Nevada State Board of Medical Examiners

Renewal Responses Report

Thursday, September 18, 2014



License Num 7617	ber Licensee License Ty Samuel Louis AUERBACH Medical Doc		
Question		Answer	Date
medicine with re	medical condition which in any way impairs or limits your ability to peasonable skill and safety? Yes" during the time period July 1, 2005 - June 30, 2007 email to @medboard.nv.gov	ractice N	06/01/2007
medicine, is the practice, the se If you answer "	edical condition which in any way impairs or limits your ability to pra at impairment or limitation reduced or ameliorated because of the fi tting, or the manner in which you have chosen to practice? Yes" during the time period July 1, 2005 - June 30, 2007 email to @medboard.nv.gov	actice N eld of	06/01/2007
medicine with I If you answer "	nical substances, does your use in any way impair or limit your abili reasonable skill and safety? Yes" during the time period July 1, 2005 - June 30, 2007 email to r@medboard.nv.gov	ity to practice N	06/01/2007

NSBME Renewal Responses Report		9/18/2014	
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

9/18/2014 **NSBME** Renewal Responses Report Have you had a medical license or license to practice any other healing art revoked, suspended. Ν 06/01/2007 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. Have you voluntarily surrendered a license to practice medicine or any other healing art in any Ν 06/01/2007 state, country or U.S. territory by the direct request of a medical board? If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov. Have you been denied membership or expelled from a medical society or other professional Ν 06/01/2007 medical organization? If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov. Ν Have you been: 06/01/2007 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.

NSBME Renewal Responses Report		9/18/2014	
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	06/0	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	06/0	01/2007
Is your license <u>currently</u> 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	06/0	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	06/0	01/2007

NSBME Renewal Responses Report		9/18/2014	
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	0	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	0	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	0	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	0	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) 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.	9/18/201 N	4 06/01/2007
I have <u>actively</u> 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

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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.

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.

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.

NSBME Renewal Responses Report f 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	9/18/2014	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.			

9/18/2014 **NSBME** Renewal Responses Report Have you been arrested, investigated for, charged with, convicted of, or pled guilty or nolo Ν 06/22/2009 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. 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 Ν 06/22/2009 permission to take an examination to practice medicine or any other healing art in any state, country or U.S. territory? 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

NSBME Renewal Responses Report		9/18/2014	
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.			

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

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

9/18/2014 **NSBME** Renewal Responses Report Are you out of compliance with court ordered child support? If this does not apply to you, Ν 06/22/2009 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. 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 Ν 06/22/2009 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. 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.

NSBME Renewal Responses Report		9/18/2014	
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

NSBME Renewal Responses Report		9/18/2014	
Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? f 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 pox.			
f 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

NSBME Renewal Responses Report	9/18/201	4
f you use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety? f 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

directly below this question.

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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

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.

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.

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

NSBME Renewal Responses Report		9/18/2014	
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	N		06/06/2011
other professional medical organization (including the ABMS)?			00,00,20
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			

NSBME Renewal Responses Report	9/18	/2014
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	06/06/201
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	06/06/201
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		

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06/06/2011

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.

(<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.)

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.

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.

06/06/2011

NSBME Renewal Responses Report	9.	/18/2014	
I hereby request my license to be placed on Inactive status, which means I will <u>not</u> 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 <u>AND</u> choose the Inactive status in the dropdown box located at the end of the questions.	N	C	06/06/201 ²
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		06/06/201
Explanation 16: For the above question if your answer is "YES", please type your new scope of practice or specialty in this text box.			

NSBME Renewal Responses Report		9/18/2014	
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

	9/18/2014	
N		05/15/2013
	N	N N

NSBME Renewal Responses Report		9/18/2014	
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	05/15/20)13
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	05/15/20)13
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	05/15/20)13
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	05/15/20	013

NSBME Renewal Responses Report	9/18/201	14
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

NSBME Renewal Responses Report	9/18/2014	
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 <u>not</u> 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 <u>AND</u> 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

NSBME Renewal Responses Report		9/18/2014	
Are you out of compliance with court ordered child support? If this does not apply to you, please answer "no".	N		05/15/2013
If "Yes" during the time period July 1, 2011 - June 30, 2013 type an explanation in the textbox directly below this question.			
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

LILENSE ICEPENTE	Date Received by Board	761
PHYSICIAN APPLICATION FOR REGISTRATION RENEWAL APPLICATION FOR REGISTRATION REPROPERTURE 2007	JUN 1 5 2005	License No
	20031	File No
	(For Board Use Only)	11/20/9
10/5 - Day 7039 Reno Nevada 09010 11010 (170)		11/2/15
st Office Box 7238 Reno, Nevada 89510 Phone (773) 000-2001 vsical Address: 1105 Terminal Way, Suite 301 Reno, Nevada 89502 31 ereby apply for renewal of biennial registration and enclose the	ne appropriate fee(s) as indica	ted below:
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(*IF YOU ARE REQUESTING NON-RENEWAL, SEE BELOW)		
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I hereby represent that I am the person named in this AP	PLICATION FOR REGISTRA	TION RENEWAL OF license to
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oractice medicine in the state of Nevada. By signing on the signature line below, I am requesting	that my license to practice	medicine in Nevada NO1 De
By signing on the signature line below, I am requesting enewed by the Nevada State Board of Medical Examiners	s. I will return this signed fo	orm to the Board office.
enewed by the Nevaua State Bould of Instantia		
Signature (SIGNATURE STA	AMP LINACCEPTABLE)	
Date Signature (SIGNATURE STA	AMI OTAGOLI IIII	
PLEASE NOTE: YOUR CURRENT M.D. LICENSE EXPIRES ON JUNE 30, 200	COMPLETED APPLICATION	I FOR REGISTRATION
YOUR CURRENT M.D. LICENSE EXPIRES ON JUNE 30, 200	E DV 111 V 4 2005 AT 5:00 P.N	I. ARE AUTOMATICALLY
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ANSWERED "YES." ALL INFORMATION YOU PROVIDE ON THIS APPLICATION	FOR REGISTRATION RENEWA	AL FORM IS PUBLIC
INFORMATION.		
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PLEASE TYPE OR 1. Active status registration renewal requires the submission renewal requires of CME in	PRINT LEGIBLE	urs of AMA Category 1 continuing
1. Active status registration renewal requires the submission medical education (CME), which includes 2 hours of CME in	of proof of completion of 44 no	f CMF in your scope of practice of
medical education (CME), which includes 2 hours of CME in	Addition	ally nursuant to Nevada Revise
appointly completed during the period July 1, 2000 times	g	a the medical consequences of a
Statutes (NRS) 63(1753(Z)(D), all applicant musicomplete		wide at least & hours of instructiv
at of terrorism that involves the use of a weapon of mass des	struction. "The course must pro	weepons of mass destruction: (
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that includes instruction in the following subjects: (1) An over Personal protective equipment required for acts of terrorism; (3) Common symptoms and me	emous of freatment associates at
Personal protective equipment required for acts of terrorism; (exposure to, or injuries caused by, chemical, biological, respectively).	adioactive and nuclear agents	5; (4) Syndronic surveinding 2:
exposure to, or injuries caused by, chemical, biological, reporting procedures for acts of terrorism that involve biologic	al agents; and (5) An overview	of the information available on, an
		npieted Application for Negistration
Renewal form. (See last page of this form for CME statement	ent.)	
Renewal form. (See last page of this remains		dy indicate the change in the spa
If your name and/or address has changed from that printe provided below. Also, please indicate your current telephone provided below.	d on the label on this form, clea	ote: a notarized or certified copy
provided below. Also, please indicate your current telephon	e and fax numbers. [Flease in	st he included.1
provided below. Also, please indicate your current telephone the document authorizing your name change (marriage lice	inse, divorce decree, etc.) ma	at be molecular.
Name		
Street 1162 BIRDNEST COURT	ARK State N	V Zip 89123
	HICK State	
Phone Number 805-953-5848 Fax	Number	

