Nevada State Board of Medical Examiners

Renewal Responses Report

Thursday, September 18, 2014

License Number	Licensee	License Type
7617	Samuel Louis AUERBACH	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 answer "Yes" during the time period July 1, 2005 - June 30, 2007 email to elicensensbme@medboard.nv.gov	N	06/01/2007
If you have a medical condition which in any way impairs or limits your ability to practice medicine, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? If you answer "Yes" during the time period July 1, 2005 - June 30, 2007 email to elicensensbme@medboard.nv.gov	N	06/01/2007
If you use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety? If you answer "Yes" during the time period July 1, 2005 - June 30, 2007 email to elicensensbme@medboard.nv.gov	N	06/01/2007

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	06/01/2007
Have you been named as a defendant, or been requested to respond as a defendant, to a legal action involving professional liability (malpractice), or had a professional liability claim paid on your behalf, or paid such a claim yourself?	Y	06/01/2007
Have you been investigated for, arrested for, charged with, convicted of, or plead guilty or nolo contendere to any offense or violation of any federal (including the U.S. Military), state or local law, including any foreign country, which is in a foreign jurisdiction equivalent to, a misdemeanor, gross misdemeanor, court martial, or felony, excluding any minor traffic offense (driving or being in control of a motor vehicle while under the influence of any chemical substance and/or including alcohol, is not considered a minor traffic offense), or for any offense which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? Please note that you MUST disclose ANY investigation or arrest, even if the ultimate disposition was dismissal or expungement. If you answer "Yes" during the time period July 1, 2005 - June 30, 2007 email to	N	06/01/2007
Have you been denied a license, permission to practice medicine or any other healing art, or permission to take an examination to practice medicine or any other healing art in any state, country or U.S. territory? If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov.	N	06/01/2007

Have you had a medical license or license to practice any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory? If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov.	N	06/01/2007
Have you voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory by the direct request of a medical board? If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov.	N	06/01/2007
Have you been denied membership or expelled from a medical society or other professional medical organization? If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov.	N	06/01/2007
Have you been: a) notified that you were under investigation for; b) investigated for; c) charged with; or d) convicted of any violation of a statute, rule or regulation governing your practice as a physician by any medical licensing board, hospital, medical society, governmental entity or agency other than the Nevada State Board of Medical Examiners? If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov.	N	06/01/2007

Have you surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov.	N	06/01/2007
Have you had hospital staff privileges denied, suspended, limited, revoked or not renewed by the hospital? *If you have answered "Yes" you will be required to submit a list of any and all resignations from any medical staff in lieu of disciplinary or administrative action via email to elicensensbme@medboard.nv.gov (Please Note: Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance.)* If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov.	N	06/01/2007
Is your license currently contingent upon compliance with the Diversion program also known as the Nevada Health Professionals Assistance Foundation? If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov.	N	06/01/2007
Was your license issued contingent upon maintaining certification by the American Board of Medical Specialties in the specialty of Family Practice, Emergency Medicine or Preventative medicine? If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov.	N	06/01/2007

Are you a foreign medical doctor, who holds a Conditional Resident Alien Card, Employment Authorization Card, or Visa with the Department of Homeland Security, Immigration and Naturalization Services? If "yes" please fax a copy of proof to (775) 688-2551 ATTN:Online License Renewal.	N	06/01/2007
Are you out of compliance with court ordered child support? **If this does not apply to you please answer "no".** If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov.	N	06/01/2007
Do you want to change your scope of practice or specialty? If you answer "Yes" during the time period July 1, 2005 - June 30, 2007 email your request to elicensensbme@medboard.nv.gov	N	06/01/2007
Are you currently supervising a Physician Assistant or an Advanced Practitioner of Nursing? If you answer "Yes" please email a list of names of those you are supervising to elicensensbme@medboard.nv.gov	N	06/01/2007

