Nevada State Board of Medical Examiners

Renewal Responses Report

Wednesday, July 16, 2014

License Number	Licensee	License Type
12973	Carolyn Laurice CORNELIUS	Medical Doctor

Question	Answer	Date
Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? **If you do not have a medical condition, select No.**	N	06/02/2009
Explanation 1: For the above question if your answer is "Yes" for the time period July 1, 2007 - June 30, 2009, or since your last renewal, please type your explanation in this text box.		
If you have a medical condition which in any way impairs or limits your ability to practice medicine, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? **If you do not have a medical condition, select No.**	N	06/02/2009

Explanation 2: For the above question if your answer is "Yes" for the time period July 1, 2007 - June 30, 2009, or since your last renewal, please type your explanation in this text box.		
If you use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety? **If you do not use chemical substances, select No.**	N	06/02/2009
Explanation 3: For the above question if your answer is "Yes" for the time period July 1, 2007 - June 30, 2009, or since your last renewal, please type your explanation in this text box.		
Have you been named as a defendant, or been requested to respond as a defendant or potential defendant, to a legal action involving professional liability (malpractice)? Please include: who, what, where (provide state), and when in the textbox directly below this question.	N	06/02/2009

Explanation 4: For the above question if your answer is "Yes" for the time period July 1, 2007 - June 30, 2009, or since your last renewal, please type your explanation in this text box.		
Have you had a professional liability (malpractice) claim paid on your behalf or paid such a claim yourself (including any military tort claims if applicable)? Please include: who, what, where (provide state), when and case number in the textbox directly below this question. Please fax a copy of the complaint, civil or otherwise to 775-688-2551.	N	06/02/2009
Explanation 5: For the above question if your answer is "Yes" for the time period July 1, 2007 - June 30, 2009, or since your last renewal, please type your explanation in this text box. Please fax a copy of the complaint, civil or otherwise to 775-688-2551.		
Have you been arrested, investigated for, charged with, convicted of, or pled guilty or nolo contendere to any criminal offense related to the manufacture, distribution, prescribing, or dispensing of controlled substances?**Please note that you MUST disclose ANY investigation or arrest, including those where the final disposition was dismissal, sealing of a record, or expungement.**	N	06/02/2009

Explanation 6: For the above question if your answer is "Yes" for the time period July 1, 2007 - June 30, 2009, or since your last renewal, please type your explanation in this text box.		
Have you been arrested, investigated for, charged with, convicted of, or pled guilty or nolo contendere to any criminal offense other than a criminal offense listed in Question #6? **Please note that you MUST disclose ANY investigation or arrest, including those where the final disposition was dismissal, sealing of a record, or expungement.**	N	06/02/2009
Explanation 7: For the above question if your answer is "Yes" for the time period July 1, 2007 - June 30, 2009, or since your last renewal, please type your explanation in this text box.		
Have you been denied a license, permission to practice medicine or any other healing art, or permission to take an examination to practice medicine or any other healing art in any state, country or U.S. territory?	N	06/02/2009

Explanation 8: For the above question if your answer is "Yes" for the time period July 1, 2007 - June 30, 2009, or since your last renewal, please type your explanation in this text box.		
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?	Y	06/02/2009
Explanation 9: For the above question if your answer is "Yes" for the time period July 1, 2007 - June 30, 2009, or since your last renewal, please type your explanation in this text box.		06/02/2009
Have you voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory in lieu of any disciplinary action?	N	06/02/2009

Explanation 10: For the above question if your answer is "Yes" for the time period July 1, 2007 - June 30, 2009, or since your last renewal, please type your explanation in this text box.

Have you been denied membership, been asked to resign or expelled from a medical society or other professional medical organization (including the ABMS)?	N	06/02/2009

Explanation 11: For the above question if your answer is "Yes" for the time period July 1, 2007 - June 30, 2009, or since your last renewal, please type your explanation in this text box.

Regarding any medical licensing board, hospital medical society, or other governmental entity or agency (other than the Nevada State Board of Medical Examiners), have you been: (a) Asked to respond to an investigation; (b) Notified that you were under investigation for; (c) Investigated for; (d) Charged with; or (e) Convicted of any violation of a statute, rule or regulation governing your practice as a physician?	N	06/02/2009

Explanation 12: For the above question if your answer is "Yes" for the time period July 1, 2007 - June 30, 2009, or since your last renewal, please type your explanation in this text box.

Have you surrendered your state or federal controlled substance registration or had it revoked or restricted in any way?	N	06/02/2009

Explanation 13: For the above question if your answer is "Yes" for the time period July 1, 2007 - June 30, 2009, or since your last renewal, please type your explanation in this text box.

Have you had hospital staff privileges denied, suspended, limited, revoked or not renewed by the hospital, including any and all resignations from any medical staff in lieu of disciplinary or administrative action? If the answer is " Yes," type the name of the hospital, the hospital's mailing address, the type of action taken, and the date or dates of the actions taken in the textbox directly below this question. **(Please Note:) Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance.)**	N	06/02/2009

Explanation 14: For the above question if your answer is "Yes" for the time period July 1, 2007 - June 30, 2009, or since your last renewal, please type your explanation in this text box.		
Are you out of compliance with court ordered child support? **If this does not apply to you, please answer "no".** If "Yes" during the time period July 1, 2007- June 30, 2009 type an explanation in the textbox directly below this question.	N	06/02/2009
Explanation 15: For the above question if your answer is "YES" for the time period July 1, 2007 - June 30, 2009, or since your last renewal, please type your explanation in this text box.		
I hereby request my license to be placed on Inactive status, which means I will not physically practice in the state of Nevada. If you choose to place your license on Inactive status, make certain to select "Yes" to this question **AND** choose the Inactive status in the dropdown box located at the end of the questions.	N	06/02/2009

Explanation 16: For the above question, if your answer is "Yes" and you want to change to Inactive status for the next biennial July 1, 2009 – June 30, 2011, please provide a brief explanation in this text box.		
Do you want to change your scope of practice or specialty? If you answer "Yes" type your current scope of practice or specialty in the textbox directly below this question.	N	06/02/2009
Explanation 17: For the above question if your answer is "YES" , please type your new scope of practice or specialty in this text box.		
I have completed the required amount of AMA Category 1 CME within the current biennial. (Review CME information online at www.medboard.nv.gov) I understand that I may be included in a random audit following the July 1st, 2009 renewal. I agree to retain CME's taken between July 1, 2007 and June 30, 2009. If renewing to an Inactive status, CME is not required and "No" can be selected.	Y	06/02/2009

I SWEAR OR AFFIRM UNDER THE PENALTY OF PERJURY THAT I PERSONALLY ANSWERED ALL OF THE QUESTIONS IN THIS APPLICATION AND THAT THE ANSWERS I HAVE PROVIDED ARE TRUE AND CORRECT.	Y	06/02/2009
Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? **If you do not have a medical condition, select No.**	N	06/03/2011
Explanation 1: For the above question if your answer is "Yes" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box.		
If you have a medical condition which in any way impairs or limits your ability to practice medicine, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? **If you do not have a medical condition, select No.**	N	06/03/2011

Explanation 2: For the above question if your answer is "Yes" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box.		
If you use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety? **If you do not use chemical substances, select No.**	N	06/03/2011
Explanation 3: For the above question if your answer is "Yes" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box.		
Have you been named as a defendant, or been requested to respond as a defendant, to a legal action involving professional liability, malpractice, including any military tort claims if applicable? Please include: who, what, where (provide state), and when in the textbox directly below this question.	N	06/03/2011

Explanation 4: For the above question if your answer is "Yes" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box.

Have you had a professional liability, malpractice, claim paid on your behalf or paid such a claim yourself including any military tort claims if applicable? If "Yes" during the time period July 1, 2009 - June 30, 2011 type an explanation in the textbox directly below this question.	N	06/03/2011

Explanation 5: For the above question if your answer is "Yes" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box.
Please fax a copy of the complaint, civil or otherwise to 775-688-2551.

