desert, CA	I	11/99	186
Brooklyn Heights, NY	II	5/00	164
Culver City, CA	II	8/00	197
Las Vegas, NV	III	1/04	17[illegible] (170)
Las Vegas, NV	III	6/04	186

d. LMCC (Licentiate of the Medical Council of Canada): (ALSO INCLUDE ALL INFORMATION PERTAINING TO ANY AND ALL FAILED EXAMINATIONS.)

Location	Part Taken	Date (Mo/Yr)	Results (Scores)

e. State Written Examination:

Location	Part Taken	Date (Mo/Yr)	Results (Scores)

f. SPEX (Special Purpose Examination):

Location	Part Taken	Date (Mo/Yr)	Results (Scores)

22. State your scope of practice specialty(ies): Obstetrics & Gynecology

23. List any and all certifications and re-certifications by a board or sub-board recognized by the **AMERICAN BOARD OF MEDICAL SPECIALTIES.**

Specialty Board	Certification #	Dates of Certification/Recertification (Mo/Yr)

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Roy Silver, M.D.

24. Account for, in chronological order, all activities since graduation from medical school. **ALL PERIODS OF TIME MUST BE ACCOUNTED FOR.**

Activities	Location (City/State/Country)	From (Mo./Yr.)	To (Mo./Yr.)
OB/Gyn Rotation @ Jackson Memorial Hosp.	Miami/FL/USA	07/00	10/00
Internship OBGyn NYU Downtown Hospital		11/00	06/31/01
Residency OBGyn UMC Hospital		07/1/01	10/31/04

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(All information must begin on the application, if more space is needed, please attach separate sheet.)

25. List below the requested information for all hospitals in which you **ARE, OR HAVE EVER BEEN** a staff member at any level during the last ten years. If none, please indicate. Do not list internship, residency or fellowship affiliation.

Hospital	Complete Mailing Address	Dates of Appointment From (Mo./Yr.)	To (Mo./Yr.)
None			

(All information must begin on the application, if more space is needed, please attach separate sheet.)

26. List any and all licenses (including training licenses and permits) **YOU HOLD OR HAVE HELD** to practice medicine in any state, territory or country.

State/Territory Country	License #	Date of Issuance	Dates of Practice From (Mo./Yr.) To (Mo./Yr.)
Nevada	LL1282	07-01-01	07/01 - 10/04

(All information must begin on the application, if more space is needed, please attach separate sheet.)

27. Have you ever been denied a license, permission to practice medicine or any other healing art, or permission to take an examination to practice medicine or any other healing art in any state, country or U.S. territory? (If "Yes," attach explanation on separate sheet.) ______Yes ✓ No

28. Have you ever had a medical license or license to practice any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory? This does not include lapsed or non-renewed licenses (If "Yes," attach explanation on separate sheet.) ______Yes ✓ No

29. Have you ever voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory? This does not include lapsed or non-renewed licenses. (If "Yes," attach explanation on separate sheet.) ______Yes ✓ No

30. Have you ever been denied membership or expelled from a medical society or other professional medical organization? (If "Yes," attach explanation on separate sheet.) ______Yes ✓ No

31. 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? (If "Yes," attach explanation on separate sheet.) ______Yes ✓ No

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NEVADA STATE

Roy Silver, M.D.

32. Have you ever surrendered your state or [redacted] controlled substance registration or had it revoked [redacted] restricted in any way? ______Yes ✓ No
(If "Yes," attach explanation on separate sheet.)

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

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

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(All information must begin on the application, if more space is needed, please attach separate sheet)

CHILD SUPPORT STATEMENT

The law of the state of Nevada requires that all applicants for issuance of a license be required to provide the following information concerning the support of a child. You are advised that this questions is part of your application, your response is given under oath, and any response hereto which is false, fraudulent, misleading, inaccurate or incomplete, may result in your application being denied. You must mark one of the following responses, and failure to mark one of the responses may result in denial of your application.