YOU HAVE RETIRED OR M	STUD	MA	erbach_	עוון				
eSRMUEL L	20000	_1,0						
et				State				
ne Number_ ndicate below your primary	County							
Nbor				nation using the foll	lowin	ig codes:		
ne Number	and seco	idary	scopes of pr	actice daming the same				
ndicate below your party		eco!	DES OF PRAC	CTICE CODES				
		300	200		06	PEDIATRIC, L	JROLOGY	
		44 N	UROLOGY	**************************************				TION
ADDICTION MEDICINE		45 NI	=URO-OPHTHAL	MOLOGY	00	DHYSICAL ME	EDICINE/REHABILITA	, HON
ADOLESCENT MEDICINE AEROSPACE MEDICINE		AC N	=I IROPA I HULU'	Gi	89	PREVENTIVE	MEDICINE	
AEROSPACE MEDIOINE		47 N	EURORADIOLO(J1	90	PSYCHIATRY	(N VCIC	
ALLERGY ALLERGY/IMMUNOLOGY		48 N	EUROTOLOGY	NAL MEDICINE	91	PSYCHOANA	TIC MEDICINE	
AMBULATORY MEDICINE		49 N	UCLEAR MEDIC	INE	92	PUBLIC HEA	LTH	
ANESTHESIOLOGY		51 N	UTRITION		0.4	DULMONARY	Y DISEASES	
BI OODBANKING				NEGOLOCY	95	OCCUPATIO	NAL MEDICINE	
BRONCO-ESOPHAGOLOGY	6	E2 (BOTFTRICS/GY	NECULUGI	06		•	
CARDIOVASCULAR DISEASES CATSCAN/ULTRASOUND	-	54 (CCUPA HONAL	MEDICINE	0.7		DIAGNOSTIC	
- ALTERNACION		55 (NCOLOGY	NECOLOGICAL	08	RADIOLOGY	(INTERVENTIONAL	
A CHILD BSYCHIATRY		56 (NCOLOGY, HE	MATOLOGY	99	RADIOLOGY	Y, THERAPEUTIC	
4 CLINICAL PHARMACOLOGY		EQ (NICOLOGY, RAI	DIATION	100	0 KADIOLOGI	Y, VASCULAR	
5 CRITICAL CARE		50 (ONCOLOGY, SUI	RGICAL	10	2 RHEUMATO	LOGY	
6 DERMATOLOGY		60 (SPHTHALMOLO	GY	10	13 RHINOLOG	Y	
7 DERMATOPATHOLOGY		61	OTOLARYNGOL	OGY	10	14 SLEEP DISC	ORDERS	
8 EMERGENCY MEDICINE 19 ENDOCRINOLOGY		62	OTOLOGY	ENT	10	15 SPORTS ME	EDICINE	
		63	PAIN MANAGEM	EN	10	6 SURGERY,	ABDOMINAL	
24 FORENSIC MEDICINE		64	PATHOLOGY PATHOLOGY, A	NATOMIC	10)7 SURGERY,	CARDIOTHORACIC	
22 GASTROENTEROLOGY		cc	DATHOLOGY, C	LINICAL	10)8 SURGERY,	CARDIOVASCULAR COLON/RECTAL	
22 CENERAL PRACTICE		67	PATHOLOGY, F	ORENSIC	10	J9 SURGERT,	CRANIOFACIAL	
24 GERIATRIC PSYCHIATRY		~~	DEDIATRIC ALL	ERGI	11	11 SURGERY,	GENERAL	
25 GERIATRICS		60	DEDIATRIC, AN	ESTHESIOTOG I	4 .	12 SHRGFRY.	. HAND	
26 GYNECOLOGY 27 HAIR TRANSPLANTATION		70	DEDIATRIC CA	RDIOLOGI	4	13 SHRGERY.	HEAD/NEUK	
27 HAIR TRANSPLANTATION 28 HEMATOLOGY		71	PEDIATRIC, CR	IERGENCY MEDICINE	4	14 SHRGERY	MAXILLUFACIAL	
29 HOMEOPATHY					1	15 SURGERY	NEUROLOGICAL	
30 HYPNOSIS			OFFINEDIC (20	STRUENTENOCOOT		16 SURGERY	ORTHOPEDIC	
24 IMMUNOLOGY		74 75			1	117 SURGERY 118 SURGERY	THORACIC	
32 INFECTIOUS DISEASES		76	DEDIATRIC, IN	FECTIONS DISEVOES	1	118 SURGERT	TRANSPLANT	
33 INFERTILITY		77	DEDIATRIC IN	TENSIVIST	1	120 SURGERY	Y, TRAUMATIC	
34 INTERNAL MEDICINE		70		-PHRULUG I	4	121 SHRGFRY	Y, UROLOGIC	
35 LARYNGOLOGY 36 LEGAL MEDICINE		79	PEDIATRIC, N	EUROLOGY OPHTHALMOLOGY		122 SURGERY	Y, VASCULAR	
27 MATERNAL/FETAL MEDICII	1E	80	PEDIATRIC,	OF LITTIAL MOLOGO		123 TOXICOLO	OGY	
37 MATERINALITETY STATES			PEDIATRIC, PI	HYSIATRY		124 TRANSPL	ANIATION	
39 MEDICAL ETHICS		81	PEDIATRIC, PI	ULMONARY		125 URGENT	CARE V	
AN MEDICAL GENETICS	_		DEDIATRIC R	ADIOLOGT		126 UROLOG	· i	
44 NEO/PERINATAL MEDICINE	=	84	PEDIATRIC, R	HEDMATOROGI				
42 NEOPLASTIC DISEASES		85	PEDIATRIC, S	URGERY			Code	
43 NEPHROLOGY	C	ode					<u> </u>	
	<u>~</u>					of Dractice	56	
n Sacno of Practic	e 40	2		Secondary Sc				
Primary Scope of Practic	·				D 05	DTIELCATI	ON & RECERTIFIC	CAT
Primary Scope of Practic	RICAN BOA	RD O	F MEDICAL S	PECIALTIES BOAR Date of Initial Ce	rtificat	tion	Date of Last Rece	ertific
Board							(Mo./Yr.)	
							_	
Subboard				(Mo./Yr			(Mo.Yr.)	

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

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

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

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

WRITTEN EXPLANATION(S) ON A SEPARATE SHEET ATTACHED TO TOOK COME EXTENSION OF THE WRITTEN EXPLANATION (S) ON A SEPARATE SHEET ATTACHED TO TOOK COME EXTENSION OF THE WRITTEN ATTACHED TO TOOK COME EXTENSION OF THE W
1. Do you have a medical condition which in any way impairs of limits your ability to proceed the second Yes
2. If you have a medical condition which in any way impairs or limits your ability to practice medicine, is that impairment of limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen toYesNo _V _N/A
3. If you use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable YesNoV_N/A skill and safety?
4. Have you failed to initiate the performance of public service within one year after the date the public service is required to begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local begin to satisfy a requirement for your medical education?
5. Have you been a defendant in a legal action involving professional liability (malpractice) or had a professional liability claim. YesYes
6. Have you ever been investigated for, charged with, convicted of, or plead guilty or nolo contendere to any otherse of 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 substance of controlled substances?
7. Have you ever been denied a license, permission to practice medicine or any other healing art, or permission to take an experimentary to practice medicine or any other healing art in any state, country or U.S. territory?
8. Have you ever had a medical license or license to practice any other healing art revoked, suspended, limited, or respectively. No
9. Have you ever voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. Yes
10. Have you ever been denied membership or expelled from a medical society or other professional medical organization? YesVNo
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

12. Have you ever surrendered	I your state or tederal	controlled substance reg	gistration or nad it revoked or restricted in arry
way?			YesNo
List any and all resignations from suspensions or restrictions for f maintain required malpractice in	n any medical staff in li ailure to complete hos nsurance.) (If more sp Mailing	ieu of disciplinary or adm spital medical records, a ace is needed, attach a Type of	Dates of Action
Hospital	Address	Action	From (Mo./Yr.) To (Mo./Yr.)
_NA			
CHILD SUPPORT STATEMEN	<u></u>		
Please place a check mark no	ext to one of the follo	owing statements:	
(a) I am not subject to			
compliance with a plan approve amount owed pursuant to the complete to the com	ed by the district attor order; OR	ney or other public agen	en and am in compliance with the order or am in cy enforcing the order for the repayment of the
a plan approved by the district pursuant to the order.	court order for the sup t attorney or other pul	port of one or more childrolic agency enforcing the	en and am NOT in compliance with the order or e order for the repayment of the amount owed
CONTINUING MEDICAL EDU	CATION (CME) STA	TEMENT	
in medical ethics and 20 hours continuing medical education i (b) I was initially licens	num of 44 hours of AM of which were in my so n acts of terrorism, du sed in Nevada during riod, and completed a tin medical ethics an	A Category 1 continuing cope of practice or specia ring the past biennial pethe time period January minimum of 34 hours of d 20 hours of which we	medical education (CME), 2 hours of which were alty, and an additional 4 hours of AMA Category 1 priod of July 1, 2003 through June 30, 2005; 1, 2004 through June 30, 2004, the second six AMA Category 1 continuing medical education are in my scope of practice or specialty, and an of terrorism;
months of the pact biognial po	riod, and completed a e in medical ethics an	i minimum of 24 hours of id 18 hours of which we	2004 through December 31, 2004, the third six f AMA Category 1 continuing medical education re in my scope of practice or specialty, and an of terrorism;
	riod, and completed a e in medical ethics a	a minimum of 14 hours o nd 8 hours of which we	y 1, 2005 through June 30, 2005, the fourth six f AMA Category 1 continuing medical education re in my scope of practice or specialty, and an of terrorism; OR
(e) I am exempt from a full year of residency or fello proof of completion of 4 hours	wship training during	the biennial period July	dical education (CME) because I have completed 1, 2003 through June 30, 2005, but must submit ation in acts of terrorism.
IT YOU COMPLETED A FILL	<u>L YEAR</u> OF RESIDEN LINE 30, 2005, ATTACH	CY OR FELLOWSHIP TR/ I A COPY OF PROOF OF	MEDICAL EDUCATION (CME) HOURS. AINING DURING THE BIENNIAL PERIOD COMPLETION OF YOUR TRAINING. T BE RETURNED TO YOU.
1 HAVE HAVE NOT	(CHECK ONE) A	CTIVELY PRACTICED MI	EDICINE IN NEVADA WITHIN THE PAST

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).

1 , 1

6-11-05

Date

Signature (SIGNATURE STAMP UNACCEPTABLE)

PHYSICIAN APPLICATION FOR PECISTRATION PENEWAL	Date Received by Board	Licenso No. 7617
APPLICATION FOR REGISTRATION RENEWAL FOR THE BIENNIAL REGISTRATION PERIOD 2003-2005	MUN 1 6 20173	Total Total
NEVADA STATE BOARD OF MEDICAL EXAMINERS	man # in sult3	Aile No
Post Office Box 7238 Reno, Nevada 89510 Phone (775) 688-2559 Physical Address: 1105 Terminal Way, Suite 301 Reno, Nevada 89502	(For Board Use Only)	•
I hereby apply for renewal of biennial registration and enclose	the apprøpriate fee(s) as ind	licated below:
ACTIVE STATUS \$	400.00	
	200.00(INACTIVE STAT	
I REQUEST NON-RENEWAL OF MY LICENSE* (*IF YOU ARE REQUESTING NON-RENEWAL, SEE BELOW)		OF MEDICINE <u>INCLUDING</u> F <u>PRESCRIPTIONS</u> IN NEVADA)
Filenoi Licensemos 76107		,
	D. Malia	ah ada a sabla ha
18615 Burbank Blvd #214		checks payable to: OARD OF MEDICAL EXAMINERS
Tarzana CA 91356	(Foreign check	s must indicate "U.S. FUNDS")
Request for NON-RENEWAL of Lice		
I hereby represent that I am the person named in this Alpractice medicine in the state of Nevada.	PPLICATION FOR REGISTR	ATION RENEWAL of license to
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 Examiner	s. I will return this signed	form to the board office.
Date Signature (SIGNATURE ST	AMP UNACCEPTABLE)	
RENEWAL FORMS NOT RECEIVED AT THE BOARD OF SUSPENDED FOR NON-PAYMENT. EXTENSIONS OF HAS NO GRACE PERIOD. (USE THE ENCLOSED ENTREGISTRATION RENEWAL FORM.) YOUR LICENSE WILL NOT BE RENEWED UNLESS YOUR REGISTRATION RENEWAL FORM. YOU MUST PROMANSWERED "YES." ALL INFORMATION YOU PROVIDE ON THIS APPLICATION OF THE PROMATION.	TIME ARE NOT ALLOWED INVELOPE TO MAIL YOUR CO OU ANSWER ALL QUESTION VIDE WRITTEN EXPLANATI	FOR ANY REASON, AS NEVADA OMPLETED APPLICATION FOR NS ON THIS APPLICATION FOR IONS FOR ALL QUESTIONS
PLEASE TYPE C	R PRINT LEGIBL	Υ
1. Active status registration renewal requires the submission of medical education (CME), which includes 2 hours of CME in respecialty completed during the period July 1, 2001 through your completed Application for Registration Renewal form.	of proof of completion of 40 honedical ethics and 20 hours of hours of hours 30, 2003. Submit you	ours of AMA Category 1 continuing f CME in your scope of practice or r proof of completion of CME with
2. If your name and/or address has changed from that print space provided below. Also, please indicate your current tele copy of the document authorizing your name change (marrial)	phone and fax numbers. [Pl	ease note: a notarized or certified
Name SAMUEL LOUIS AUERBACH		
Street 4415 WEY FLAMINGO		
City LAS VEGAS County CLA	P/c 0 1)1.	1 7in 89112
City LAS VEGAS County LA	State NV	21p 0 110 3
Phone Number 702 - 220 - 77 60 Fax No	umber 10 2 - 220 -	1861
3. IF YOU HAVE RETIRED OR MOVED YOUR PRACTICE	, indicate the location of patie	ent records below:
Name		
Street		
CityCounty		Zip
Phone Number		