have completed the required amount of AMA Category 1 CME within the current biennial. (Review CME information online at www.medboard.nv.gov) I understand that I may be included in a random audit following July 1st 2007 renewal. I agree to retain CME's taken between July 1, 2005 and June 30, 2007.	N	06/01/2007
I have actively practiced medicine in Nevada within the past 24 months.	Y	06/01/2007
I hereby request my license to be placed on Inactive status. I will not physically practice in the state of Nevada.	N	06/01/2007
I HEREBY SWEAR OR AFFIRM UNDER THE PENALTIES OF PERJURY THAT I AM IN FULL COMPLIANCE WITH ANY AND ALL OBLIGATIONS, TERMS OR CONDITIONS OF MY NEVADA MEDICAL LICENSE SPECIFIED BY THE BOARD.	Y	06/01/2007

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	06/22/2009
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	06/22/2009
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	06/22/2009
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	06/22/2009
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	06/22/2009
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	06/22/2009
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	06/22/2009
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	06/22/2009
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?	N	06/22/2009

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.

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	06/22/2009

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	06/22/2009

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	06/22/2009

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	06/22/2009
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	06/22/2009
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	06/22/2009
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	06/22/2009
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	06/22/2009
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	06/22/2009
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	06/22/2009

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	06/06/2011
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	06/06/2011
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	06/06/2011
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	06/06/2011
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	06/06/2011

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	06/06/2011

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	06/06/2011

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	06/06/2011

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	06/06/2011

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	06/06/2011

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	06/06/2011
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	06/06/2011
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	06/06/2011
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	06/06/2011
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	06/06/2011
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	06/06/2011
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	06/06/2011
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	06/06/2011
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	06/06/2011

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	05/15/2013
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	05/15/2013
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	05/15/2013
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	05/15/2013

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	05/15/2013
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	05/15/2013
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	05/15/2013
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	05/15/2013

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	05/15/2013
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	05/15/2013
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	05/15/2013
Have you surrendered your state or federal controlled substance registration or had it revoked or restricted in any way?	N	05/15/2013

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	05/15/2013
Have you actively practiced medicine in Nevada within the past 12 months?	Y	05/15/2013
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	05/15/2013
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	05/15/2013

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	05/15/2013
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	05/15/2013
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	05/15/2013

LICENSE RENEWAL

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 → FED EX

Date Received by Board
JUN 15 2005
(For Board Use Only)

License No. 7617
File No. 11/72/95

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

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

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

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

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

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

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

PLEASE NOTE:

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

PLEASE TYPE OR PRINT LEGIBLY

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

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

Name SAMUEL LOUIS AUERBACH MD
Street 1162 BIRDNEST COURT
City LAS VEGAS County CLARK State NV Zip 89123
Phone Number 805-953-5848 Fax Number -

3. **IF YOU HAVE RETIRED OR MOVED YOUR PRACTICE,** indicate the location of patient [illegible]

Name SAMUEL LOUIS AUERBACH MD

Street _____

City _____ County _____ State _____ Zip _____

Phone Number _____

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

SCOPES OF PRACTICE CODES

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

Primary Scope of Practice Code 26

Secondary Scope of Practice Code 56

PLEASE INDICATE AMERICAN BOARD OF MEDICAL SPECIALTIES BOARD CERTIFICATION & RECERTIFICATION

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

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 other than the Nevada State Board of Medical Examiners? ____Yes ✓ No

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

_____Yes ✓ No

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

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

CHILD SUPPORT STATEMENT

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

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

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

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

CONTINUING MEDICAL EDUCATION (CME) STATEMENT

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

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

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

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

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

_____ (e) I am exempt from submitting proof of completion of continuing medical education (CME) because I have completed a full year of residency or fellowship training during the biennial period July 1, 2003 through June 30, 2005, but must submit proof of completion of 4 hours of AMA Category 1 continuing medical education in acts of terrorism.

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

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

BY SIGNING ON THE SIGNATURE LINE BELOW:

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

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

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

6-11-05

Date

Signature (SIGNATURE STAMP UNACCEPTABLE)

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

Date Received by Board
JUN 16 2003
(For Board Use Only)

License No. 7617
File No.