Have you been arrested, investigated for, charged with, convicted of, or pled guilty or nolo contendere to any offense or violation of any federal (including the Uniform Code of Military Justice), state or local law, or the laws of any foreign country, which is a misdemeanor, gross misdemeanor, felony, violation of the Uniform Code of Military Justice, or synonymous thereto in a foreign jurisdiction, excluding any minor traffic offense (driving or being in control of a motor vehicle while under the influence of a chemical substance, including alcohol, is not considered a minor traffic offense), or for any offense which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? **Please note that you MUST disclose ANY investigation or arrest, including those where the final disposition was dismissal, or expungement.**	N	06/03/2011

Explanation 6: For the above question if your answer is "Yes" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box.

Have you been denied a license, permission to practice medicine or any other healing art, or permission to take an examination to practice medicine or any other healing art in any state, country or U.S. territory?	N	06/03/2011

Explanation 7: For the above question if your answer is "Yes" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box.

Have you had a medical license or license to practice any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory?	N	06/03/2011

Explanation 8: For the above question if your answer is "Yes" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box.

Have you voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory in lieu of any disciplinary action?	N	06/03/2011

Explanation 9: For the above question if your answer is "Yes" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box.

Have you been denied membership, been asked to resign or expelled from a medical society or other professional medical organization (including the ABMS)?	N	06/03/2011

Explanation 10: For the above question if your answer is "Yes" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box.

Have you been: a) asked to respond to an investigation; b) notified that you were under investigation for; c) investigated for; d) charged with; or e) convicted of any violation of a statute, rule or regulation governing your practice as a physician by any medical licensing board, hospital, medical society, governmental entity or agency other than the Nevada State Board of Medical Examiners?	N	06/03/2011

Explanation 11: For the above question if your answer is "Yes" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box.

Have you surrendered your state or federal controlled substance registration or had it revoked or restricted in any way?	N	06/03/2011

Explanation 12: For the above question if your answer is "Yes" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box.

Have you had hospital staff privileges denied, suspended, limited, revoked or not renewed by the hospital, including any and all resignations from any medical staff in lieu of disciplinary or administrative action? If the answer is " Yes," type the name of the hospital, the hospital's mailing address, the type of action taken, and the date or dates of the actions taken in the textbox directly below this question. **(Please Note:) Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance.)**	N	06/03/2011

Explanation 13: For the above question if your answer is "Yes" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box.

Are you out of compliance with court ordered child support? **If this does not apply to you, please answer "no".** If "Yes" during the time period July 1, 2009 - June 30, 2011 type an explanation in the textbox directly below this question.	N	06/03/2011

Explanation 14: For the above question if your answer is "YES" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box.

I hereby request my license to be placed on Inactive status, which means I will not physically practice in the state of Nevada. If you choose to place your license on Inactive status, make certain to select "Yes" to this question **AND** choose the Inactive status in the dropdown box located at the end of the questions.	N	06/03/2011

Explanation 15: For the above question, if your answer is "Yes" and you want to change to Inactive status for the next biennial July 1, 2011 – June 30, 2013, please provide a brief explanation in this text box.

Is your license contingent upon maintaining certification with the American Board of Medical Specialties (ABMS) in the specialty of Family Practice, Emergency Medicine, or Preventative Medicine?	N	06/03/2011

Explanation 16: For the above question if your answer is "YES" , please type your new scope of practice or specialty in this text box.

Do you want to change your scope of practice or specialty? If you answer "Yes" type your current scope of practice or specialty in the textbox directly below this question.	N	06/03/2011

Explanation 17: For the above question if your answer is "Yes" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box.

I have completed the required amount of AMA Category 1 CME within the current biennial. (Review CME information online at www.medboard.nv.gov) I understand that I may be included in a random audit following the July 1st, 2011 renewal. I agree to retain CME's taken between July 1, 2009 and June 30, 2011. If renewing to an Inactive status, CME is not required and "No" can be selected.	Y	06/03/2011

I SWEAR OR AFFIRM UNDER THE PENALTY OF PERJURY THAT I PERSONALLY ANSWERED ALL OF THE QUESTIONS IN THIS APPLICATION AND THAT THE ANSWERS I HAVE PROVIDED ARE TRUE AND CORRECT.	Y	06/03/2011
Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? **If you do not have a medical condition, select No.**	N	06/24/2013
If you have a medical condition which in any way impairs or limits your ability to practice medicine, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? **If you do not have a medical condition, select No.**	N	06/24/2013
If you use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety? **If you do not use chemical substances, select No.**	N	06/24/2013

Have you been named as a defendant, or been requested to respond as a defendant, to a legal action involving professional liability, malpractice, including any military tort claims if applicable? Please include: who, what, where (provide state), and when in the textbox directly below this question.	N	06/24/2013
Have you had a professional liability, malpractice, claim paid on your behalf or paid such a claim yourself including any military tort claims if applicable? If "Yes" during the time period July 1, 2011 - June 30, 2013 type an explanation in the textbox directly below this question.	N	06/24/2013
Have you been arrested, investigated for, charged with, convicted of, or pled guilty or nolo contendere to any offense or violation of any federal (including the Uniform Code of Military Justice), state or local law, or the laws of any foreign country, which is a misdemeanor, gross misdemeanor, felony, violation of the Uniform Code of Military Justice, or synonymous thereto in a foreign jurisdiction, excluding any minor traffic offense (driving or being in control of a motor vehicle while under the influence of a chemical substance, including alcohol, is not considered a minor traffic offense), or for any offense which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? **Please note that you MUST disclose ANY investigation or arrest, including those where the final disposition was dismissal, or expungement.**	N	06/24/2013
Have you been denied a license, permission to practice medicine or any other healing art, or permission to take an examination to practice medicine or any other healing art in any state, country or U.S. territory?	N	06/24/2013

Have you had a medical license or license to practice any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory?	N	06/24/2013
Have you voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory in lieu of any disciplinary action?	N	06/24/2013
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	06/24/2013
If you believe that you are in compliance with the Centers for Disease Control safe injection practices, your answer should be "YES". I hereby attest to knowledge of and compliance with the guidelines of the Centers for Disease Control and Prevention concerning the prevention of transmission of infectious agents through safe and appropriate injection practices. I also attest that any person who is currently, or will be under my control as their supervising physician in the future, and who is not licensed pursuant to chapter 630 of the Nevada Revised Statutes and whose duties involve injection practices, has knowledge of and is in compliance with the guidelines of the Centers for Disease Control and Prevention concerning the prevention of transmission of infectious agents through safe and appropriate injection practices.	Y	06/24/2013

Have you surrendered your state or federal controlled substance registration or had it revoked or restricted in any way?	N	06/24/2013
Have you had hospital staff privileges denied, suspended, limited, revoked or not renewed by the hospital, including any and all resignations from any medical staff in lieu of disciplinary or administrative action? If the answer is " Yes," type the name of the hospital, the hospital`s mailing address, the type of action taken, and the date or dates of the actions taken in the textbox directly below this question. **(Please Note: Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance.)**	N	06/24/2013
Have you actively practiced medicine in Nevada within the past 12 months?	Y	06/24/2013
I hereby request my license to be placed on Inactive status, which means I will not physically practice in the state of Nevada. If you choose to place your license on Inactive status, make certain to select "Yes" to this question **AND** choose the Inactive status in the dropdown box located at the end of the questions.	N	06/24/2013

The submission of the in-office surgery/procedure forms is required for all medical doctors, whether in state, out of state, active or inactive status! THIS IS NOT OPTIONAL. DO NOT answer this attestation until you have completed the requisite form. Once you have completed this action, you may proceed in answering the renewal attestations and questions. The online renewal site will retain your previous responses. Please go to the website, click on the following link for instructions and complete the required form.Click on the following link for the instructions and forms: http://medboard.nv.gov/New_In_Office_Surgery_Forms.htm **If you have submitted your In-Office Surgery/Procedure Reporting Forms (A/B forms) to the Board and are in compliance with NRS 630.30665, your answer should be**	Y	06/24/2013
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, 2011 - June 30, 2013 type an explanation in the textbox directly below this question.	N	06/24/2013
I have completed the required amount of AMA Category 1 CME within the current biennial. I understand that I may be included in a random audit. I agree to retain CME's taken between July 1, 2011 and June 30, 2013. (Review CME information online at www.medboard.nv.gov) If renewing to an Inactive status, CME is not required and "No" can be selected.	Y	06/24/2013
I SWEAR OR AFFIRM UNDER THE PENALTY OF PERJURY THAT I PERSONALLY ANSWERED ALL OF THE QUESTIONS IN THIS APPLICATION AND THAT THE ANSWERS I HAVE PROVIDED ARE TRUE AND CORRECT.	Y	06/24/2013

RECEIVED

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

Date Received by Bo
NOV 1 0 2008
NEVADA STATE BOARD OF MEDICAL EXAMINERS

License No._____
File No._____
(For Board Use Only)

File No.