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

SCOPES OF PRACTICE CODES

SOURCE OF THAT TO LESS					
	ADDICTION MEDICINE	41	NEOPLASTIC DISEASES	81	PEDIATRIC, RHEUMATOLOGY
1			NEPHROLOGY		PEDIATRIC, SURGERY
2	ADOLESCENT MEDICINE		NEUROLOGY		PEDIATRIC, UROLOGY
3	AEROSPACE MEDICINE	43	NEURO-OPHTHALMOLOGY		•
4	ALLERGY		NEUROPATHOLOGY	85	PHYSICAL MEDICINE/REHABILITATION
5	ALLERGY/IMMUNOLOGY		NEURORADIOLOGY	86	PREVENTIVE MEDICINE
6	AMBULATORY MEDICINE	46 47		87	PSYCHIATRY
7	ANESTHESIOLOGY	47	NUCLEAR MEDICINE	88	PSYCHOANALYSIS
8	BLOODBANKING	49	NUTRITION	89	PUBLIC HEALTH
9	BRONCO-ESOPHAGOLOGY	50	OBSTETRICS	90	PSYCHOMATIC MEDICINE
10	CARDIOVASCULAR DISEASES		OBSTETRICS OBSTETRICS/GYNECOLOGY	91	PULMONARY DISEASES
11	CATSCAN/ULTRASOUND	51		92	RADIOLOGY
12	CHILD NEUROLOGY	52 53	ONCOLOGY	93	RADIOLOGY, DIAGNOSTIC
13	CHILD PSYCHIATRY		ONCOLOGY, GYNECOLOGICAL	94	RADIOLOGY, INTERVENTIONAL
14	CLINICAL PHARMACOLOGY	54	ONCOLOGY, GYNECOLOGICAL ONCOLOGY, HEMATOLOGY	95	RADIOLOGY, NUCLEAR
15	CRITICAL CARE	55		96	RADIOLOGY, THERAPEUTIC
16	DERMATOLOGY		ONCOLOGY, RADIATION	97	RADIOLOGY, VASCULAR
17	DERMATOPATHOLOGY	57	ONCOLOGY, SURGICAL	98	RHEUMATOLOGY
18	EMERGENCY MEDICINE		OPHTHALMOLOGY	99	RHINOLOGY
19	ENDOCRINOLOGY		OTOLARYNGOLOGY		SLEEP DISORDERS
20	FAMILY PRACTICE		OTOLOGY		SPORTS MEDICINE
21	GASTROENTEROLOGY		PAIN MANAGEMENT		SURGERY, ABDOMINAL
22	GENERAL PRACTICE		PATHOLOGY ANATOMIC		SURGERY, CARDIOTHORACIC
23	GERIATRIC PSYCHIATRY		PATHOLOGY, ANATOMIC		SURGERY, CARDIOVASCULAR
24	GERIATRICS		PATHOLOGY, CLINICAL		SURGERY, COLON/RECTAL
25	GYNECOLOGY		PATHOLOGY, FORENSIC		SURGERY, GENERAL
26	HAIR TRANSPLANTATION		PEDIATRIC, ALLERGY		SURGERY, HAND
27	HEMATOLOGY	67			SURGERY, HEAD/NECK
28	HOMEOPATHY	68	PEDIATRIC, CRITICAL CARE		SURGERY, MAXILLOFACIAL
29	HYPNOSIS	69	PEDIATRIC, EMERGENCY MEDICINE		SURGERY, NEUROLOGICAL
30	IMMUNOLOGY		PEDIATRIC, ENDOCRINOLOGY		SURGERY, ORTHOPEDIC
31	INFECTIOUS DISEASES	71	PEDIATRIC, GASTROENTEROLOGY		SURGERY, PLASTIC
32	INFERTILITY		PEDIATRIC, HEMATOLOGY/ONCOLOGY		SURGERY, THORACIC
33	INTERNAL MEDICINE		PEDIATRIC, INFECTIOUS DISEASES		SURGERY, TRANSPLANT
34	LARYNGOLOGY		PEDIATRIC, INTENSIVIST		SURGERY, TRAUMATIC
35	LEGAL MEDICINE		PEDIATRIC, NEPHROLOGY		SURGERY, UROLOGIC
36	MATERNAL/FETAL MEDICINE		PEDIATRIC, NEUROLOGY		SURGERY, VASCULAR
37	MEDICAL ACUPUNCTURE		PEDIATRIC, OPHTHALMOLOGY		•
38	MEDICAL ETHICS		PEDIATRIC, PHYSIATRY		TOXICOLOGY
39	MEDICAL GENETICS		PEDIATRIC, PULMONARY		URGENT CARE
40	NEO/PERINATAL MEDICINE	80	PEDIATRIC, RADIOLOGY	120	UROLOGY
		Code			Code
					<u></u>
Primary Scope of Practice5 \			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.

 Do you have a medical co safety? 	ondition which in any w	ay impairs or limits your abil	ity to practice medicine with		ill and No
If you have a medical collimitation reduced or amelia practice?			g, or the manner in which		sen to
If you use chemical subs skill and safety?	stances, does your use	in any way impair or limit y	our ability to practice medi Yes	cine with rease	nable N/A
4. Have you failed to initiate begin to satisfy a requiren government for your medica	nent of your receiving			t or a state or	Jocal
5. Have you been a defenda paid in your behalf or paid s		olving professional liability (malpractice) or had a profe	essional liability	elaim No
6. Have you ever been inviviolation of any federal, stated felony, excluding any minor substance is not considered dispensing of controlled substance	te or local law, includi traffic offense (driving ed a minor traffic offe	ng any foreign country, whi I or in control of a motor ve	ich is a misdemeanor, gro hicle while under the influe	oss misdemean ence of any che	or, or emical pg, or
7. Have you ever been den examination to practice me	ied a license, permiss dicine or any other hea	ion to practice medicine or ling art in any state, country	any other healing art, or p y or U.S. territory?	ermission to ta	ke an No
8. Have you ever had a med any state, country or U.S. te		to practice any other healing	g art revoked, suspended, l 	limited, or restric	nted in
Have you ever voluntaril territory?	y surrendered a licens	e to practice medicine or ar	ny other healing art in any : 	state, country o	⊀U.S. No
10. Have you ever been de	nied membership or e	xpelled from a medical soci	ety or other professional n	nedical organiza	ation? No
11. Have you ever been: a) any violation of a statute, ru medical society, governmen	ıle or regulation gover	ning your practice as a phy	sician by any medical licer	nsing board, ho	spital,
12. Have you ever surrend way?	ered your state or fed	eral controlled substance re	egistration or had it revoke	ed or restricted Yes	in any No
13. List all hospitals where List any and all resignations suspensions or restrictions maintain required malpracti	from any medical staff for failure to complete	in lieu of disciplinary or adr	ministrative action. (<u>Please</u>	<u>e Note</u> : Do not ir	nclude
	Mailing	Type of Action		ates of Action No./Yr.) To (Mo)./Yr.)
Maintain required maipracti		Type of Action		ates of Action Mo./Yr.) To (Mo	o./Yr.)

CHILD SUPPORT STATEMENT

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 incompliance 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:
$\sqrt{}$ (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 size 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 size 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.
HAVE NOT <i>(CHECK ONE)</i> 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 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

BIRGIAN		
PHYSICIAN APPLICATION FOR REGISTRATION RENEWAL	Date Received b	y Board License No. 7617
FOR THE BIENNIAL REGISTRATION PERIOD 2001-2003	JUN 2 7 2001	License No. 1 1
NEVADA STATE BOARD OF MEDICAL EXAMINERS	/	File No
Post Office Box 7238 Reno, Nevada 89510 Phone (775) 688-2559	(For Board Use	
I hereby apply for renewal of biennial registration and enclose ACTIVE STATUS	tne appropriate tee(s \$600.00	as indicated below:
INACTIVE STATUS		RED STATUS REQUIRES THAT THE
RETIRED STATUS		LICANT <u>NOT PRACTICE MEDICINE</u>
SUPERVISING/COLLABORATING PHYSICIAN	\$200.00 <u>ANY</u>	WHERE)
de menos companiono sys		
Samuel L AUERBACH	M.D.	Make checks payable to:
18615 Burbank Blvd		TATE BOARD OF MEDICAL EXAMINERS eign checks must indicate "U.S. FUNDS")
# 214	(Fore	sign checks must indicate 0.3. FONDS)
Tarzana, CA 91356		
PLEASE NOTE:		
► YOUR CURRENT M.D. LICENSE EXPIRES ON JUNE 30	, 2001. COMPLETE	D APPLICATION FOR REGISTRATION
RENEWAL FORMS NOT RECEIVED AT THE BOARD O	FFICE BY JULY 1, 20	001 AT 5:00 P.M. ARE AUTOMATICALLY
SUSPENDED FOR NON-PAYMENT. EXTENSIONS OF		
HAS <u>NO GRACE PERIOD</u> . (USE THE ENCLOSED ENV REGISTRATION RENEWAL FORM.)	ELOPE TO WAIL TO	UR COMPLETED APPLICATION FOR
■ YOUR LICENSE WILL NOT BE RENEWED UNLESS YO	OU ANSWER ALL QU	ESTIONS ON THIS APPLICATION FOR
REGISTRATION RENEWAL FORM. YOU MUST PROV	IDE WRITTEN EXPL	ANATIONS FOR ALL QUESTIONS
ANSWERED "YES." ALL INFORMATION YOU PROVIDE ON THIS APPLICATION.	TION FOR REGISTR	ATION DENEWAL EODM IS BUILDED.
INFORMATION.	HOW FOR REGISTRA	A TION RENEWALT ORM IS FOREIC
PLEASE TYPE O	R PRINT LE	GIBLY
1. To be eligible to act as a SUPERVISING PHYSICIAN FO		
PHYSICIAN FOR AN ADVANCED PRACTITIONER OF NURS		
you must complete the enclosed Application for Approval a payment in the amount of \$200.00 in the enclosed envelope.	is Supervising/Collai	borating Pnysician and return it with your
,		
2. Active status registration renewal requires the submission of	of proof of completion	of 40 hours of AMA Category 1 continuing
medical education (CME), which includes 2 hours of CME in r	nedical ethics and 20	hours of CME in your scope of practice or
specialty completed during the period July 1, 1999 through your completed Application for Registration Renewal form. (S		
		·
3. If your name and/or address has changed from that printed		
provided below. Also, please indicate your current telephone a document authorizing your name change (marriage license, document authorizing your name change).		
	•	•
Name		
Street		
CityCounty	State	e Zip
City County Phone Number 818 - 609 - 9670 Fax Number	umber (NONE))
4. IF YOU HAVE RETIRED OR MOVED YOUR PRACTICE,	indicate the location o	of patient records below:
NameNA		
Street		
CityCounty	State	Zin
Phone Number	State	∠ıμ
Filotic Nutificel		
5. Indicate below the EXACT NAME AND LOCATION of the M	Medical School from w	hich you graduated and your EXACT DATE
of graduation:		· · ·
Universida Dez Noresque: TAMPICO TAMPS	MEXICA	JUNE 06 1980
Medical School Name and Location		ate of Graduation (Month / Day / Year)