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;

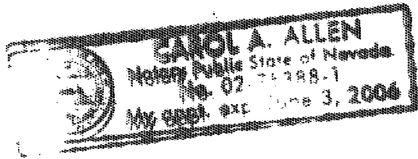
_____ (b) I am subject to a court order for the support of one or more children and am in compliance with the order or am in compliance with a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order; **OR**

_____ (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.

I, Ray Silva being duly sworn, depose and say: That the answers to the foregoing questions and statements made in the above application as well as any and all further explanations contained on any separate attached pages 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) 3/22/04 (date)

(NOTARY SEAL)



State of NV County of Clark

Subscribed and sworn to before me this 22 day of March, 2004.

By: Carol A. Allen

Notary Public for the State of Nevada

My Commission Expires: 6/3/04

Residing at: Las Vegas, NV

Signature of Notary: Carol A. Allen

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) ______________ 7/3/04 (date)

Roy Silver PhD

RESIDENT
APPLICATION FOR REGISTRATION RENEWAL
FOR A LIMITED LICENSE
NEVADA STATE BOARD OF MEDICAL EXAMINERS
Post Office Box 7238 Reno, Nevada 89510 Phone (775) 688-2559

Date Received by Board RECEIVED
APR 2 0 2004
NEVADA STATE BOARD OF MEDICAL EXAMINERS
(For Board Use Only)

License No.________
File No.________

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."

LL1282 expires: 06/30/2004 M.D.
Roy SILVER
10525 Courtney Cove
Las Vegas NV 89144-

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.]

Name________
Street________ State________ Zip________
City________ County________
Phone Number________ Fax Number________

THIS PORTION OF THE APPLICATION FOR REGISTRATION RENEWAL IS TO BE COMPLETED BY THE DIRECTOR OF MEDICAL EDUCATION FOR THE RESIDENCY PROGRAM

UNIV OF NEVADA SCHOOL OF MEDICINE OB/GYN
Residency Program and Field of Training

2040 W. CHARLESTON BLVD, STE 200 LAS VEGAS, NV 89102
Residency Program Address

7/1/03 - 6/30/04
Dates Training Began and Ended

12
Months of Accreditation Council for Graduate Medical Education (ACGME) Credit Received

Satisfactory Result
Indicate Quality of Resident's Work

Please indicate if any actions, restrictions, limitations, probations, or hearings have been conducted on this resident's performance during the past year. YES ________ NO X
(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 Residency Program, recommend this resident to continue in the above-named residency program.

6/8/04
Date Signature of Director of Medical Education for the Above-Named Residency Program

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

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MEDICAL EXAMINERS

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

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

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

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

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

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

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

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

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

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

5. Have you been a defendant in a legal action involving professional liability (malpractice) or had a professional liability claim paid in your behalf or paid such a claim yourself? ______Yes ✓ No

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

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

8. Have you ever had a medical license or license to practice any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory? ______Yes ✓ No

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

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

11. Have you ever been: a) notified [redacted] 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 [redacted] any medical licensing board, hospital, medical society, governmental entity or other agency <u>other than</u> the Nevada State Board of Medical Examiners?

_______Yes ___✓___No

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

_______Yes ___✓___No

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

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

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

CHILD SUPPORT STATEMENT

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

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

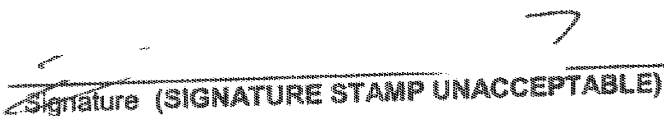
_______ (b) I am subject to a court order for the support of one or more children and am in compliance with the order or am in compliance with a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order; **OR**

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

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;**
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 <u>ALL</u> QUESTIONS THEREON AND/OR ATTACHED THERETO WRITTEN EXPLANATION(S) TO ANY "YES" ANSWER(S).**

7/25/04
Date



Signature **(SIGNATURE STAMP UNACCEPTABLE)**

RESIDENT
APPLICATION FOR REGISTRATION RENEWAL
FOR A LIMITED LICENSE

NEVADA STATE BOARD OF MEDICAL EXAMINERS

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

Date Received by Board

(For Board Use Only)

License No.____________

File No.____________

- **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."**

File no: . License no: LL1282

Roy SILVER M.D.
10525 Courtney Cove
Las Vegas NV 89144

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MAY 3 0 2003
NEVADA STATE BOARD OF MEDICAL EXAMINERS

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.]