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

✓	ACTIVE STATUS	$400.00
	INACTIVE STATUS	$200.00.....(*INACTIVE STATUS DOES NOT PERMIT THE PRACTICE OF MEDICINE INCLUDING THE WRITING OF PRESCRIPTIONS IN NEVADA*)
	I REQUEST NON-RENEWAL OF MY LICENSE* (*IF YOU ARE REQUESTING NON-RENEWAL, SEE BELOW)	

File no: [redacted] License no: 7617

Samuel L AUERBACH M.D.
18615 Burbank Blvd #214
Tarzana CA 91356

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 SAMUEL LOUIS AUERBACH
Street 4415 WEST FLAMINGO
City LAS VEGAS County CLARK State NV Zip 89103
Phone Number 702-220-7700 Fax Number 702-220-7567

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

Name _____
Street _____
City _____ County _____ State _____ Zip _____
Phone Number _____

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

SCOPES OF PRACTICE CODES

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

	Code		Code
Primary Scope of Practice	51	**Secondary Scope of Practice**	54

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CHILD SUPPORT STATEMENT

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

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

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

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

CONTINUING MEDICAL EDUCATION (CME) STATEMENT

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

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

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

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

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

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

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

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

BY SIGNING ON THE SIGNATURE LINE BELOW:

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

6-3-03 _____

Date Signature **(SIGNATURE STAMP UNACCEPTABLE)**

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 27 2001
(For Board Use Only)

License No. 7617

File No.

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

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

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

11/22/95

file no. [redacted] candidate no. 5470

Samuel L AUERBACH
18615 Burbank Blvd
214
Tarzana, CA 91356

M.D.

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 N/A

Street

City County State Zip

Phone Number 818-609-9070 Fax Number (NONE)

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

Name N/A

Street

City County State Zip

Phone Number

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

UNIVERSIDAD DEL NORESTE, TAMPICO, TAMPS, MEXICO
Medical School Name and Location

JUNE 06 1980
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		Code		Code
Primary Specialty	48	**Secondary Specialty**	51	**Tertiary Specialty**	23

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.)
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.

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).**

6/25/01

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 Board
JUN 2 5 1999
(Board Use Only)

License No._____

File No._____

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

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

Samuel Louis Auerbach, MD
18615 Burbank Blvd #214
Tarzana CA 91356

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 N/A

Street_____

City_____ County_____ State_____ Zip_____

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

Name N/A

Street_____

City_____ County_____ State_____ Zip_____

7. Are you currently active in medicine?

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

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

SCOPE OF PRACTICE SPECIALTY CODES

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

	Code	Percent of Time	Board Certified (Indicate Yes/No)
Primary	38	20	No
Secondary	20	60	No
Tertiary	26	20	No

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

	Date of Initial Certification	Date of Last Certification
Board N/A	(Mo./Yr.)	(Mo./Yr.)
Subboard	(Mo./Yr.)	(Mo/Yr.)
Board	(Mo./Yr.)	(Mo./Yr.)
Subboard	(Mo./Yr.)	(Mo./Yr.)

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

SELF-EMPLOYED:

(1001) Solo Practice
1002 Partnership or Group Practitioners

SALARIED, EMPLOYED BY:

1003 Individual Practitioner
1004 Partnership or Group of Practitioners
1005 Group Health Plan Facility (such as H.M.O.)
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 ✓ 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(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 ✓ 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 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

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.)

PLEASE CHECK ONE OF THE FOLLOWING:

__✓__ 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:

__✓__ 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____ 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.

818-809-9070 — Business Telephone #
4/18/99 — Date
_____ — Signature **(SIGNATURE STAMP UNACCEPTABLE)**

Date received by Board

APPLICATION FOR RENEWAL REGISTRATION
NEVADA STATE BOARD OF
MEDICAL EXAMINERS

License No._____

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

File No. _____

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

✓	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

Samuel Louis Auerbach, MD
18615 Burbank Blvd #214
Tarzana, CA 91356

Make checks payable to:
EVADA 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. [ ] 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 - Pelvic + Breast	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	45	20-25	NO
Secondary	38	20-25	NO
Tertiary	26	50	NO

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 SELF EMPLOYED (Use the following codes)

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

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 ✓ 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 of chemical substance(s) 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

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 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 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

8. Have you ever had a medical license 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 a 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 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

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

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

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

If more space is needed, attach separate sheet.