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

Prir	nary Specialty48	Sec	ondary Specialty	T	ertiary Specialty <u>23</u>
	<u>Code</u>		<u>Code</u>		<u>Code</u>
39	NEPHROLOGY	78	PEDIATRIC, SURGERY		
38	NEOPLASTIC DISEASES		PEDIATRIC, RADIOLOGY		
37	NEO/PERINATAL MEDICINE	76	PEDIATRIC, PULMONARY	115	UROLOGY
36	MEDICAL GENETICS	75	PEDIATRIC, PHYSIATRY		URGENT CARE
35	MEDICAL ETHICS		PEDIATRIC, OPHTHALMOLOGY		SURGERY, VASCULAR
34	MEDICAL ACUPUNCTURE		PEDIATRIC, NEUROLOGY		SURGERY, UROLOGIC
33	MATERNAL/FETAL MEDICINE	72	PEDIATRIC, NEPHROLOGY		SURGERY, TRAUMATIC
32	LEGAL MEDICINE	71	PEDIATRIC, INTENSIVIST	110	SURGERY, TRANSPLANT
31	LARYNGOLOGY	70	PEDIATRIC, INFECTIOUS DISEASES	109	SURGERY, THORACIC
30	INTERNAL MEDICINE	69	PEDIATRIC, HEMATOLOGY/ONCOLOGY	108	SURGERY, PLASTIC
29	INFERTILITY	68	PEDIATRIC, GASTROENTEROLOGY	107	SURGERY, ORTHOPEDIC
28	INFECTIOUS DISEASES	67	PEDIATRIC, ENDOCRINOLOGY	106	SURGERY, NEUROLOGICAL
27	IMMUNOLOGY	66	PEDIATRIC, EMERGENCY MEDICINE	105	SURGERY, MAXILLOFACIAL
26	HYPNOSIS		PEDIATRIC, CRITICAL CARE		SURGERY, HEAD/NECK
25	HOMEOPATHY		PEDIATRIC, CARDIOLOGY		SURGERY, HAND
24	HEMATOLOGY		PEDIATRIC, ALLERGY		SURGERY, GENERAL
23	GYNECOLOGY		PATHOLOGY, FORENSIC		SURGERY, COLON/RECTAL
	GERIATRICS		PATHOLOGY, CLINICAL		SURGERY, CARDIOVASCULAR
21	GENERAL PRACTICE	60	PATHOLOGY, ANATOMIC	99	SURGERY, CARDIOTHORACIC
20	GASTROENTEROLOGY	59	PATHOLOGY	98	SURGERY, ABDOMINAL
19	FAMILY PRACTICE		PAIN MANAGEMENT	97	SPORTS MEDICINE
18	ENDOCRINOLOGY		OTOLOGY	96	SLEEP DISORDERS
17	EMERGENCY MEDICINE	56	OTOLARYNGOLOGY	95	RHINOLOGY
16	DERMATOLOGY		OPHTHALMOLOGY	94	RHEUMATOLOGY
15	DERMATOLOGY		ONCOLOGY, RADIATION ONCOLOGY, SURGICAL	93	RADIOLOGY, THERAPEUTIC RADIOLOGY, VASCULAR
14	CRITICAL CARE	52 53	ONCOLOGY, REMATOLOGY ONCOLOGY, RADIATION	92	RADIOLOGY, NUCLEAR RADIOLOGY, THERAPEUTIC
13	CLINICAL PHARMACOLOGY	51 52	ONCOLOGY, GYNECOLOGICAL ONCOLOGY, HEMATOLOGY	90 91	RADIOLOGY, INTERVENTIONAL RADIOLOGY, NUCLEAR
11 12	CHILD NEUROLOGY CHILD PSYCHIATRY	50 51	ONCOLOGY ONCOLOGY, GYNECOLOGICAL	89 90	RADIOLOGY, DIAGNOSTIC RADIOLOGY, INTERVENTIONAL
10	CATSCAN/ULTRASOUND	49 50	OCCUPATIONAL MEDICINE	88	RADIOLOGY DIACNOSTIC
9	CARDIOVASCULAR DISEASES		OBSTETRICS/GYNECOLOGY	87	PULMONARY DISEASES
8	BRONCO-ESOPHAGOLOGY	47	OBSTETRICS	86	PUBLIC HEALTH
7	BLOODBANKING	46	NUTRITION	85	PSYCHOMATIC MEDICINE
6	ANESTHESIOLOGY	45	NUCLEAR MEDICINE	84	PSYCHOANALYSIS
5	ALLERGY/IMMUNOLOGY	44	NON-CONVENTIONAL MEDICINE	83	PSYCHIATRY
4	ALLERGY	43	NEURORADIOLOGY	82	PREVENTIVE MEDICINE
3	AEROSPACE MEDICINE		NEUROPATHOLOGY	81	PHYSICAL MEDICINE/REHABILITATION
2	ADOLESCENT MEDICINE	41	NEURO-OPHTHALMOLOGY	80	PEDIATRICS
					PEDIATRIC, UROLOGY

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.

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

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

 Do you have a med safety? 	ical condition which	in any way impairs or limits you	ur ability to practice medicine with reaso Ye	
2. If you have a med limitation reduced or a practice?	ical condition which ameliorated becaus	n in any way impairs or limits y se of the field of practice, the	our ability to practice medicine, is that setting, or the manner in which you h	ave chosen to
3. If you use chemical and safety?	substances, does y	our use in any way impair or lin	nit your ability to practice medicine withYes	reasonable skill NoN/A
 Have you failed to begin to satisfy a requi for your medical educ 	rement of your rece	ance of public service within or viving a loan or scholarship fron	ne year after the date the public service the federal government or a state or lo Yes	cal government
5. Have you been a depaid in your behalf or	efendant in a legal a paid such a claim y	action involving professional lia ourself?	bility (malpractice) or had a profession	al liability claim
of any federal, state of excluding any minor tra	or local law, includ affic offense (driving n <mark>or traffic offense</mark>	ing any foreign country, which g or in control of a motor vehicle	ead guilty or nolo contendere to any offer is a misdemeanor, gross misdemea while under the influence of any chemic anufacture, distribution, prescribing, or Ye	nor, or felony, cal substance is
7. Have you ever bee examination to practic	n denied a license, e medicine or any c	permission to practice medici ther healing art in any state, c	ne or any other healing art, or permise ountry or U.S. territory?	sion to take an
8. Have you ever had any state, country or U	a medical license o J.S. territory?	r license to practice any other h	ealing art revoked, suspended, limited	, or restricted in
9. Have you ever volս territory?	ıntarily surrendered	l a license to practice medicine	e or any other healing art in any state, e	country or U.S. sNo
10. Have you ever be	en denied member	ship or expelled from a medica	al society or other professional medica Yes	l organi ∕ ation? sNo
any violation of a state	ute, rule or regulation	on governing your practice as	; b) investigated for; c) charged with; or a physician by any medical licensing b vada State Board of Medical Examiner ————Ye	ooard, hospital
12. Have you ever sur	rendered your state	or federal controlled substanc	e registration or had it revoked or restric	cted in any way? esNo
any and all resignatio	ns from any medic tions for failure to c	al staff in lieu of disciplinary or complete hospital medical reco	ded, limited, revoked or not renewed by to readministrative action. (<u>Please Note:</u> ords, attend hospital department or sta	Do not include
Hospital	Mailing Address	Type of Action	Dates of Action From (Mo./Yr) To (Mo.	/Yr.)
NIA				