Carolyn Laurice Cornelius, M.D.
1930 Dresden Court
Henderson, NV 89014

YOUR COMPLETED 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.]

Name_____

Street_____

City_____ County_____ State_____ Zip_____

Phone Number_____ Fax Number_____

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	NEPHROLOGYNEUROLOGY
44	NEURO-OPHTHALMOLOGY
45	NEUROPATHOLOGY
46	NEURORADIOLOGY
47	NEUROTOLOGY
48	NON-CONVENTIONAL MEDICINE
49	NUCLEAR MEDICINE
50	NUTRITION
51	OBSTETRICS
52	OBSTETRICS/GYNECOLOGY
53	OCCUPATIONAL MEDICINE
54	ONCOLOGY
55	ONCOLOGY, GYNECOLOGICAL
56	ONCOLOGY, HEMATOLOGY
57	ONCOLOGY, RADIATION
58	ONCOLOGY, SURGICAL
59	OPHTHALMOLOGY
60	OTOLARYNGOLOGY
61	OTOLOGY
62	PAIN MANAGEMENT
63	PATHOLOGY
64	PATHOLOGY, ANATOMIC
65	PATHOLOGY, CLINICAL
66	PATHOLOGY, FORENSIC
67	PEDIATRIC, ALLERGY
68	PEDIATRIC, ANESTHESIOLOGY
69	PEDIATRIC, CARDIOLOGY
70	PEDIATRIC, CRITICAL CARE
71	PEDIATRIC, EMERGENCY MEDICINE
72	PEDIATRIC, ENDOCRINOLOGY
73	PEDIATRIC, GASTROENTEROLOGY
74	PEDIATRIC, HEMATOLOGY/ONCOLOGY
75	PEDIATRIC, INFECTIOUS DISEASES
76	PEDIATRIC, INTENSIVIST
77	PEDIATRIC, NEPHROLOGY
78	PEDIATRIC, NEUROLOGY
79	PEDIATRIC, OPHTHALMOLOGY
80	PEDIATRIC, PHYSIATRY
81	PEDIATRIC, PULMONARY
82	PEDIATRIC, RADIOLOGY
83	PEDIATRIC, RHEUMATOLOGY
84	PEDIATRIC, SURGERY
85	PEDIATRIC, UROLOGY
86	PEDIATRICS
87	PHYSICAL MEDICINE/REHABILITATION
88	PREVENTIVE MEDICINE
89	PSYCHIATRY
90	PSYCHOANALYSIS
91	PSYCHOMATIC MEDICINE
92	PUBLIC HEALTH
93	PULMONARY DISEASES
94	OCCUPATIONAL MEDICINE
95	RADIOLOGY
96	RADIOLOGY, DIAGNOSTIC
97	RADIOLOGY, INTERVENTIONAL
98	RADIOLOGY, NUCLEAR
99	RADIOLOGY, THERAPEUTIC
100	RADIOLOGY, VASCULAR
101	RHEUMATOLOGY
102	RHINOLOGY
103	SLEEP DISORDERS
104	SPORTS MEDICINE
105	SURGERY, ABDOMINAL
106	SURGERY, CARDIOTHORACIC
107	SURGERY, CARDIOVASCULAR
108	SURGERY, COLON/RECTAL
109	SURGERY, CRANIOFACIAL
110	SURGERY, GENERAL
111	SURGERY, HAND
112	SURGERY, HEAD/NECK
113	SURGERY, MAXILLOFACIAL
114	SURGERY, NEUROLOGICAL
115	SURGERY, ORTHOPEDIC
116	SURGERY, PLASTIC
117	SURGERY, THORACIC
118	SURGERT, TRANSPLANT
119	SURGERY, TRAUMATIC
120	SURGERY, UROLOGIC
121	SURGERY, VASCULAR
122	TOXICOLOGY
123	TRANSPLANTATION
124	URGENT CARE
125	UROLOGY

Code **Code**

Primary Scope of Practice 52 **Secondary Scope of Practice** _____

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 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 EVER been named as a defendant, or have been requested to respond as a defendant, to 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, arrested, 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, even if the ultimate disposition was dismissal or expungement. _____Yes ___✓___No

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

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

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

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

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

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

13. List all hospitals where you have had staff privileges denied, suspended, limited, revoked or not renewed by the hospital. List any and all resignations from any medical staff in lieu of disciplinary or administrative action. (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.)
n/a			

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

CHILD SUPPORT STATEMENT

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

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

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

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

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).**

11/7/08
Date

Signature **(SIGNATURE STAMP UNACCEPTABLE)**

RECEIVED

7/1/2008- 6/30/2009 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
AUG 07 2008 License No. _____
NEVADA STATE BOARD OF MEDICAL EXAMINERS File No. _____
(For Board Use Only)

1. Present Legal Name Cornelius, Carolyn Laurice Jefferson
Last First Middle Maiden

RECEIVED
SEP 18 2008
NEVADA STATE BOARD OF MEDICAL EXAMINERS

List any other name(s) ever used Carolyn L. Jefferson

2. Mailing Address 1930 Dresden Court Henderson, NV 89014 Clark
Street City County State Zip

3. Home Address 1930 Dresden Court Henderson, NV 89014 Clark
Street City County State Zip

4. Telephone Number (___) _____ (___) _____ Fax Number (702) 982-5672
Office Home
Cellular Number (Optional) _____ Email Address _____

5. Date of Birth /1965 Place of Birth _____, CA USA
(City, State, Country)

6. Citizenship: U.S. Citizen ✓ Alien Registration # _____ Employment Authorization # _____ Applying for Visa _____
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 _____ Color of Eyes _____ Color of Hair _____ Height _____ Weight _____
NRS 630.165(3) An application submitted pursuant to subsection 1 or 2 must include the social security number of the applicant;
NRS 630.165(5) The applicant bears the burden of proving and documenting his qualifications for licensure.

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

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

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

12. Have you **EVER** been named as a defendant or have been requested to respond as a defendant to a legal action involving professional liability (malpractice) or had a professional liability claim made 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, arrested, 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 (including driving or being in control of a motor vehicle while under the influence of any chemical substance, including alcohol, is not considered a minor traffic offense) or for any offense which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? *Please note that you MUST disclose ANY investigation or arrest, whether or not it ultimately resulted in a conviction or expungement. ____ Yes ✓ No

RECEIVED RECEIVED
OCT 2 9 2008
AUG 0 7 2008
NEVADA STATE BOARD OF MEDICAL EXAMINERS
NEVADA STATE BOARD OF MEDICAL EXAMINERS

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.)
University of California, Irvine SOM	Irvine, CA	University of California Irvine medical center	09/1987 - 06/1991

(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
University of California, Irvine SOM	Irvine, CA	06/15/1991

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

Postgraduate Year	Hospital/ Institution	City/State	Specify (I =Internship or R = Residency) (F = Fellowship)	Type of Specialty	Dates of Attendance From (Mo./Yr.) To (Mo./Yr.)
PGY 1	University Medical Center of Southern Nevada		I	OB/GYN	07/1991 - 06/1992
PGY 2-4	University Medical Center of Southern Nevada		R	OB/GYN	07/1992 - 06/1995