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, 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 ✓ 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.

818-609-9070 — Business Telephone #

5/7/97 — Date

_____ — Signature (SIGNATURE STAMP UNACCEPTABLE)

APPLICATION FOR INITIAL REGISTRATION

NEVADA STATE BOARD OF MEDICAL EXAMINERS

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

Date Received by State Board: RECEIVED NOV 22 1995

License No. 7617

File No.

This shaded section for BOARD USE ONLY

Samuel L. Auerbach, M.D.
18615 Burbank Blvd #214
Tarzana, CA 91356

NEVADA STATE BOARD OF MEDICAL EXAMINERS

Issued 11-22-95

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

PLEASE PROVIDE ALL INFORMATION AS REQUESTED.

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

Name _____

Street _____

City _____ County _____ State _____ Zip Code _____

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	40	No
Secondary	45	30	No
Tertiary	26	30	No

PLEASE INDICATE AMERICAN BOARD OF MEDICAL SPECIALTIES BOARD CERTIFICATION:

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

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

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

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

	SELF-EMPLOYED	1006	Other Non-Government Employer (hospital, school, etc.)
1001	Solo Practice	1007	Federal Government (armed services personnel only)
1002	Partnership or Group Practitioners	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 Finishing Fellowship)

FOR ALL YES RESPONSES, PLEASE EXPLAIN ON A SEPARATE SHEET AND RETURN WITH THIS REGISTRATION APPLICATION.

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

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

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

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

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

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

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

1. Have you failed to repay, in accordance with the terms of the loan, any direct loan or loan which is insured or guaranteed by the Federal Government or a state or local government which you received to finance all or any part of your medical education? ☐ Yes ☑ No
2. Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? ☐ Yes ☑ No
3. Does your use of chemical substance(s) in any way impair or limit your ability to practice medicine with reasonable skill and safety? ☐ Yes ☑ No
4. Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? ☐ Yes ☑ No
5. Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? ☐ Yes ☑ No
6. Have you ever been diagnosed as having, or have you ever been treated for pedophilia, exhibitionism, or voyeurism? ☐ Yes ☑ No
7. Are you currently engaged in the illegal use of controlled dangerous substances? ☐ Yes ☑ No
8. Are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? ☐ Yes ☑ No
9. Have you been a defendant in a legal action involving professional liability (malpractice) or had a professional liability claim paid in your behalf or paid such a claim yourself? ☐ Yes ☑ No
10. Have you ever been investigated for, charged with or convicted of, or pled nolo contendere to a violation of any federal, state or local law relating to the manufacture, distribution, prescribing, or dispensing of controlled substances? ☐ Yes ☑ No
11. Have you ever been arrested, investigated for, charged with or convicted of, or pled nolo contendere to any offense, misdemeanor or felony in any state, the United States, or a foreign country? ☐ Yes ☑ No
12. Have you previously applied for medical licensure in Nevada (including a residency program)? ☐ Yes ☑ No
13. Have you failed to initiate the performance of public service within one year after the date the public service is required to begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local government for your medical education? ☐ Yes ☑ No
14. Have you ever been denied a license, permission to practice medicine or any other healing arts, or permission to take an examination to practice medicine or any other healing arts in any state, country or U.S. territory? ☐ Yes ☑ No
15. Have you ever had a medical license revoked, suspended, limited, or restricted in any state, country or U.S. territory? ☐ Yes ☑ No
16. Have you ever voluntarily surrendered a license to practice in the healing arts in any state, country or U.S. territory? ☐ Yes ☑ No
17. Have you ever been denied membership or expelled from a medical society or other professional medical organization? ☐ Yes ☑ No
18. List all hospitals where you have had staff privileges denied, suspended, limited, revoked or not renewed by the hospital. List any and all resignations from any medical staff in lieu of disciplinary or administrative action. (Please Note: Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance.)