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 compliance with a plan approved by the district attorney or other public agency enforcing the order for the repayme amount owed pursuant to the order; OR	or am in nt of the
(c) I am subject to a court order for the support of one or more children and am NOT in compliance with the control plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed to the order.	order or a pursuant
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 medical ethics and 20 hours of which were in my scope of practice or specialty, during the past biennial period of Julthrough June 30, 2001;	nich were y 1, 1999
(b) I was initially licensed in Nevada during the time period January 1, 2000 through June 30, 2000, the semonths of the past biennial period, and completed a minimum of 30 hours of AMA Category I continuing medical e (CME), 2 hours of which were in medical ethics and 20 hours of which were in my scope of practice or specialty;	cond six ducation
(c) I was initially licensed in Nevada during the time period July 1, 2000 through December 31, 2000, the third so of the past biennial period, and completed a minimum of 20 hours of AMA Category I continuing medical education hours of which were in medical ethics and 18 hours of which were in my scope of practice or specialty;	x months (CME), 2
(d) I was initially licensed in Nevada during the time period January 1, 2001 through June 30, 2001, the fourth so of the past biennial period, and completed a minimum of 10 hours of AMA Category I continuing medical education hours of which were in medical ethics and 8 hours of which were in my scope of practice or specialty; OR	x months (CME), 2
(e) I am exempt from submitting proof of completion of continuing medical education (CME) because I have carefully year of residency or fellowship training during the biennial period July 1, 1999 through June 30, 2001.	ompleted
 ATTACH COPIES OF PROOF OF YOUR COMPLETION OF CONTINUING MEDICAL EDUCATION (CME) HO IF YOU COMPLETED A FULL YEAR OF RESIDENCY OF FELLOWSHIP TRAINING DURING THE BIENNIAL JULY 1, 1999 THROUGH JUNE 30, 2001, ATTACH A COPY OF PROOF OF COMPLETION OF YOUR TRAINING COMPLETION WILL NOT BE RETURNED TO YOU. 	PERIOD
I HAVE HAVE NOT (CHECK ONE) ACTIVELY PRACTICED MEDICINE IN NEVADA WITHIN THE MONTHS.	PAST 12
BY SIGNING ON THE SIGNATURE LINE BELOW:	
1) I HEREBY REPRESENT THAT I AM THE PERSON NAMED IN THIS APPLICATION FOR REGISTRATION RENE LICENSE TO PRACTICE MEDICINE IN THE STATE OF NEVADA AND THAT ALL STATEMENTS I HAVE MADE	EWAL OF HEREIN
ARE TRUE; 2) I UNDERSTAND THAT THIS APPLICATION FOR REGISTRATION RENEWAL WILL BE DENIED IF I HAVE I PLACED A CHECK MARK NEXT TO (a), (b), OR (c) UNDER THE CHILD SUPPORT STATEMENT SECTION 3) I UNDERSTAND THAT THIS APPLICATION FOR REGISTRATION RENEWAL WILL BE DENIED IF I HAVE ANSWERED ALL QUESTIONS THEREON AND/OR ATTACHED THERETO: (a) THE APPROPRIATE COPROOF OF CONTINUING MEDICAL EDUCATION (CME), OR RESIDENCY OR FELLOWSHIP TRAINING COMF (b) PAYMENT OF THE APPROPRIATE REGISTRATION RENEWAL FEE; AND (c) WRITTEN EXPLANATION(S "YES" ANSWER(S).	; AND AVE NOT PIES OF PLETION;

Signature (SIGNATURE STAMP UNACCEPTABLE)

PHYSICIAN	Date Received by Boa	
APPLICATION FOR RENEWAL REGISTRATION	um o = 1098	License No.
NEVADA STATE BOARD OF MEDICAL EXAMINERS	JUN 2 5 1999	Ella Nia
St Office Box 7238 Reno, Nevada 89510 Phone (775) 688-2559	(Board Use Only)	File No.
I hereby apply for renewal of biennial registration and enclose		ndicated below:
ACTIVE STATUS	\$600.00	
INACTIVE STATUS	\$200.00	
RETIRED STATUS	\$ 50.00	
SUPERVISING/COLLABORATING PHYSICIAN	\$200.00	
Command I amine Ourselbank MD		
Samuel Louis Auerbach, MD 18615 Burbank Blvd #214	Make o	checks payable to:
Tarzana CA 91356		ARD OF MEDICAL EXAMINERS
Tai Zana On 71550	(Foreign checks r	must indicate "U.S. FUNDS")
PLEAS NEVADA HAS NO GRACE PERIOD	SE NOTE LICENSES NOT REN	EWED BY JULY 1. 1999
ARE AUTOMATICALLY SUS		
EXTENSIONS OF TIME ARE N		and the second of the second o
YOUR LICENSE WILL NOT BE RENEWED	WITHOUT ANSWERIN	G ALL QUESTIONS
	MUST BE EXPLAINED	
YOU MUST INCLUDE PROOF OF 40 HOURS		
2 HOURS IN MEDICAL ETHICS AND 20 HOURS		
ALL FEES MUST BE PAID	· · · · · · · · · · · · · · · · · · ·	
	H THROUGH THE MAI	
PLEASE ALLOW SIXTY (60) DAYS FO	R PROCESSING OF YO	OUR APPLICATION.
PLEASE TYPE	OR PRINT LEGIB	IY
1. YOUR CURRENT M.D. LICENSE EXPIRES ON JUN LICENSE.		
2. To be eligible to act as a supervising physician for a phys	sician's assistant, or as a coll or Approval as Supervising/C	aborating physician for an advand ollaborating Physician.
3. ACTIVE STATUS REGISTRATION RENEWAL REQU CATEGORY 1 CONTINUING MEDICAL EDUCATION which of practice or specialty completed during the period July 1, 1 completed Application for Registration Renewal form.	ch includes 2 hours of medica	al ethics and 20 hours in your sco
4. In order to provide sufficient time for processing, please contained Application for Approval as Supervising/Collaborating Category I CME and the correct fee(s) BY JUNE 30, 19 completed form(s) and fee(s).	Physician form (if applicabl	e) with your proof of 40 hours A
5. If your name and/or address has changed from that prints A notarized or certified copy of the document authorizing you included.	ed on this form, clearly indica ur name change (marriage li	te the change in the space provid cense, divorce decree, etc.) must
NameNA		
Street	**************************************	
StreetCounty	State	7in
6. IF YOU HAVE RETIRED OR MOVED YOUR PRACTICE,		
Name NIA		
NameN A Street		
CityCounty	State	Zip

7. Are you currently active in medicine?			
a. [] YES, in training.	b. 🎮 YES, working full-tim	e	
c. [] YES, working part tim	e d.[] NO, retired.		
e. [] NO, other (specify)	7"
8 Please indicate your primary case	nden, and todies, acceleties and con-	- A - E	
following codes:	ndary and tertiary specialties and perce	nt of practice time spent in e	ach, using the
lonowing codes.	SCOPE OF PRACTICE SPECIALTY CODES		
102 ADDICTION MEDICINE	31 NEOPLASTIC DISEASES	62 PEDIATRIC, RADIOLOGY	
1 ADOLESCENT MEDICINE 2 AEROSPACE MEDICINE	32 NEPHROLOGY 33 NEUROLOGY	63 PEDIATRIC, SURGERY 64 PEDIATRIC, UROLOGY	
3 ALLERGY/IMMUNOLOGY	34 NEUROPATHOLOGY	65 PEDIATRICS	
104 ALTERNATIVE MEDICINE	35 NEURORADIOLOGY	66 PHYSICAL MEDICINE/REHA	ABILITATION
4 ANESTHESIOLOGY 5 BLOODBANKING	36 NUCLEAR MEDICINE 37 NUTRITION	67 PREVENTIVE MEDICINE 68 PSYCHIATRY	
6 BRONCO-ESOPHAGOLOGY	-38 OBSTETRICS/GYNECOLOGY	69 PSYCHOANALYSIS	
7 CARDIOVASCULAR DISEASES	39 OBSTETRICS	70 PSYCHOMATIC MEDICINE	
8 CATSCAN/ULTRASOUND 9 CHILD NEUROLOGY	40 OCCUPATIONAL MEDICINE 41 ONCOLOGY	71 PUBLIC HEALTH	
10 CHILD PSYCHIATRY	45 ONCOLOGY, GYNECOLOGICAL	72 PULMONARY DISEASES 73 RADIOLOGY	
11 CLINICAL PHARMACOLOGY	42 ONCOLOGY, HEMATOLOGY	74 RADIOLOGY, DIAGNOSTIC	
12 CRITICAL CARE	43 ONCOLOGY, RADIATION	75 RADIOLOGY, NUCLEAR	
13 DERMATOLOGY 14 EMERGENCY MEDICINE	44 ONCOLOGY, SURGICAL 46 OPHTHALMOLOGY	76 RADIOLOGY, THERAPEUT77 RHEUMATOLOGY	IC
15 ENDOCRINOLOGY	47 OTOLARYNGOLOGY	78 RHINOLOGY	
16 FAMILY PRACTICE	48 OTOLOGY	79 SLEEP DISORDERS	
17 GASTROENTEROLOGY 18 GENERAL PRACTICE	49 PAIN MANAGEMENT 50 PATHOLOGY	100 SPORTS MEDICINE 80 SURGERY, ABDOMINAL	
19 GERIATRICS	51 PATHOLOGY, ANATOMIC	103 SURGERY, CARDIOTHORA	CIC
20 GYNECOLOGY	52 PATHOLOGY, CLINICAL	81 SURGERY, CARDIOVASCU	LAR
21 HEMATOLOGY	53 PATHOLOGY, FORENSIC	91 SURGERY, COLON/RECTA	L
105 HOMEOPATHY 22 HYPNOSIS	54 PEDIATRIC, ALLERGY 55 PEDIATRIC, CARDIOLOGY	82 SURGERY, GENERAL 83 SURGERY, HAND	
23 IMMUNOLOGY	99 PEDIATRIC, CRITICAL CARE	84 SURGERY, HEAD/NECK	
24 INFECTIOUS DISEASES	97 PEDIATRIC, EMERGENCY MEDICINE	92 SURGERY, MAXILLOFACIA	
25 INFERTILITY 26 INTERNAL MEDICINE	56 PEDIATRIC, ENDOCRINOLOGY 57 PEDIATRIC, HEMATOLOGY/ONCOLOGY	93 SURGERY, NEUROLOGICA 85 SURGERY, ORTHOPEDIC	L (*
27 LARYNGOLOGY	58 PEDIATRIC, INFECTIOUS DISEASES	85 SURGERY, ORTHOPEDIC 86 SURGERY, PLASTIC	i .
28 LEGAL MEDICINE	59 PEDIATRIC, INTENSIVIST	87 SURGERY, THORACIC	
29 MATERNAL/FETAL MEDICINE	60 PEDIATRIC, NEPHROLOGY	88 SURGERY, TRAUMATIC	
106 MEDICAL ACUPUNCTURE 107 MEDICAL ETHICS	98 PEDIATRIC, NEUROLOGY 101 PEDIATRIC, OPHTHALMOLOGY	89 SURGERY, UROLOGIC 90 SURGERY, VASCULAR	
30 NEO/PERINATAL MEDICINE	61 PEDIATRIC, PHYSIATRY	94 UROLOGY	
	95 PEDIATRIC, PULMONARY		
0.1	5		
Code	Percent of Time	Board Certified (Indicate Ye	es/No)
Primary 38		<u></u>	
Secondary 20		ν_o	
Tertiary	20	No	
DI EASE INDICATE ALL AMEDICAN D	OARD OF MEDICAL SPECIALTIES BO	ABD OB SUBBOARD OFF	TIFICATIONS.
PLEASE INDICATE ALL AMERICAN B	OARD OF MEDICAL SPECIALTIES BU	Date of	
	Init		Date of st Certification
Board NA		iai Certification La	ist Certification
		(Mo./Yr.)	(Mo./Yr.)
Subboard		(110.3.11.)	(1410.3 11.)
		(Mo./Yr.)	(Mo/Yr.)
Board		(,	(
		(Mo./Yr.)	(Mo./Yr.)
Subboard			
		(Mo./Yr.)	(Mo./Yr.)
0.5	(I)		
9. Form of employment is 1001	(Use one of the following c	odes.)	
SELF-EMPLOYED:	SALARIED, EM	PLOYED BY: (continued)	
(1001) Solo Practice	1006 Other Non-Go	vernment Employer (hospital,	school, etc.)
1002 Partnership or Group Practitio		ment (armed services person	nnei only)
SALARIED, EMPLOYED BY: 1003 Individual Practitioner		nment (civilian, P.H.S., etc.)	
1003 Individual Practitioner 1004 Partnership or Group of Pract	1009 State Governm		
1004 Partnership of Group of Pract 1005 Group Health Plan Facility (st			
1000 Group Health Flath Facility (St	ich as n.ivi.O.j IUII Local Governm	eni	
1012 Other (s	pecify)		
	• //		