Name Roy Silver
Street 10525 Courtney Cove Ave. State ______ Zip ______
City ______ County ______
Phone Number ______ Fax Number ______

THIS PORTION OF THE APPLICATION FOR REGISTRATION RENEWAL IS TO BE COMPLETED BY THE DIRECTOR OF MEDICAL EDUCATION FOR THE RESIDENCY PROGRAM

UNIV OF NEVADA SCHOOL OF MEDICINE, OB/GYN
Residency Program and Field of Training

2040 W CHARLESTON BLVD, STE 200, LAS VEGAS, NV 89102
Residency Program Address

7/1/02 - 6/30/03
Dates Training Began and Ended

12
Months of Accreditation Council for Graduate Medical Education (ACGME) Credit Received

Satisfactory
Indicate Quality of Resident's Work

Please indicate if any actions, restrictions, limitations, probations, or hearings have been conducted on this resident's performance during the past year. YES ______ NO ✓
(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 Residency Program, recommend this resident to continue in the above-named residency program.

29/5/03
Date

[signature]
Signature of Director of Medical Education for the Above-Named Residency Program
(SIGNATURE STAMP UNACCEPTABLE)

THIS PORTION OF THE APPLICATION FOR REGISTRATION RENEWAL
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 abreast of medical developments;
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks such as physician examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

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

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

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

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

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

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

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

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

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

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

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

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

10. Have you ever been denied membership or expelled from a medical society or other professional medical organization? ______Yes __✓__No

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

_______Yes ___✓___No

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

_______Yes ___✓___No

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

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

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

CHILD SUPPORT STATEMENT

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

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

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

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

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

5/15/02
Date

Signature (SIGNATURE STAMP UNACCEPTABLE)

RESIDENT
APPLICATION FOR REGISTRATION RENEWAL
FOR A LIMITED LICENSE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

No.______
Post Office Box 7238 Reno, Nevada 89510 Phone (775) 688-2559

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Date Received by Board
JUN 0 5 2002
NEVADA STATE BOARD OF MEDICAL EXAMINERS
(For Board Use Only)

License No.______
File

- 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."

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.]

Name Ray Silver
Street 10525 Courtney Cove Ave.
City Las Vegas County Clark State NV Zip 89144
Phone Number 702-839-2728 Fax Number 702-671-2333

THIS PORTION OF THE APPLICATION FOR REGISTRATION RENEWAL IS TO BE COMPLETED BY THE DIRECTOR OF MEDICAL EDUCATION FOR THE RESIDENCY PROGRAM

UNIV OF NEVADA SCHOOL OF MEDICINE ; OB/GYN
Residency Program and Field of Training

2040 W. CHARLESTON BLVD. STE 200 LAS VEGAS, NV 89102
Residency Program Address

7/1/01 - 6/30/02
Dates Training Began and Ended

TWELVE
Months of Accreditation Council for Graduate Medical Education (ACGME) Credit Received

SATISFACTORY
Indicate Quality of Resident's Work

Please indicate if any actions, restrictions, limitations, probations, or hearings have been conducted on this resident's performance during the past year. YES ______ NO X

(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 Residency Program, recommend this resident to continue in the above-named residency program.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11. Have you ever been: a) notified that you were under investigation for; b) investigated for; c) charged with; or d) convicted of any violation of a statute, rule or regulation governing your practice as a physician by any medical licensing board, hospital, medical society, governmental entity or other agency other than the Nevada State Board of Medical Examiners?
_______ Yes ___✓___ No

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

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

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

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

CHILD SUPPORT STATEMENT

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

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

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

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

BY SIGNING ON THE SIGNATURE LINE BELOW:

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3) I 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).