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

18. List all non-ACGME approved 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.)
n/a			

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

19. Have you **EVER** been investigated or have any actions, restrictions, limitations, probations or disciplinary actions 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#: n/a

21. For each of the following licensing examinations, list the location, parts and dates taken, and scores obtained, (also include any failed examinations). **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 (Two Digit Scores)
California	I	09/1989	Passed 76
California	II	09/1990	Passed 75
Nevada	III	05/1992	passed 75

Cornelius

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

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

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 (Two Digit Scores)

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): OB/GYN

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)
American Board of Obstetrics and Gynecology	95C417	11/1999

 Cornelius

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

Activities	Location (City/State/Country)	From (Mo./Yr.) To (Mo./Yr.)
OB/GYN - Internship	Las Vegas, NV	07/1991 - 06/1992
OB/GYN - Residency	Las Vegas, NV	07/1992 - 06/1995
Captain, Physician, Medical Director - United States Air Force	Cannon AFB, NM	07/1995 - 12/1996
Physician - Glassman, Krammer, and Scarff P.C.	Las Vegas, NV	01/1997 - 08/1998
Physician - Women's Health Center, Southern Nevada	Henderson, NV	08/1998 - 12/1999
Proprietor, Physician - For Women Only, Inc.	Las Vegas, NV	01/2000 - 06/2003
Unemployed (Permanently Disabled since 2003)	Henderson, NV	06/2003 - Present

RECEIVED
OCT 29 2008
NEVADA STATE BOARD OF MEDICAL EXAMINERS

RECEIVED
AUG 07 2008
NEVADA STATE BOARD OF MEDICAL EXAMINERS

(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 or surgery centers 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.

RECEIVED
SEP 18 2008
NEVADA STATE BOARD OF MEDICAL EXAMINERS

Hospital	Complete Mailing Address	Dates of Appointment From (Mo./Yr.) To (Mo./Yr.)
University Medical Center of Southern Nevada	1800 W. Charleston Blvd. Las Vegas, NV 89102	07/1997 - 06/2003
Desert Springs Hospital Medical Center	2075 E. Flamingo Road Las Vegas, NV 89119	05/1997 - 02/2003
St. Rose Dominican Hospital-Rose Delma	106 E. Lake Mead Parkway Henderson, NV 89015	07/1997 - 12/2002
St. Rose Dominican Hospital-Sienna	3001 Saint Rose Parkway Henderson, NV 89052	07/1997 - 12/2002

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

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 #	Exact Date of Issuance	Dates of Practice From (Mo./Yr.) To (Mo./Yr.)
Nevada	7147	07/01/1994	07/1994 - 06/2003
Nevada	636	07/01/1991	07/1991 - 06/1994

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

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 agency other than the Nevada State Board of Medical Examiners?

(If "Yes," attach explanation on separate sheet .) ____Yes ✓ No

Cornelius

32. Have you EVER surrendered your state or federal controlled substance registration or had it revoked or 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.)
n/a				

RECEIVED
AUG 07 2008
NEVADA STATE BOARD OF MEDICAL EXAMINERS

(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, Carolyn Laurice Cornelius, MD 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.

_____ 7/25/08
(signature of applicant) (date)

(NOTARY SEAL)

JESSICA CANDIDO
NOTARY PUBLIC
STATE OF NEVADA
APPT. No. 06-108308-1
MY APPT. EXPIRES JULY 28, 2010

State of NV County of Clark

Subscribed and sworn to before me this 25 day of July, 2008.

Notary Public for the State of Nevada

My Commission Expires: July 28 2010.

Residing at: 2196 Olympic Ave Henderson NV 89014.

Signature of Notary: _____

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) 7/25/08 (date)

ATTENTION APPLICANT!

RESPONSIBILITY STATEMENT

Please sign and return this statement with your application for licensure to:
The Nevada State Board of Medical Examiners,
P.O. Box 7238, Reno, NV 89510
or
1105 Terminal Way, Ste 301, Reno, NV 89502
(775) 688-2559

Because you are applying for the privilege of practicing medicine in Nevada, you should know that our state has some of the most stringent licensing requirements and comprehensive investigation programs in the United States.

Our licensing specialists are likely to discover if data you have submitted on your application is erroneous or incomplete, or that you have omitted vital information.

Explaining and documenting a problem to your licensing specialist will be much less painful than discussing your honesty before the entire Board of Medical Examiners. This includes a sanction or disciplinary action you may have experienced during medical school or your postgraduate training, or any conflict you may have had with the legal system— even if the charge(s) has been expunged, lessened, or dismissed, and no matter how long ago it occurred the FBI will have your fingerprints on file. This will be discovered.

ONLY YOU—NOT A LAWYER, DOCTOR, SPOUSE, OR CREDENTIALING COMPANY — ARE RESPONSIBLE FOR READING AND ANSWERING EVERY QUESTION ACCURATELY AND COMPLETELY.

If you have *any* questions about your application, ASK YOUR LICENSING SPECIALIST. Our licensing specialists are here to help you.

o o o o o

I have read this cover sheet and understand that I alone am responsible for completing my application for medical licensure in Nevada.

Print your name Carolyn L. Cornelius

Sign your name _____

Date 7/25/08

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
MAY 31 2005
(For Board Use Only)

License No. 7147

File No.

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

_____ 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. [illegible] License No. 7147

Carolyn Laurice CORNELIUS M.D.
1930 Dresden Court
Henderson NV 89014-

Make checks payable to:
/ADA 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.

5/25/05
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. If your name and/or address has changed from that printed on the label on this form, clearly indicate the change in the space provided below. Also, please indicate your current telephone and fax numbers. [Please note: a notarized or certified copy of the document authorizing your name change (marriage license, divorce decree, etc.) must be included.]

Name_____

Street_____

City_____ County_____ State_____ Zip_____

Phone Number_____ Fax Number_____

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

Name_____

Street_____

City_____ County_____ State_____ Zip_____

Phone Number_____

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

SCOPES OF PRACTICE CODES

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

	Code		Code
Primary Scope of Practice	_____	**Secondary Scope of Practice**	_____

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(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.

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;**

3) **I UNDERSTAND THAT THIS *APPLICATION FOR REGISTRATION RENEWAL* WILL BE DENIED IF I HAVE NOT ANSWERED ALL QUESTIONS THEREON AND/OR ATTACHED THERETO PAYMENT OF THE APPROPRIATE REGISTRATION RENEWAL FEE AND WRITTEN EXPLANATION(S) TO ANY "YES" ANSWER(S);**

4) **I UNDERSTAND THAT BY REGISTERING IN INACTIVE STATUS, I MAY NOT PRACTICE MEDICINE IN THE STATE OF NEVADA, AND THAT THE PRACTICE OF MEDICINE INCLUDES THE WRITING OF PRESCRIPTIONS; AND**

5) **I UNDERSTAND THAT AN INACTIVE STATUS LICENSEE IN NEVADA MUST MEET STATUTORY REQUIREMENTS TO CHANGE TO ACTIVE STATUS, AND A CHANGE TO ACTIVE STATUS REQUIRES SPECIFIC FORMAL APPROVAL BY THE NEVADA STATE BOARD OF MEDICAL EXAMINERS.**

_____ _____

Date Signature **(SIGNATURE STAMP UNACCEPTABLE)**

PHYSICIAN
APPLICATION FOR REGISTRATION RENEWAL
FOR THE BIENNIAL REGISTRATION PERIOD 2003- 2005
NEVADA STATE BOARD OF MEDICAL EXAMINERS
Post Office Box 7238 Reno, Nevada 89510 Phone (775) 688-2559
Physical Address: 1105 Terminal Way, Suite 301 Reno, Nevada 89502

Date Received by Bd.
JUL 0 2 2003
(For Board Use Only)

License No. 7147
File No.
issued 7/1/94 INACTIVE

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

_____	ACTIVE STATUS	$400.00
X	INACTIVE STATUS	$200.00.....(*INACTIVE STATUS DOES NOT PERMIT THE PRACTICE OF MEDICINE INCLUDING THE WRITING OF PRESCRIPTIONS IN NEVADA)*
_____	I REQUEST NON-RENEWAL OF MY LICENSE*	