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? YesNo
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? YesNoV_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? YesNoV_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? YesNoN/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? YesNo
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? 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
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
9. Have you ever voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory? YesNo
10. Have you ever been denied membership or expelled from a medical society or other professional medical organization? YesNo

11. Have you ever been investigated the practice of medicine by any medicine b	d for, charged with, o dical licensing board,	or convicted of any violat hospital, medical socie	ion of a statute, rule or regulation governing ty, governmental entity or other agency? YesNo
12. Have you ever surrendered you way?	ur state or federal co	ntrolled substance regis	stration or had it revoked or restricted in an, YesNo
List any and all resignations from any suspensions or restrictions for failure maintain required malpractice insura	medical staff in lieu c e to complete hospita ance).	of disciplinary or adminis al medical records, atter	ted, revoked or not renewed by the hospital. strative action. (Please Note: Do not include not hospital department or staff meetings, or
	iling dress	Type of Action	Dates of Action From (Mo./Yr.) To (Mo./Yr.)
NA			
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compliance with a plan approved by amount owed pursuant to the order; I am subject to a court orde	er for the support of er for the support of ey the district attorney or er for the support of oney or other public as	one or more children ar or other public agency on ne or more children and gency enforcing the ord	nd am in compliance with the order or am in enforcing the order for the repayment of the d am NOT in compliance with the order or a der for the repayment of the amount owed
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ATTACH COPIES OF PROOF OF			CME CREDITS WILL NOT BE RETURNED.
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I HAVE HAVE NOT A			THE PAST 12 MONTHS. (CHECK ONE)
RENEWAL OF LICENSE TO STATEMENTS I HAVE MAD	PRACTICE ME E HEREIN ARE	DICINE IN THE ST	PPLICATION FOR REGISTRATION TATE OF NEVADA AND THAT ALL
878- 6 09-9070 Business Telephone # Date	<i>99</i> '	•	STAMP UNACCEPTABLE)

		Date received by	Board			
APPLICATION FOR RENEWAL REGIST		License No				
NEVADA STATE BOARD OF MEDICAL EXAMINERS						
Post Office Box 7238 Reno, Nevada 89510 Phor	e (702) 688-2559	(Board Use Only)	File No.			
hereby apply for renewal of biennial reginates ACTIVE STATUS	stration and enclos	e the appropriate fe				
NACTIVE STATUS	\$600.00 \$150.00	PLEASE NOTE: NEVADA HAS NO GRACE PERI				
RETIRED STATUS	\$ 50.00		LICENSES NOT RENEWED BY			
P.A. SUPERVISING PHYSICIA			JULY 1, 1997 ARE AUTOMATICALLY SUSPENDED FOR NON-PAYMENT			
	02 00		SOSPENDED FOR NON-PATMENT			
Samuel Louis Auerbach, N	MD					
18615 Burbank Bivd #214			Make checks payable to:			
Tarzana, CA	91356		DA STATE BOARD OF MEDICAL EXAMINERS			
raizana, ev		(Foreign checks must indicate "U.S. FUNDS")				
 LICENSE. To be eligible to act as a supervising p as Supervising Physician form. ACTIVE STATUS REGISTRATION F CATEGORY I, CONTINUING MEDICAL Submit your proof of CME with your compet. In order to provide sufficient time for provide Application for Approval as Supervisional Application for Approval as Supervisional the correct fee(s) PRIOR TO JULY 1, and fee(s). If your name and/or address has changed. 	hysician for a physician for a physician for a physician form (1997. Use the encled from that printed	cian assistant, com RES THE SUBMISS pleted during the por Registration Reneal return you if applicable) with you osed self-addressed on this form, clearly	S THE NOTICE TO RENEW YOUR M.D. plete the enclosed Application for Approval BION OF PROOF OF 40 HOURS OF AMA eriod July 1, 1995 through June 30, 1997. Eval form. Four proof of 40 hours AMA Category I CME denvelope to return your completed form(s) indicate the change in the space provided riage license, divorce decree, etc.) must be			
Name						
Street						
CityCounty_		State	Zip			
·	OUR PRACTICE,		THE LOCATION OF FORMER PATIENT			
Street						
CityCounty		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

	c. [🗸] Y	ES, in training. ES, working part-time C, other (appoint)	e d.[]	NO, retired.	un-ume	,		
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	Please indicate yo	ur primary, secondar	y and tertiary sp	ecialties and perd	ent of ti	me spent in each	, using the to	llowing codes.
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	INDICATE AMERICA	N BOARD OF MEDI	ICAL SPECIAL	TIES BOARD CE	RTIFIC <i>I</i> D	ATION: ate of Initial Cert	ification	Date of Last Certification
Board			-			(Mo./Yr.)		(Mo./Yr.)
Subboard						(Mo./Yr.)		(Mo./Yr.)
3. Form 1001 1002 1003 1004 1005	of employment is SELF-EMPLOYED Solo Practice Partnership or Grou SALARIED, EMPLO Individual Practition Partnership or Grou Group Health Plan F	p Practitioners YED BY: er p of Practitioners	1006 1007 1008 1009 1010	Other Non-Gove Federal Governr Federal Governr State Governme County Governme	rnment nent (arm nent (civent nent	BY (continued) Employer (hospita med services pers vilian, P.H.S., etc.	al, school, et sonnel only))	

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. Are you currently active in medicine?

- 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
·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? YesNoVN/A
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? YesNo _V _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?YesNo
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
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?
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?
8. Have you ever had a medical license revoked, suspended, limited, or restricted in any state, country or U.S. territory?
9. Have you ever voluntarily surrendered a license to practice a healing art in any state, country or U.S. territory?
10. Have you ever been denied membership or expelled from a medical society or other professional medical organization?Yes
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?
12. Have you ever surrendered your state or federal controlled substance registration or had it revoked or restricted in any way?YesNo
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).
Mailing Type of Dates of Action Hospital Address Action From (Mo./Yr.) To (Mo./Yr.)
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Mailing Type of Dates of Action Hospital Address Action From (Mo./Yr.) To (Mo./Yr.)
Hospital Mailing Type of Dates of Action From (Mo./Yr.) To (Mo./Yr.) If more space is needed, attach separate sheet.
Mailing Address Action From (Mo./Yr.) To (Mo./Yr.) If more space is needed, attach separate sheet. EASE CHECK ONE OF THE FOLLOWING: 1. I have eamed 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 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. Lam exempt from submitting proof of continuing medical education (CME) because I have completed a full year of residency or fellowship training
Mailing Address Action From (Mo./Yr.) To (Mo./Yr.) If more space is needed, attach separate sheet. EASE 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). Signature Signature
Hospital Address Action From (Mo./Yr.) To (Mo./Yr.) If more space is needed, attach separate sheet. EASE CHECK ONE OF THE FOLLOWING: 1. I have eamed 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.
Mailing Address Action From (Mo./Yr.) To (Mo./Yr.) If more space is needed, attach separate sheet. EASE 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). 5. I am exempt from submitting proof of continuing medical education (CME). Signature Signature Stamp unacceptable IMPORTANT: ATTACH COPIES OF PROOF OF DECLARED CME CREDITS. PROOF OF CME CREDITS WILL NOT BE RETURNED.

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.

PLICENSE NO.
File No.

NIIV 2 2nd 90 bed section for BOARD USE ONLY

Samuel L. Auerbach, M.D. 18615 Burbank Blvd #214 Tarzana, CA 91356 NEVADA STATE BOARD OF MEDICAL EXAMINERS