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

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

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

818-609-9070 Business Telephone #

11/18/95 Date

X _____ Signature (SIGNATURE STAMP UNACCEPTABLE)

STATE OF NEVADA BOARD OF MEDICAL EXAMINERS APPLICATION FOR LICENSURE

PERSONAL INFORMATION:

1. Present Legal Name AUERBACH (Last) SAMUEL (First) LOUIS (Middle) _____ (Maiden)

   List any other name ever used _____

2. Business and/or Mailing Address 18615 BURBANK BLVD #214 (Street) TARZANA (City) CA (State) 91356 (Zip)

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

4. Telephone (818) 609 9070 (area code / Office) (818) 609 9070 (area code / Home)

5. Date of Birth _____ -55 Place of Birth _____ NY USA (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 39 Height _____ Weight _____ Color of Eyes _____

   Color of Hair _____ _____ Social Security # _____

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

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

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

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

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

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

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

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

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

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

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

12. Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? ___ Yes _✓_ No

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

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

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

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

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

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

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

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

EDUCATION:

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

Name	Address	Dates of Attendance From (Mo./Yr.)	To (Mo./Yr.)
NYU	NYC, NY	9-72	6-76

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

Name	Address	Place Where Instruction Received	Dates of Attendance From (Mo./Yr.)	To (Mo./Yr.)
Universidad del Noreste	PO Box 130	McAllen, Texas	8-76	6-80

23. Doctor of Medicine Degree granted by:

Medical School Name	Medical School Address	Exact Date of Issuance
Universidad del Noreste	Prolongacion Ave Hidalgo Tampico Tamps Mexico	6-6-80

GRADUATE MEDICAL EDUCATION:

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

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

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

Institution	Mailing Address	Type of Fellowship	Dates of Attendance From (Mo./Yr.)	To (Mo./Yr.)
SUNY at Buffalo Millard Fillmore Hosp	3 Gates Circle Bflo NY 14209	Advanced Pelvic Gynecologic Oncology	7-96	to 6-94
The Breast Cent.	14624 Sherman Way 6th Flr Van Nuys, CA 91405	Breast Diseases Benign and Malignant and Surgical Aspects	9-94	to 9-95

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

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

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

LICENSING EXAMINATIONS:

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

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

a. NATIONAL BOARDS:

Location	Part Taken	Date	Result (Scores)

b. FLEX (Federation Licensing Examination):

Location	Part Taken	Date	Result (Scores)
Buffalo NY	Part II	12-90	75
Brooklyn NY	Part I	12-92	75

c. State Written Examination:

Location	Part Taken	Date	Result (Scores)

d. USMLE (United States Medical Licensing Examination):

Location	Part Taken	Date	Result (Scores)

e. SPEX (Special Purpose Examination):

Location	Part Taken	Date	Result (Scores)

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

Location	Part Taken	Date	Result (Scores)
Buffalo, NY	Part I + II	1-83	75

LIST ECFMG # 312-430-2

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

Location	Part Taken	Date	Result (Scores)

AREA OF SPECIALTY:

30. State your area of specialty: Internal Medicine and OB/Gyn – Pelvic Gynecologic Oncology + Breast Diseases

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

Specialty Board	Certification #	Dates of Certification/Recertification

MEDICAL PRACTICE HISTORY:

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

City/State	From (Mo./Yr.)	To (Mo./Yr.)
See attached CV		

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

Hospital	Complete Mailing Address	Dates of Appointment From (Mo./Yr.)	To (Mo./Yr.)
Valley Hospital Medical Ctr	14500 Sherman Circle	7-94	to present

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NEVADA STATE BOARD OF MEDICAL EXAMINERS

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

State or Country	License #	Date of Issuance	Dates of Practice From (Mo./Yr.)	To (Mo./Yr.)
New York	191774	3-23-93	Have been in fellowships	
California	A053310	7-27-94	" " " "	

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

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

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

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

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

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

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

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

I, SAMUEL LOUIS AUERBACH, 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 26th day of July 1995

(Notary Seal)

TED J. BAADER JR.
COMM. #1014519
Notary Public — California
LOS ANGELES COUNTY
My Comm. Expires JAN 20,1998

Notary Public for State of CALIFORNIA.