6/4/02 _______________ Signature (SIGNATURE STAMP UNACCEPTABLE)

MEDICAL DOCTOR

STATE OF NEVADA BOARD OF MEDICAL EXAMINERS APPLICATION FOR LICENSURE

1. Present Legal Name Silver (Last) Roy (First) ______ (Middle) ______ (Maiden)

List any other name ever used ____________________

2. Business and/or Mailing Address 3183 Abington Dr., (Street) BH, (City) CA (State) 90210 (Zip)

3. Home Address 3183 Abington Dr., (Street) Beverly Hills, (City) CA (State) 90210 (Zip)

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4. Telephone (310) (area code) 497-5711 (Office) (____) (area code) ____________ (Home)

5. Date of Birth ____ -73 Place of Birth Israel (City, state, country)

6. Citizenship: U.S. Citizen __X__ Alien Registration #__________ Work Authorization#__________
Visa Type and #__________

Submit a certified copy of birth certificate, or original Certificate of Naturalization or current U.S. passport or copy of front/ back of your alien registration card, work authorization or Visa.

7. Age_____ Height_____ Weight_____ Color of Eyes_____ Color of Hair_____
Social Security Number_____

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:

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2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physician capability to perform medical tasks such as physician examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

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

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

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

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 __X__No.
If Yes, separate attached explanation required.

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

10. If you use chemical substances, does your use of chemical substance(s) in any way impair or limit your ability to practice medicine with reasonable skill and safety? _____Yes __X__No _____N/A
If yes, separate attached explanation required.

11. Have you failed to initiate the performance of public service within one year after the date the public service is required to begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local government for your medical education? ______Yes ___X___No
If yes, separate attached explanation required.

12. Have you been a defendant in a legal action involving professional liability (malpractice) or had a professional liability claim paid in your behalf or paid such a claim yourself? ______Yes ___X___No.
If Yes, separate attached explanation required.

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

14. Have you previously applied for medical licensure in Nevada (including a residency program)? ______Yes ___X___No.

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

Name	Address Place Where Instruction Received	Dates of Attendance From (Mo./Yr.)	To (Mo./Yr.)
St. George's	Grenada, WI	8/96	to 6/00

If more space is needed, please attach separate sheet.

16. Doctor of Medicine Degree granted by:

Medical School Name	Medical School Address	Exact Date of Issuance
St. George's Univ SOM	Grenada, WI	6/10/00

17. List all ACGME* approved graduate medical education you have received as an intern or resident in the United States or Canada.
*Accreditation Council for Graduate Medical Education

Hospital/ Institution	Mailing Address	Type of Service or Specialty	Dates of Attendance From (Mo./Yr.)	To (Mo./Yr.)
NYU Downtown Hosp.	170 Williams St., NY, NY 10038	Ob/Gyn	7/00	to 7/01

If more space is needed, please attach separate sheet.

18. List all Fellowship training programs attended in the United States or Canada.

Institution	Mailing Address	Type of Fellowship	Dates of Attendance From (Mo./Yr.)	To (Mo./Yr.)
		N/A		

If more space is needed, please attach separate sheet.

19. Have any actions, restrictions, limitations, or probations ever been imposed on you while participating in any type of training program? ______Yes ___X___No.
If Yes, separate explanation required.

20. If you graduated from a medical school located outside the United States of America or Canada, list your ECFMG# 0-594-585-2

21. For each of the followi[illegible]icensing examinations list the location, p[illegible] . and dates taken, and scores obtained. **FOR EACH EXAM TAKEN, HAVE CERTIFICATE OF SCORES SUBMITTED FROM THE TESTING ENTITY DIRECTLY TO THE BOARD OFFICE.**

a. NATIONAL BOARDS:

Location	Part Taken	Date	Results (Scores)
	N/A		

b. FLEX (Federation Licensing Examination):

Location	Part Taken	Date	Result (Scores)
N/A			

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c. USMLE (United States Medical Licensing Examination):

Location	Part Taken	Date	Result (Scores)
Palm desert, CA	I	11/22/99	186
Los Angeles, CA	II	8/10/00	197

d. State Written Examination:

Location	Part Taken	Date	Result (Scores)
N/A	~~I~~	~~11/22/99~~	~~186~~
	~~II~~	~~8/10/00~~	~~197~~

e. SPEX (Special Purpose Examination):

Location	Part Taken	Date	Result (Scores)
N/A			

22. State your area of specialty: Obstetrics & Gynecology

23. List any and all certifications and re-certifications by a board or sub-board recognized by the **AMERICAN BOARD OF MEDICAL SPECIALTIES.**

Specialty Board	Certification #	Dates of Certification/Recertification
N/A		

24. Account for all periods of time since graduation from medical school.
ALL PERIODS OF TIME M[illegible] BE ACCOUNTED FOR.