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

lf y	PLEASE our name and/or address has chang		NFORMATION AS REG d on this form, clearly ind		e in the space provided.
A n	notarized or certified copy of the do included.	cument authorizing	g your name change (mar	riage license, div	vorce decree, etc.) must
Naı	me				
~.					
Str	eet				
Cit	v Cour	itv	State	Zin Co	nde
1.	Are your currently active in medic	ine?	04410	Zip Co	Jac
	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, seco	ondary and tertiary	specialties and percent of	time spent in ea	ach, using the following
	codes.			•	
		SPEC	IALTY CODE:		
1	ADOLESCENT MEDICINE		RADIOLOGY		PED, UROLOGY
2	AEROSPACE MEDICINE ALLERGY / IMMUNOLOGY	36 NUCLE 37 NUTRI	AR MEDICINE		PEDIATRICS PHYSICAL MED / REHAB
4	ANESTHESIOLOGY		TRIC / GYNECOLOGY		PHYSICIAN ASSISTANT
5	BLOODBANKING	39 OBSTE	TRICS		PREVENTIVE MED
6	BRONCO-ESOPHAGOLOGY		ATIONAL MED		PSYCHIATRY
7 8	CARDIOVASC DISEASES CATSCAN / ULTRÁSOUND	41 ONCOL	OGY, GYNECOLOGIC		PSYCHOANALYSIS PSYCHOMATIC MEDICINE
9	CHILD NEUROLOGY		OGY, HEMATOLOGY		PUBLIC HEALTH
10	CHILD PSYCHIATRY		OGY, RADIATION		PULMONARY DISEASES
	CLINICAL PHARMACOL		OGY, SURGICAL		RADIOLOGY
12 13	CRITICAL CARE DERMATOLOGY		IALMOLOGY RYNGOLOGY		RADIOLOGY, DIAGNOSTIC RADIOLOGY, NUCLEAR
	EMERGENCY MEDICINE	48 OTOLO			RADIOLOGY, THERAPEUT
	ENDOCRINOLOGY		ANAGEMENT		RHEUMATOLOGY
	FAMILY PRACTICE	50 PATHO			RHINOLOGY
17 18	GASTROENTEROLOGY GENERAL PRACTICE		LOGY, ANATOMIC LOGY, CLINICAL		SLEEP DISORDERS SPORTS MEDICINE
19			LOGY, FORENSIC		SURGERY, ABDOMINAL
	GYNECOLOGY	54 PED, A			SURGERY, CARDIOVASC
	HEMATOLOGY		ARDIOLOGY		SURGERY, COLON/RECTAL
	HYPNOSIS IMMUNOLOGY		RITICAL CARE MERGENCY MED		SURGERY, GENERAL SURGERY, HAND
	INFECTIOUS DISEASES		NDOCRINOLOGY		SURGERY, HEAD/NECK
	INFERTILITY		EMAT / ONCOLOGY		SURGERY, MAXILLOFAC
	INTERNAL MEDICINE		NFECTIOUS DIS		SURGERY, NEUROLOGICAL
	LARYNGOLOGY LEGAL MEDICINE	59 PED, II			SURGERY, ORTHOPEDIC
29	MATERNAL / FETAL MED		EPHROLOGY EUROLOGY		SURGERY, PLASTIC SURGERY, THORACIC
30	NEO / PERINATAL MED		PHTHALMOLOGY		SURGERY, TRAUMATIC
31		61 PED, P			SURGERY, UROLOGIC
32 33	NEPHROLOGY NEIBOLOGY	95 PED, P			SURGERY, VASCULAR
34	NEUROLOGY NEUROPATHOLOGY	62 PED, R 63 PED, S	URGERY	94	UROLOGY
	.t#	Code	Percent of Time	Board Cert	tified (Indicate Yes/No)
Di		38	40		No
	mary			_	No.
Se	condary	45	30		
`er	rtiary	26	30	_	No

PLEASE INDICATE AMERICAN BOARD OF MEDICAL SPECIALTIES BOARD CERTIFICATION:

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

ir	t care or services		_			
h	istration (schools, agencies, asso	ciations, et	c.)			
	ng medical courses					
	ch	_				
er	(specify Finishing Fellowshi	<u> </u>				
	nt is (Use the followin					
	LOYED	1006		ment Employer (hosp	ital, sc	hool
	ice p or Group Practitioners	1007	etc.) Federal Governmen	nt (armed services pers	sonnel	only
	, EMPLOYED BY	1008		nt (civilian, P.H.S., etc		Omy
	Practitioner	1009	State Government		•	
	p or Group of Practitioners lth Plan Facility (such as H.M.O.)	1010 1011	County Government Local Government			
	rui i ian raemty (such as ii.m.o.)	1012	Other (specify	Finishing Fellowsh	10	
RE	sponses, pľease explain on a separ.	ATE SHEET A	ND RETURN WITH THIS	REGISTRATION APPLICATI	ion.	
	ing questions, these phrases or words have		gs:			
ci	e" is to be construed to include all of the for	ollowing:				
	to make appropriate clinical diagnoses ar			_		
	nicate those judgments and medical information amplifiers; and	ation to patien	ts and other health care p	providers, with or without th	e use of	aids c
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	ses or hearing aids.					
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cc	be construed to include alcohol, drugs or ordance with the prescriber's direction, as we have a superior or the construction of the construction o	well as those u	sed illegally.		•	
	n the day of, or even in the weeks or month we an ongoing impact on one's functioning a				ently eno	ugh s
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	cal substance(s) in any way impair or limit ; npairments caused by your medical conditi				TYes	
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ia,	nosed as having, or have you ever been treated in the illegal use of controlled dangerou			yeurism?	🖳 Yes	E N
rti	ipating in a supervised rehabilitation progr	ram or professi	onal assistance program	which monitors you in orde	∐ Yes r	
	ot engaging in the illegal use of controlled of ant in a legal action involving professional l			anal liability claim naid in	🖵 Yes	E N
uc	a claim yourself?		~	•	🖵 Yes	U N
	stigated for, charged with or convicted of, o facture, distribution, prescribing, or disper			any federal, state or local	🖵 Yes	O N
	sted, investigated for, charged with or convi United States, or a foreign country?	icted of, or ple	d nolo contendere to any	offense, misdemeanor or		
ap	olied for medical licensure in Nevada (includ	ding a residenc	cy program)?		☐ Yes ☐ Yes	S N
tia	te the performance of public service within your receiving a loan or scholarship from t	one year after	the date the public service	ce is required to begin to		
				•	🗆 Yes	□ N
	led a license, permission to practice medici medicine or any other healing arts in any s			sion to take an	☐ Yes	N N
ne	lical license revoked, suspended, limited, o	or restricted in	any state, country or U.S	6. territory?	🛄 Yes	
er	ly surrendered a license to practice in the h led membership or expelled from a medical	society or oth	er professional medical o	organization?	☐ Yes ☐ Yes	N C
ere	you have had staff privileges denied, suspe-	ended, limited,	revoked or not renewed b	by the hospital. List any and	_ 100	
e t	y medical staff in lieu of disciplinary or adn o complete hospital medical records, attend	hospital depar	tion. (Please Note: Do not tment or staff meetings, o	t include suspensions or or maintain required malpract	tice insu	rance
	Mailing	-	Type of	Dates of A	Action	
	Address		Action	From (Mo./Yr.)	To (Mo./	Yr.)
	NA		NA	N/A		
					Type of Dates of A	Type of Dates of Action

STATE OF NEVADA BOARD OF MEDICAL EXAMINERS APPLICATION FOR LICENSURE

PE	RSONAL INFORMATION	ON:				
1.	Present Legal Name _	AUERBACH Last	SAMUEZ First	Louis	Ма	den
	List any other name ev	ver used			WILL	
2.	Business and/or Mailir	ng Address 18615 Stree	BURBANK BLUD #.	214 TARZANA	State	91376 Zip
3.	Home Address	Street	- · . City	State	 Zip	
4.	Telephone (& & & area code	609 9070 Office	(<u>\$1</u> 8 area cod	609 90	·	
5.	Date of Birth	-55	Place of B	i rth	NY USA	
6.	Citizenship: U.S. Citize SUBMIT A CERTIFIED OR A CERTIFIED CO	en Alien Regis D COPY OF BIRTH CEI PY OF ALIEN REGISTI	tration # RTIFICATE, AN ORIGI	Other		ZATION AND/
7.	Age 39 Heigh	nt	Weight	_ Color of Eyes _		
	Color of Hair ,		Social Sec	curity #		
Fo	r the purpose of the folio	owing questions, these j	ohrases or words have	these meanings:		
"M orti	and keep abreast of 2.The ability to commu or without the use of 3.The physician capat	ty to make appropriate of medical developments; inicate those judgments aids or devices, such a pility to perform medical ds or devices, such as of udes physiological, mer and hearing impairment	clinical diagnoses and e and and medical informations s voice amplifiers; and I tasks such as physic corrective lenses or hea antal or psychological costs, cerebral palsy, epilep	exercise reasoned ron to patients and or its patients and or its patients and or its patients are aring aids. Onditions or disorders, muscular dystromatics.	ther health care point surgical procedures, such as, but apply, multiple scle	oroviders, with dures, with or not limited to, erosis, cancer,
los	is, drug addiction, and a	llcoholism.	onar or memariiniess, e	specific learning dis	abilities, i ii v uise	ase, tubercu-
"Ci pre	nemical substances" is scription for legitimate n	s to be construed to inclu nedical purposes and in	ide alcohol, drugs or me accordance with the pr	edications, including escriber's direction,	those taken purs as weli as those	uant to a valid used illegally.
it m	urrently" does not mear leans recently enough s past two years.	on the day of, or even in o that the use of drugs i	n the weeks or months p may have an ongoing ir	receding the comple npact on one's func	etion of this applic ctioning as a licer	cation. Rather, usee, or within
(e.ç	egal use of controlled g. heroin or cocaine) as scription or not taken in	well as the use of cont	rolled dangerous subst	ances which are no	ot obtained pursu	ained illegally lant to a valid
8.	Have you failed to repa by the Federal Govern education? Yes	ment of a state or local	e terms of the loan, any government which you	direct loan or loan received to finance	which is insured of all or any part of	or guaranteed your medical
9.	Do you have a medical and safety? Yes	condition which in any	way impairs or limits yo	ur ability to practice	medicine with re	asonable skill
10.	Does your use of chem and safety?Yes	ical substance(s) in any	way impair or limit you	ur ability to practice	medicine with re-	asonable skill

11.	Are the limitations or impairment treatment (with or without med					
12.	Are the limitations or impairmen the setting, or the manner in w					e of the field of practice,
13.	Have you ever been diagnosed Yes No	l as having, or l	nave you eve	r been treated for p	pedophilia, exhibitio	onism, or voyeurism?
14.	Are you currently engaged in the	ne illegal use of	controlled da	ingerous substance	es?Yes	No
15.	Are you currently participating i you in order to assure that you					
16.	Have you been a defendant in a paid in your behalf or paid such				actice) or had a pro	fessional liability claim
17.	Have you ever been investigate state or local law relating to the Yes No					
18.	Have you ever been arrested, misdemeanor or felony in any					
19.	Have you previously applied fo	r medical licens	sure in Nevad	a (including a resid	lency program)?	YesNo
20.	Have you failed to initiate the pe begin to satisfy a requirement government for your medical e	of your receiving	ng a loan or ş	cholarship from the	r the date the publi e federal governm	c service is required to ent or a state or local
	UCATION:					
21.	List name and address of all co was received.	leges or univers			is where professio Dates of A	
	Name		Addre	SS	From (Mo./Yr.)	To (Mo./Yr.)
	Nya		NYC, NY		9-72 lo	6-76
22.	List name and address of all sch AN OFFICIAL TRANSCRIPT [ools where profe	essional medi THE BOARD.			
	Name	Address		Place Where Instruction Rece		es of Attendance o./Yr.) To (Mo./Yr.)
U	unversidad del Noreste	POBOX 130	McAllen,	Texas 78505-	0130 8	-76 ho 6-80
23.	Doctor of Medicine Degree gra Medical School Name		ledical Schoo	ol Address	Exact Date	e of Issuance
-	Universidad del Doras	Le Pro	longación	Ave Hidalic	6-6	6-80
		Vo	amprio Vi	Ave Mdalzi amps		
			Mexico	V		