(*IF YOU ARE REQUESTING NON-RENEWAL, SEE BELOW)

File no: [redacted] License no: 7147

Carolyn L CORNELIUS M.D.
1930 Dresden Court
Henderson NV 89014

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

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

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

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

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

PLEASE NOTE:

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

PLEASE TYPE OR PRINT LEGIBLY

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

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

Name _____

Street _____

City _____ County _____ State _____ Zip _____

Phone Number (702) 454-4990 Fax Number (702) 454-4479

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

Name Storage West self storage

Street 3869 East Sunset Road

City ~~Henderson~~ Las Vegas County Clark State Nevada Zip 89120-3920

Phone Number (702) 812-3498

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

SCOPES OF PRACTICE CODES

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

	Code		Code
Primary Scope of Practice	51	**Secondary Scope of Practice**	

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

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

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

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

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

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

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

1. Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? ___X___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 ___X___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? ___X___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 ___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 <u>other than</u> 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. (<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.)
		NA	

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

CHILD SUPPORT STATEMENT

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

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

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

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

CONTINUING MEDICAL EDUCATION (CME) STATEMENT

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

_____ (a) I completed a minimum of 40 hours of AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics and 20 hours of which were in my scope of practice or specialty, during the past biennial period of July 1, 2001 through June 30, 2003;

_____ (b) I was initially licensed in Nevada during the time period January 1, 2002 through June 30, 2002, the second six months of the past biennial period, and completed a minimum of 30 hours of AMA Category I continuing medical education (CME), 2 hours of which were in medical ethics and 20 hours of which were in my scope of practice or specialty;

_____ (c) I was initially licensed in Nevada during the time period July 1, 2002 through December 31, 2002, the third six months of the past biennial period, and completed a minimum of 20 hours of AMA Category I continuing medical education (CME), 2 hours of which were in medical ethics and 18 hours of which were in my scope of practice or specialty;

_____ (d) I was initially licensed in Nevada during the time period January 1, 2003 through June 30, 2003, the fourth six months of the past biennial period, and completed a minimum of 10 hours of AMA Category I continuing medical education (CME), 2 hours of which were in medical ethics and 8 hours of which were in my scope of practice or specialty; **OR**

_____ (e) I am exempt from submitting proof of completion of continuing medical education (CME) because I have completed a full year of residency or fellowship training during the biennial period July 1, 2001 through June 30, 2003.

- **ATTACH COPIES OF PROOF OF YOUR COMPLETION OF CONTINUING MEDICAL EDUCATION (CME) HOURS.**
- **IF YOU COMPLETED A FULL YEAR OF RESIDENCY OR FELLOWSHIP TRAINING DURING THE BIENNIAL PERIOD JULY 1, 2001 THROUGH JUNE 30, 2003, ATTACH A COPY OF PROOF OF COMPLETION OF YOUR TRAINING.**
- **YOUR COPIES OF PROOF OF CME OR TRAINING COMPLETION WILL NOT BE RETURNED TO YOU.**

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

BY SIGNING ON THE SIGNATURE LINE BELOW:

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

6/30/03
Date

Signature **(SIGNATURE STAMP UNACCEPTABLE)**

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 Carolyn L. Cornelius, M.D.	**License No. 7147**

ORDER

The above named physician, having been automatically suspended from inactive licensure in the state of Nevada for failure to pay the applicable fee for biennial registration when due on or before close of business July 1, 2003, and having paid the sum of FOUR HUNDRED DOLLARS ($400.00), representing twice the amount of the current fee for biennial registration to the secretary-treasurer, having submitted the statement required pursuant to NRS 630.197, and having been found to be in good standing and qualified under the provisions of Chapter 630 of the Nevada Revised Statutes, it is hereby ORDERED:

THE ABOVE-NAMED PHYSICIAN'S INACTIVE STATUS IN THE STATE OF NEVADA IS REINSTATED

DATED this 17th day of July 2003.

STATE BOARD OF MEDICAL EXAMINERS ORGANIZED MARCH 1899 NEVADA

Cheryl Hug-English MD

CHERYL A. HUG-ENGLISH, President
Nevada State Board of Medical Examiners

CERTIFICATE OF MAILING

I certify that I am an employee of the Nevada State Board of Medical Examiners, and that on this day I deposited for certified mailing with return receipt at Reno, Nevada, a true copy of the within ORDER REINSTATING INACTIVE STATUS, addressed to:

Carolyn L. Cornelius, M.D.
1930 Dresden Ct.
Henderson, NV 89014

DATED this 17th day of July, 2003

Employee

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

Date Received by Board
~~JUN 0 3 2001~~ JUN 15 2001
(For Board Use Only)

License No. 7147
File No.

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

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

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

file no: [redacted] candidate no: 3654[redacted]

Carolyn L CORNELIUS M.D.
4275 S. Burnham Ave.
Suite # 260
Las Vegas NV 89119

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

PLEASE NOTE:

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

PLEASE TYPE OR PRINT LEGIBLY

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

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

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

Name_____
Street N/A
City_____ County_____ State_____ Zip_____
Phone Number_____ Fax Number_____

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

Name_____
Street N/A
City_____ County_____ State_____ Zip_____
Phone Number_____

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

University of California, Irvine - California College of Medicine 6-15-91
Medical School Name and Location Date of Graduation (Month / Day / Year)

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

SCOPE OF PRACTICE
SPECIALTY CODES

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

	Code
Primary Specialty	48
Secondary Specialty	
Tertiary Specialty	

//

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CHILD SUPPORT STATEMENT

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

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

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

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

CONTINUING MEDICAL EDUCATION (CME) STATEMENT

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

__✓__ (a) I completed a minimum of 40 hours of AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics and 20 hours of which were in my scope of practice or specialty, during the past biennial period of July 1, 1999 through June 30, 2001;

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

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

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

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

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

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

BY SIGNING ON THE SIGNATURE LINE BELOW:

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

6·4·01 _____

Date Signature **(SIGNATURE STAMP UNACCEPTABLE)**

PHYSICIAN
APPLICATION FOR RENEWAL REGISTRATION
NEVADA STATE BOARD OF
MEDICAL EXAMINERS

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

Date Received by Bo[illegible]
JUN 17 1999
(Board Use Only)

License No. 7147

File No. [illegible]

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

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

Carolyn L. Cornelius, M.D.
98 E Lake Mead Dr #307
Henderson NV 89015-5540

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

PLEASE NOTE

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

PLEASE TYPE OR PRINT LEGIBLY

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

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

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

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

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

Name NO CHANGE

Street _____

City _____ County _____ State _____ Zip _____

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

Name _____

Street NO CHANGE

City _____ County _____ State _____ Zip _____

7. Are you currently active in medic?

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

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

SCOPE OF PRACTICE SPECIALTY CODES

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

	Code	Percent of Time	Board Certified (Indicate Yes/No)
Primary	38	100	
Secondary			
Tertiary			

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

	Date of Initial Certification (Mo./Yr.)	Date of Last Certification (Mo./Yr.)
Board_____		
Subboard_____		
Board_____		
Subboard_____		

9. Form of employment is 1003. (Use one of the following codes.)

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

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

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

1012 Other (specify)_____

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

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

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

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

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

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

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

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

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

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

4. Have you failed to initiate the performance of public service within one year after the date the public service is required to begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local government for your medical education? ____Yes __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? __X__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(s), or permission to take an examination to practice medicine or any other healing art(s) in any state, country or U.S. territory? ____Yes __X__No

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

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

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

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

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

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

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

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

PLEASE CHECK ONE OF THE FOLLOWING:

__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 public agency enforcing the order for the repayment of the amount owed pursuant to the order.