City/State/Country		From (Mo./Yr.) To (Mo./Yr.)
Miami/FL/USA	Univ. of Miami OB/Gyn elective	7/00 to 10/00
NY/NY/USA	NYU Downtown Hosp. Internship	11/00 to Present

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If more space is needed, attach separate sheet.

25. List below the requested information for all hospitals in which you **ARE, OR HAVE EVER BEEN** a staff member at any level during the last ten years. If none, please indicate. Do not list internship, residency or fellowship affiliation.

Hospital	Complete Mailing Address	Dates of Appointment From (Mo./Yr.) To (Mo./Yr.)

If more space is needed, attach separate sheet.

26. List any and all licenses **YOU HOLD OR HAVE HELD** to practice medicine in any state, territory or country.

State/Territory Country	License #	Date of Issuance	Dates of Practice From (Mo./Yr.) To (Mo./Yr.)

If more space is needed, attach separate sheet.

27. Have you ever been denied a license, permission to practice medicine or any other healing arts, or permission to take an examination to practice medicine or any other healing arts in any state, country or U.S. territory? ______Yes __X__ No.
If Yes, separate attached explanation required.

28. Have you ever had a medical license revoked, suspended, limited, or restricted in any state, country or U.S. territory? ______Yes __X__ No
If yes, separate attached explanation required.

29. Have you ever voluntarily surrendered a license to practice a healing art in any state, country or U.S. territory? ______Yes __X__ No.
If yes, separate attached explanation required.

30. Have you ever been denied membership or expelled from a medical society or other professional medical organization? ______Yes __X__ No.
If yes, separate attached explanation required.

31. Have you ever been in[illegible]igated for, charged with, or convicted of [illegible] violation of a statute, rule or regulation governing the practice of medicine by any medical licensing board, hospital, medical society, governmental entity or other agency? ______Yes __X__No

If Yes, separate attached explanation required.

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

If yes, separate attached explanation required.

33. 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 staff meetings, or maintain required malpractice insurance).

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

RECEIVED
APR 2 0 2001
NEVADA STATE BOARD OF MEDICAL EXAMINERS

If more space is needed, attach separate sheet.

CHILD SUPPORT INFORMATION

The law of the state of Nevada requires that all applicants for issuance or renewal of a professional license be provided the opportunity to indicate if one of the following circumstances is applicable to the applicant.

You are advised that this question is part of your application, your response is given under oath, and that any response hereto which is false, fraudulent, misleading, inaccurate, or incomplete, may result in your application being denied.

You must mark one of the following responses, and failure to mark one of the responses may result in denial of your application.

PLACE AN X ON THE APPROPRIATE LINE

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

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

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

Roy Silver, M.D.
Type or print name

Social Security Number

Signature

4/10/01
Date

I, ______________________ ______________being duly sworn, depose and say: That the answers to the foregoing questions and statements made in the above application as well as any and all further explanations contained on any separate attached pages 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

(Notary Seal)

EDWINA A. JOHNSON
Notary Public, State of New York
No. 01JO6029156
Qualified in Queens County
Commission Expires June 13, 200_

Subscribed and sworn to before me this ______ day of ______________

Notary Public for State of New York

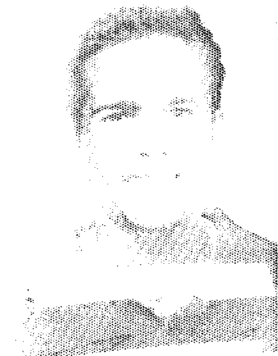
My Commission Expires ______________

Residing at ______________

____
Signature of Notary

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

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



Proof photos and negatives are not acceptable

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

____
Signature of Applicant

____
Date