My Commission Expires 1-20-98.

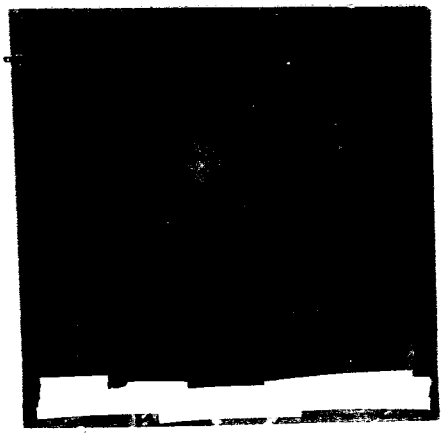
Residing at VAN NUYS, CA.

Signature of Notary

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

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

Proof photos and negatives are not acceptable.



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

Signature of Applicant

7/18/95
Date

CALIFORNIA ALL-PURPOSE ACKNOWLEDGMENT

No. 5907

State of California

County of Los Angeles

On October 20, 1995 (DATE) before me, TED J. BAADER, JR. (NAME, TITLE OF OFFICER - E.G., "JANE DOE, NOTARY PUBLIC"),

personally appeared Samuel Averbach, MD (NAME(S) OF SIGNER(S)),

☐ personally known to me - **OR** - ☒ proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

WITNESS my hand and official seal.

TED J. BAADER JR.
COMM. #1014519
Notary Public — California
LOS ANGELES COUNTY
My Comm. Expires JAN 20,1998

SIGNATURE OF NOTARY

OPTIONAL

Though the data below is not required by law, it may prove valuable to persons relying on the document and could prevent fraudulent reattachment of this form.

CAPACITY CLAIMED BY SIGNER

☐ INDIVIDUAL
☐ CORPORATE OFFICER

_____
TITLE(S)

☐ PARTNER(S) ☐ LIMITED ☐ GENERAL
☐ ATTORNEY-IN-FACT
☐ TRUSTEE(S)
☐ GUARDIAN/CONSERVATOR
☐ OTHER: _____

SIGNER IS REPRESENTING:
NAME OF PERSON(S) OR ENTITY(IES)

DESCRIPTION OF ATTACHED DOCUMENT

_____
TITLE OR TYPE OF DOCUMENT

_____
NUMBER OF PAGES

_____
DATE OF DOCUMENT

_____
SIGNER(S) OTHER THAN NAMED ABOVE

NOTICE

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AUG 14 1995
NEVADA STATE BOARD OF MEDICAL EXAMINERS

FAILURE TO RETURN THIS FORM CAN RESULT IN THE DELAY OF YOUR APPLICATION FOR LICENSURE

1. Have you taken Part III of the examination given by the National Board of Medical Examiners? Yes ___ No ✓
   If answer is yes, indicate date taken. _____

2. Have you taken the Special Purpose Examination (SPEX)? Yes ___ No ✓
   If answer is yes, indicate date taken. _____

3. Have you taken Component II of the Federation Licensing Examination (FLEX)? Yes ✓ No ___
   If answer is yes, indicate date taken. 12-92 Comp I
   12-90 Comp II

4. Have you taken Step III of the United States Medical Licensing Examination (USMLE)? Yes ___ No ✓
   If answer is yes, indicate date taken. _____

5. Have you received certification by a specialty board of the American Board of Medical Specialties? Yes ___ No ✓
   If answer is yes, indicate date of certification. _____

IF YOU HAVE NOT TAKEN ANY OF THESE EXAMINATIONS WITHIN TEN YEARS OF THE DATE YOUR APPLICATION IS RECEIVED BY THE BOARD, YOU WILL NEED TO SIT FOR THE SPECIAL PURPOSE EXAMINATION (SPEX) IN ORDER TO BE ELIGIBLE FOR MEDICAL LICENSURE IN THE STATE OF NEVADA.

_____
Signature of Applicant

6/20/95
Date