Signature _____
(SIGNATURE STAMP UNACCEPTABLE)

PLEASE CHECK ONE OF THE FOLLOWING:

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

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

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

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

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

IMPORTANT

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

Signature _____
(SIGNATURE STAMP UNACCEPTABLE)

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

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

702 566-8070 — Business Telephone #
6/7/99 — Date
_____ — Signature **(SIGNATURE STAMP UNACCEPTABLE)**

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

Date received by Board
MAY 19 1997
(Board Use Only)

License No._____

File No._____

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

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

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

Name Change

Carolyn ~~Jefferson~~-Cornelius, MD
1934 E Sahara Ave
Las Vegas, NV 89104

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

INSTRUCTIONS - TYPE OR PRINT LEGIBLY

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

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

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

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

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

Name_____

Street_____

City_____ County_____ State_____ Zip_____

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

Name_____

Street_____

City_____ County_____ State_____ Zip_____

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

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

ALL FEES ARE NON-REFUNDABLE

DO NOT SEND CASH THROUGH THE MAIL

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

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

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

SPECIALTY CODE:

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

	Code	Percent of Time	Board Certified (Indicate Yes/No)
Primary	38	100 %	NO
Secondary			
Tertiary			

PLEASE INDICATE AMERICAN BOARD OF MEDICAL SPECIALTIES BOARD CERTIFICATION:

	Date of Initial Certification	Date of Last Certification
Board_____	(Mo./Yr.)	(Mo./Yr.)
Subboard_____	(Mo./Yr.)	(Mo./Yr.)

3. Form of employment is 1004 (Use the following codes)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

If more space is needed, attach separate sheet.

PLEASE CHECK ONE OF THE FOLLOWING:

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

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

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

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

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

Signature _____

Signature stamp unacceptable

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

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

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

702-369-5758	4-16-97		
Business Telephone #	Date		Signature (SIGNATURE STAMP UNACCEPTABLE)

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

Date Received by State Board
JUN 30 1995

License No. _____
File No. _____
This shaded section for BOARD USE ONLY

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

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

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

Carolyn Jefferson-Cornelius, MD
2040 W Charleston #200
Las Vegas NV 89102-0000

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

FINAL NOTICE

INSTRUCTIONS - TYPE OR PRINT LEGIBLY

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

Name _____

Street _____

City _____ County _____ State _____ Zip Code _____

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

Name _____

Street _____

City _____ County _____ State _____ Zip Code _____

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

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

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

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

PLEASE PROVIDE ALL INFORMATION AS REQUESTED.

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

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

SPECIALTY CODE:

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

	Code	Percent of Time	Board Certified (Indicate Yes/No)
Primary	38	100%	NO
Secondary			
Tertiary			

PLEASE INDICATE AMERICAN BOARD OF MEDICAL SPECIALTIES BOARD CERTIFICATION:

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

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

4. Form of employment is 1010 . (Use the following codes.)

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

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

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

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

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

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

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

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

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

1. Have you failed to repay, in accordance with the terms of the loan, any direct loan or loan which is insured or guaranteed by the Federal Government or a state or local government which you received to finance all or any part of your medical education? ☐ Yes ☒ No
2. Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? ☐ Yes ☒ No
3. Does your use of chemical substance(s) in any way impair or limit your ability to practice medicine with reasonable skill and safety? ☐ Yes ☒ No
4. Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? ☐ Yes ☒ No
5. Have you been diagnosed as having, or have you been treated for pedophilia, exhibitionism, or voyeurism? ☐ Yes ☒ No
6. Are you currently engaged in the illegal use of controlled dangerous substances? ☐ Yes ☒ No
7. Have you been a defendant in a legal action involving professional liability (malpractice) or had a professional liability claim paid in your behalf or paid such a claim yourself? ☐ Yes ☒ No
8. Have you been investigated for, charged with or convicted of, or pled nolo contendere to a violation of any federal, state or local law relating to the manufacture, distribution, prescribing, or dispensing of controlled substances? ☐ Yes ☒ No
9. Have you been arrested, investigated for, charged with or convicted of, or pled nolo contendere to any offense, misdemeanor or felony in any state, the United States, or a foreign country? ☐ Yes ☒ No
10. Have you previously applied for medical licensure in Nevada (including a residency program)? ☒ Yes ☐ No
11. Have you failed to initiate the performance of public service within one year after the date the public service is required to begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local government for your medical education? ☐ Yes ☒ No
12. Have you been denied a license, permission to practice medicine or any other healing arts, or permission to take an examination to practice medicine or any other healing arts in any state, country or U.S. territory? ☐ Yes ☒ No
13. Have you had a medical license revoked, suspended, limited, or restricted in any state, country or U.S. territory? ☐ Yes ☒ No
14. Have you voluntarily surrendered a license to practice in the healing arts in any state, country or U.S. territory? ☐ Yes ☒ No
15. Have you been denied membership or expelled from a medical society or other professional medical organization? ☐ Yes ☒ No
16. List all hospitals where you have had staff privileges denied, suspended, limited, revoked or not renewed by the hospital. List any and all resignations from any medical staff in lieu of disciplinary or administrative action. (Please Note: Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance.)

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

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

CONTINUING MEDICAL EDUCATION

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

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

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

(b) Be approved by the board; and

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

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

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

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

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

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

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

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

PLEASE CHECK ONE OF THE FOLLOWING:

____ 1. I have earned a minimum of 40 hours approved AMA Category I continuing medical education (CME) for the biennial period July 1, 1993 through June 30, 1995.

____ 2. I was initially licensed in Nevada during the second six months of the biennial period July 1, 1993, through June 30, 1995 and have earned a minimum of 30 hours approved AMA Category I continuing medical education (CME).

____ 3. I was initially licensed in Nevada during the third six months of the biennial period July 1, 1993, through June 30, 1995 and have earned a minimum of 20 hours approved AMA Category I continuing medical education (CME).

____ 4. I was initially licensed in Nevada during the fourth six months of the biennial period July 1, 1993, through June 30, 1995 and have earned a minimum of 10 hours approved AMA Category I continuing medical education (CME).

__✓__ 5. I am exempt from submitting proof of continuing medical education (CME) because I have completed a full year of residency or fellowship training during the biennial period July 1, 1993 through June 30, 1995.

Signature _____ (SIGNATURE STAMP UNACCEPTABLE)

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

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

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

383-2271 (702) 5/1/95 X _____

Business Telephone # Date Signature (SIGNATURE STAMP UNACCEPTABLE)

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

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

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

3. The board shall notify a licensee:

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

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

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

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

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

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

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

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

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

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

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

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

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

630.256 Retired licensees: Duties; requirements for reinstatement.

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

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

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

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

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

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

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

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

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

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

new lic se

APPLICATION FOR REGISTRATION

NEVADA STATE BOARD OF MEDICAL EXAMINERS

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

Date Received by State Board: JUL 01 1994

License No. 7147

File No.

New ☐ Renewal ☐

This shaded section for BOARD USE ONLY

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

RECEIVED
JUN 01 1994
NEVADA STATE BOARD OF MEDICAL EXAMINERS

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

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

CArolyn Jefferson-Cornelius, M.D.
2040 W Charleston #200
Las Vegas, NV 89102

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

INSTRUCTIONS – TYPE OR PRINT LEGIBLY

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

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

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

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

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

Name _____

Street _____

City _____ County _____ State _____ Zip Code _____

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

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

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

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

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

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

SPECIALTY CODE:

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

	Code	Percent of Time	Board Certified (Indicate Yes/No)
Primary	38	100%	NO
Secondary	_____	_____	_____
Tertiary	_____	_____	_____

PLEASE INDICATE AMERICAN BOARD OF MEDICAL SPECIALTIES BOARD CERTIFICATION:

Board _____

Subboard _____

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

4. Form of employment is 1012 . (Use the following codes.)

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

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

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

PLEASE LIST CURRENT HOSPITAL AFFILIATION(S):

University of Southern Nevada Medical Center 1800 W Charleston LV, NV 89102
Name Address

Name Address

Name Address

Name Address

CONTINUING MEDICAL EDUCATION

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

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

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

(b) Be approved by the board; and

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

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

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

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

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

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

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

PLEASE CHECK ONE OF THE FOLLOWING:

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

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

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

Signature _____
(SIGNATURE STAMP UNACCEPTABLE)

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

Date of Birth: ___ ___ 165 (month/day/year) Social Security Number: _____ _____

DEA Number: _____

Medical School:	University of Calif. Irvine School of Medicine	Irvine (City)	California (State)
Internship:	University of Southern Nevada Medical Center	Las Vegas (City)	Nevada (State)
Residency:	University of Southern Nevada Medical Center	Las Vegas (City)	Nevada (State)
		(City)	(State)
		(City)	(State)
Fellowship:		(City)	(State)

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

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

(702) 383-2000 (Business Telephone #) 5/28/94 (Date) X _____ Signature (SIGNATURE STAMP UNACCEPTABLE)

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

STATE OF NEVADA BOARD OF MEDICAL EXAMINERS APPLICATION FOR LICENSURE

PERSONAL INFORMATION:

1. Present Legal Name Jefferson Cornelius, Carolyn Laurice Jefferson
   (Last, First, Middle, Maiden)

   List any other name ever used Carolyn Laurice Jefferson

2. Business and/or Mailing Address 2040 West Charleston Blvd Las Vegas NV 89102
   (Street, City, State, Zip)

3. Home Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

   RECEIVED APR 6 1994 NEVADA STATE BOARD OF MEDICAL EXAMINERS

4. Telephone (702) 383-2271 (Office) ( ) _____ (Home)
   (area code) (area code)

5. Date of Birth 65 Place of Birth California
   (city, state, country)

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

7. Age _____ Height _____ Weight _____ Color of Eyes _____

   Color of Hair _____ Social Security # _____

8. Have you failed to repay, in accordance with the terms of the loan, any direct loan or loan which is insured or guaranteed by the Federal Government or a state or local government which you received to finance all or any part of your medical education? ___ Yes ✓ No

9. Are you now in psychiatric or psychologic treatment or in treatment for a mental illness, drug addiction, or acute or chronic substance, drug or alcohol abuse? ___ Yes ✓ No

10. Do you currently take any prescription drugs for therapeutic purposes? ___ Yes ✓ No

11. 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

12. Have you ever been investigated for, charged or convicted of, or pled nolo contendere to a violation of any federal, state or local law relating to the manufacture, distribution, prescribing, or dispensing of controlled substances?
    ___ Yes ✓ No

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

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

15. 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

EDUCATION:

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

Name	Address	Dates of Attendance From (Mo./Yr.)	To (Mo./Yr.)
Los Angeles Southwest Jr. College	1600 W. Imperial Hwy Los Angeles Ca 90047	9/82	8/83
University of Calif - Davis	Davis, California 95616	9/83	6/87

17. 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.)
University of California - Irvine School of Medicine	Irvine, Ca		9/87	6/91

RECEIVED
APR 25 1994
MEDICAL BOARD

18. Doctor of Medicine Degree granted by:

Medical School Name	Medical School Address	Exact Date of Issuance
University of California Irvine School of Medicine	Irvine Ca	6/15/91

GRADUATE MEDICAL EDUCATION:

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

Hospital/ Institution	Mailing Address	Type of Service or Specialty	Dates of Attendance From (Mo./Yr.)	To (Mo./Yr.)
~~UCI~~ University Medical Center	2040 W Chapman Suite 200	OB/GYN	7/91	present

APR 6 1994
MEDICAL STAFF

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

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

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

22. List any other postgraduate medical education not accounted for in questions 18 and 19 above.

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

LICENSING EXAMINATIONS:

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

a. NATIONAL BOARDS:

Location	Part Taken	Date	Result (Scores)
Irvine - California	I	9-89	405
Irvine - California	II	9-90	305
Long Beach - California	III	5-92	330

b. FLEX (Federation Licensing Examination):

Location	Part Taken	Date	Result (Scores)
N/A			

c. State Written Examination:

Location	Part Taken	Date	Result (Scores)
N/A			

d. USMLE (United States Medical Licensing Examination):

Location	Part Taken	Date	Result (Scores)
N/A			

e. SPEX (Special Purpose Examination):

Location	Part Taken	Date	Result (Scores)
N/A			

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

Location	Part Taken	Date	Result (Scores)
N/A			

LIST ECFMG # _____

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

Location	Part Taken	Date	Result (Scores)
N/A			

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

AREA OF SPECIALTY:

25. State your area of specialty: Obstetrics and Gynecology

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

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

MEDICAL PRACTICE HISTORY:

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

City/State	From (Mo./Yr.)	To (Mo./Yr.)
Las Vegas / Nevada	7/91	present

28. 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 or residency affiliation.

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

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

State or Country	License #	Date of Issuance	Dates of Practice From (Mo./Yr.)	To (Mo./Yr.)
Nevada	LL636	7-1-1991	7-1	-present

30. Have any disciplinary or administrative actions ever been taken against any healing arts license which you now hold or have ever held? Include any disciplinary and administrative actions by the U.S. Military, U.S. Public Health Service or other U.S. federal government entity. ___ Yes ✓ No

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

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

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

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

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

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

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

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

RECEIVED
APR 6 1994
NEVADA STATE BOARD OF

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

Signature of Applicant

Subscribed and sworn to before me this 24th day of March 1994

JACQUELINE M. ABLEMAN
(Notary Seal)
Notary Public - State of Nevada
Appointment Recorded in Clark County
My Appointment Expires April 7, 1994

Notary Public for State of Nevada

My Commission Expires April 7, 1994

Residing at Las Vegas NV 89124

Jacqueline M. Ableman
Signature of Notary

Attach a finished photograph of passport quality of your

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

Signature of Applicant

4-15-94
Date

APPLICANT
Do Not Write In This Box
For Use At Time of Oral Examination

I verify that all statements made on my application for licensure in the state of Nevada received on _____ 4/25/94 , are still true and valid on _____ 6/11/94 , the date of my oral examination.

Signed: _____

Witness: Kathy K. Diamond

STATE OF NEVADA
BOARD OF MEDICAL EXAMINERS
APPLICATION FOR LICENSURE

1. Name Jefferson-Cornelius (Last), Carolyn (First), Lauriee (Middle), Jefferson (Maiden)

If you have ever used another name, please indicate Carolyn Laurice Jefferson

2. Business and/or Mailing Address 4012 Verano Place (Street #) Irvine (City) Calif. (State) 92715 (Zip)

3. Home Address _____ (Street #) _____ (City) _____ (State) _____ (Zip)

4. Telephone Number (714) 856-0945 (Office) ( ) _____ (Home)

5. Date of Birth -65 Place of Birth , California

6. Citizenship: US Citizen YES Alien Registration # _____ Other _____
Submit a certified copy of birth certificate, Certificate of Naturalization and/or Alien Registration Card with this application.

7. Have you ever previously applied for medical licensure in Nevada? ☐ Yes ☒ No

If YES, give date of previous application _____

8. List name and address of all colleges or universities attended other than schools where professional medical instruction was received. Have each school submit an official transcript directly to the board.

Name	Address	Dates of Attendance	
		From (Mo/Yr)	To (Mo/Yr)
Los Angeles Southwest College	1600 W Imperial Hwy, L.A. Calif 90047	2/82 - 6/83	
UC Davis	UC Davis, Davis, Calif. 95616	9/83	6/87

9. 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)
UCI-ccm	UCI - Irvine, Ca 92715	UCI-ccm	9/87	6/91

10. Doctor of Medicine Degree granted by:

Name of Medical School	Address of Medical School	Exact Date of Issuance
UCI-ccm		6/14/91

11. Have you taken any part of the National Boards? ☒ Yes ☐ No If YES, list location, parts taken, date and score(s). Have certificate of scores submitted from National Boards to the board.

Location	Part Taken	Date	Result (Score(s))
UCI-ccm	NBME I	9-89	405
UCI-ccm	NBME II	9-90	305

MAR 20 1991

12. Have you taken SPEX or any part of the FLEX? ☐ Yes ☒ No If YES, list location, parts taken, date and score(s). Have certificate of scores submitted from FLEX/SPEX directly to the board.