	* A source distortion ('ou socii'	for Craduata Madical Education		
	Hospital/	for Graduate Medical Education Mailing	Type of Service	Dates of Attendance
	Institution	Address	or Specialty	From (Mo./Yr.) To (Mo./Yr.)
		See attacked s	host	
				*
 25.	List any and all Fellows	ship training programs attended in the		. Dates of Attendance
	Institution	Mailing Address	Type of , , Fellowship	From (Mo./Yr.) To (Mo./Yr.)
111	at Buffalo	3 Gales Circle Bflo M1429	Advanced felvin	7-96 Ho 6-94
	d Fillmore Hesp	14624 Shorm Way 6th Fle	Breest Diseases Ber	
e t	reast Centr	Van Nues CA 9140.	and Malynant time	3 9-91-6 9-95
26.	Have any actions, restri program? Yes	ctions, limitations, or probations ever be No	Sugget Aspects een imposed on you while	participating in any type of trainin
27.	List any other postgrad	uate medical education not accounted Mailing	d for in questions 24 and to Type of Service	25 above. Dates of Attendance
	Institution	Address	or Specialty	From (Mo./Yr.) To (Mo./Yr.)
	ENSING EXAMINATIO			
28.	Have you ever failed a s FMGEMS, USMLE or s For each of the following	state licensure examination, any part on SPEX, even if subsequently passed? In the location of the location o	Ves No ion, parts and dates take	n, and scores obtained. For eac
28.	Have you ever failed a s FMGEMS, USMLE or s For each of the following	state licensure examination, any part o SPEX, even if subsequently passed?	Ves No ion, parts and dates take	n, and scores obtained. For eac
28. 29.	Have you ever failed a FMGEMS, USMLE or SFor each of the following exam taken, have certifications.	state licensure examination, any part on SPEX, even if subsequently passed? In the location of the location o	Ves No ion, parts and dates take	n, and scores obtained. For eac
28. 29.	Have you ever failed a s FMGEMS, USMLE or s For each of the followin exam taken, have certi NATIONAL BOARDS:	state licensure examination, any part of SPEX, even if subsequently passed? In glicensing examinations list the locate ficate of scores submitted from the testing the scores submitted from the scores submi	No ion, parts and dates take sting entity directly to the	n, and scores obtained. For ead Board.
28. 29. a.	Have you ever failed a s FMGEMS, USMLE or s For each of the followin exam taken, have certi NATIONAL BOARDS:	state licensure examination, any part of SPEX, even if subsequently passed? In glicensing examinations list the locate ficate of scores submitted from the test of the part Taken	No ion, parts and dates take sting entity directly to the	n, and scores obtained. For ead Board.
28. 29. a.	Have you ever failed a serial FMGEMS, USMLE or serial For each of the following exam taken, have certination Location FLEX (Federation Lice Location	state licensure examination, any part of SPEX, even if subsequently passed? In glicensing examinations list the locate ficate of scores submitted from the test state. Part Taken Insing Examination): Part Taken	_V Yes No ion, parts and dates take sting entity directly to the Date	n, and scores obtained. For ead Board. Result (Scores)
28. 29. a.	Have you ever failed a sering FMGEMS, USMLE or sering For each of the following exam taken, have certination Location FLEX (Federation Lice	state licensure examination, any part of SPEX, even if subsequently passed? In glicensing examinations list the locate ficate of scores submitted from the test of the scores submitted from the scores		n, and scores obtained. For ead Board. Result (Scores)

d. USMLE (United States N Location	Medical Licensing Examination): Part Taken	Date	Result (Scores)
41			
e. SPEX (Special Purpose Location	Examination): Part Taken	Date	Result (Scores)
f. ECFMG (Educational Co Location	ommission for Foreign Medical Gra Part Taken	duates) Examination: Date	Result (Scores)
Buthalo, NY	PartIX	1-83	75
	cal Graduates Examination in the	Medical Sciences): Date	Result (Scores)
REA OF SPECIALTY: 0. State your area of specia	ilty: Inhernal Mediene and Os	3/6n-Reluc Gine	rologic Oncology + Breast Disea
	ons by a board recognized by the		lical Specialties.
Specialty Board	Certificat		Dates of Certification/Recertification
	•		
MEDICAL PRACTICE HISTO			
 Account for all periods of be accounted for. City/State 	time since graduation from medica	l school (include military	y service). All periods of time must From (Mo./Yr.) To (Mo./Yr.)
	See affacled	'cV.	

Hospital	Comple	te Mailing Address	o <u>r fellowship affilia</u> Dates From (Mo./Y	of Appoir	ntment To (Mo./`	Yr.)
Valley Hispital Medica	•	Skrman Grebé	7-94	Lo fr	escut	-
]	RECI	EIVE	ΕD
				AUG	1 4 199	15
			·	NEVADA ST MEDICAL	ATE BOA.	AU U
. List any and all licenses <u>yo</u> State or	ou hold or have held to pro	actice medicine in any s	tate or country.	Dates o	f Practic	Δ.
Country	License #	Date of Issu	uance From	n (Mo./Yr.)		
New York	191774	3-23-	23 Han	ebeen in	fellow.	ship
California	A053310	7-27-9	/.	ei ei	•?	
examination to practice med. Have you ever had a med. Yes V No	edicine or any other heali	ng arts in any state, cou	ntry or U.S. territo	country o	∕es <u>V</u> r U.S. te	_ No rritory
examination to practice med. Have you ever had a med. Yes No Have you ever voluntarily Yes No	edicine or any other heali ical license revoked, susp surrendered a license to p	ng arts in any state, could be arts in any state, could be arts in the healing are	ntry or U.S. territo	country o	∕es <u>V</u> r U.S. ter	No rritory
Have you ever had a medical Yes V No Have you ever voluntarily No Have you ever been denie No List all hospitals where you List any and all resignation include suspensions or remeetings, or maintain requirements	edicine or any other healing ical license revoked, susponential surrendered a license to produce the membership or expelled the have had staff privileges as from any medical staff strictions for failure to contained malpractice insurance.	ng arts in any state, could be ended, limited, or restrict oractice in the healing and from a medical society denied, suspended, limit in lieu of disciplinary or applete hospital medical rice.)	entry or U.S. territor eted in any state, ets in any state, controller profession and the records of the ecords, attend her	country or untry or u	r U.S. terrical organ d by the hase Note partment	No rritory' itory? ization nospita: Do not or sta
examination to practice medical. Have you ever had a medical Yes No Have you ever voluntarily Yes No Have you ever been denied No List all hospitals where you List any and all resignation include suspensions or resignation.	edicine or any other healing ical license revoked, suspondered a license to produce the discontinuous discontinuo disc	ng arts in any state, could be and a limited, or restrict or actice in the healing and from a medical society denied, suspended, limit in lieu of disciplinary or applete hospital medical rece.)	entry or U.S. territor eted in any state, ets in any state, controller profession and the records of the ecords, attend her	country or lonal medic ot renewed tion. (Pleadospital de	r U.S. terrical organ d by the hase Note partment	Note that the second of the se

correct; that I am the person named in the credentials to be su	ns and statements made in the above application are true and ibmitted; and that the same were procured in the regular course tion. I understand that if any of my responses on this application
(Notary Seal) TED J. BAADER JR. COMM. #1014519 Notary Public — Collifornia LOS ANGELES COUNTY My Comm. Expires JAN 20,1998	Signature of Applicant Subscribed and sworn to before me this
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

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State of California	
County of Los Angelos	
On October 20, 1895 before r	ne, TED J. BAADER JA. NAME, TITLE OF OFFICER - E.G., "JANE DOE, NOTARY PUBLIC" ALERDACH, MD
DATE	NAME, TITLE OF OFFICER - E.G., "JANE DOE, NOTARY PUBLIC"
personally appeared	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.
TED J. BAADER JR. COMM. \$1014519 Notary Public — California LOS ANGELES COUNTY My Comm. Expires JAN 20,1998	WITNESS my hand and official seal.
	prove valuable to persons relying on the document and could prevent
CAPACITY CLAIMED BY SIGNER	DESCRIPTION OF ATTACHED DOCUMENT
☐ INDIVIDUAL ☐ CORPORATE OFFICER	
TITLE(S)	TITLE OR TYPE OF DOCUMENT
PARTNER(S) LIMITED GENERAL	
ATTORNEY-IN-FACT TRUSTEE(S) GUARDIAN/CONSERVATOR OTHER:	NUMBER OF PAGES
	DATE OF DOCUMENT
SIGNER IS REPRESENTING: NAME OF PERSON(S) OR ENTITY(IES)	
	SIGNER(S) OTHER THAN NAMED ABOVE

NOTICE

RECEIVED

AUG 1 4 1995

FAILURE TO RETURN THIS FORM CAN RESULT IN THE DELAY NEVADA STATE BOARD OF MEDICAL EXAMINERS

IS	YOU HAVE NOT TAKEN ANY OF THESE EXAMINATIONS WITHIN TEN YEARS OF THE DATE YOU RECEIVED BY THE BOARD, YOU WILL NEED TO SIT FOR THE SPECIAL PURPOSE EXAMI RIDER TO BE ELIGIBLE FOR MEDICAL LICENSURE IN THE STATE OF NEVADA.		
5.	Have you received certification by a specialty board of the American Board of Medical Specialties? If answer is yes, indicate date of certification.	Yes	_ No
4.	Have you taken Step III of the United States Medical Licensing Examination (USMLE)? If answer is yes, indicate date taken.	Yes	_ No 🗸
3.	Have you taken Component II of the Federation Licensing Examination (FLEX)? If answer is yes, indicate date taken.	Yes <u>↓</u> 	No
2.	Have you taken the Special Purpose Examination (SPEX)? If answer is yes, indicate date taken.	Yes	_ No <u>i</u>
1.	Have you taken Part III of the examination given by the National Board of Medical Examiners? If answer is yes, indicate date taken.	Yes	_ No