Location	Part Taken	Date	Result (Score(s))

13. Have you taken any part of ECFMG or FMGEMS? ☐ Yes ☒ No If YES, list part(s) taken, location, date and result(s) of examination. Have certification of examination(s) submitted from the ECFMG directly to the board. List ECFMG # _____

Location	Part Taken	Date	Result (Score(s))

14. Have you received ACGME* approved postgraduate training in the United States or Canada? ☐ Yes ☒ No If YES, fill in the information requested below.
*Accreditation Council on Graduate Medical Education

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

15. Have you completed any ACGME*approved Fellowship programs? ☐ Yes ☒ No If YES, fill in the information requested below.

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

16. List any other postgraduate medical education not accounted for in questions 14 and 15 above.

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

17. Area of Specialty: Obstetrics and Gynecology
18. Are you Board Certified by a Board recognized by the American Board of Medical Specialties? ☐ Yes ☒ No If YES, complete the following:

Specialty Board	Certification #	Dates of:	
		Certification	Recertification

19. Location of medical practice since graduation (Include Military Service). Account for all periods of time.

City/State	From (Mo/Yr)	To (Mo/Yr)
NONE		

20. List below the requested information for **all** hospitals of which you are, or have ever been a Staff Member at any level. If none, please indicate. Do not list internship or residency affiliation.

Hospital	Complete Mailing Address	Date of Appointment	
		From (Mo/Yr)	To (Mo/Yr)
NONE			

21. Have you ever been licensed to practice medicine in any state or country? ☐ Yes ☒ No If YES, complete the following information:

State or Country	License #	Date of Issuance	Dates of Practice in Agency's Jurisdiction	
			From (Mo/Yr)	To (Mo/Yr)

22. Have any disciplinary or administrative actions ever been taken against any healing arts license which you now hold or have ever held? Include any disciplinary and administrative actions by the U.S. Military, U.S. Public Health Service or other U.S. federal government entity. ☐ Yes ☒ No

23. 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 art in any state, country or U.S. territory? ☐ Yes ☒ No

24. Have you ever had a medical license revoked, suspended, or limited in any state, country or U.S. territory? ☐ Yes ☒ No

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

✓ 26. Have you ever failed a state licensure examination, any part of FLEX, any part of National Boards, or any part of ECFMG, FMGEMS or SPEX, even if subsequently passed? ☒ Yes ☐ No

27. Have you ever had staff privileges in a hospital denied, suspended, limited, revoked or not renewed, or have you ever resigned from a medical staff in lieu of disciplinary or administrative action? (PLEASE NOTE: THIS REQUIREMENT DOES NOT INCLUDE SUSPENSIONS OR RESTRICTIONS FOR FAILURE TO COMPLETE HOSPITAL MEDICAL RECORDS) ☐ Yes ☒ No

28. Have you ever been investigated for, charged with, or convicted of unprofessional conduct, professional incompetence, gross or repeated malpractice, or any other violation of a statute, rule or regulation governing the practice of medicine by any medical licensing board or other agency, hospital or medical society? ☐ Yes ☒ No

29. Have you ever been denied membership or expelled from a medical society or other professional medical organization? ☐ Yes ☒ No

30. Have you ever received psychiatric or psychologic treatment? ☐ Yes ☒ No

31. Have you ever undergone treatment for a mental illness, drug addiction, or acute or chronic substance, drug or alcohol abuse? ☐ Yes ☒ No

32. Do you regularly take any prescription drugs for therapeutic purposes? ☐ Yes ☒ No

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

34. Are you now or were you in the past, addicted to controlled substances, including, but not limited to narcotics or alcohol? ☐ Yes ☒ No

35. Have you ever been investigated for, charged or convicted of, or pled nolo contendere to a violation of any federal, state or local law relating to the manufacture, distribution, or dispensing of controlled substances, or to drug addiction? ☐ Yes ☒ No

36. Have you ever been arrested, investigated for, charged or convicted of, or pled nolo contendere to any offense, misdemeanor or felony in any state, the United States, or a foreign country? (Except violations of traffic laws resulting in fines of $75 or less.) ☐ Yes ☒ No

NOTE: You are required to list any conviction that has been set aside and dismissed under any other provision of law.

If you answered YES to any of questions 22 through 36 please explain the circumstances and disposition on a separate sheet(s) and attach to this application.

37. If granted a license, do you intend to practice in Nevada? ☒ Yes ☐ No

If YES: Location Affiliated Hosp. Residency Training Program UN School of Medicine Date July 1, 1991
Department of OB/GYN

38. Personal Information

Age ____ Height ____ Weight ____ Color of Eyes. ____ Race ____

Color of Hair Brown Social Security Numbe ____

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

OFFICIAL SEAL
DENNIS WM. GOOD
Notary Public-California
ORANGE COUNTY
My Commission Expires
July 15, 1994

(Notary Seal)

Signature of Applicant

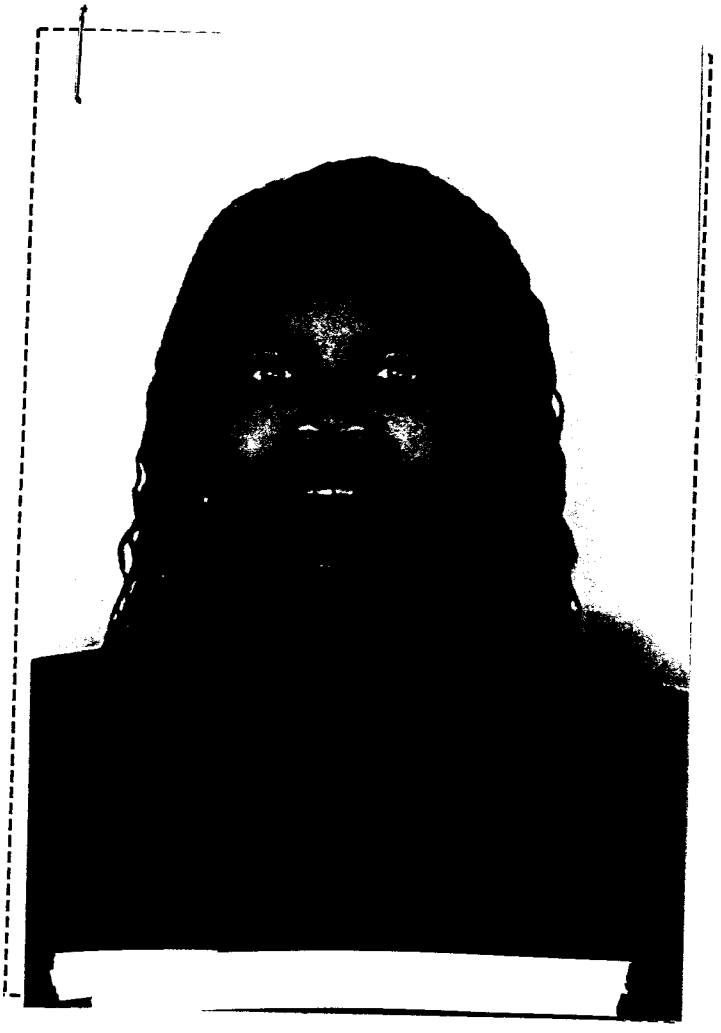
Subscribed and sworn to before me this 6th

day of May, 1991

Notary Public for State of California

My Commission Expires July 15, 1994

Residing at Irvine California



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

Signature of Applicant

May 6, 1991
Date

NOTE: All items in this application are mandatory; none are voluntary. Failure to provide any of the requested information will result in the application not being processed or being rejected as incomplete. The information provided will be used for identification and to determine qualification for licensure per Nevada Revised Statute 630 which authorizes the collection of this information.

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

Signature of Applicant

Date

NOTE: All items in this application are mandatory; none are voluntary. Failure to provide any of the requested information will result in the application not being processed or being rejected as incomplete. The information provided will be used for identification and to determine qualification for licensure per Nevada Revised Statute 630 which authorizes the collection of this information.