#8817

STATE OF NEVADA BOARD OF MEDICAL EXAMINERS APPLICATION FOR LICENSURE

RECEIVED SEP 27 1990 \$400

NEVADA STATE BOARD OF MEDICAL EXAMINERS

| 4. М | IEW | | Adam | Vin | CENT | MEDICALE | XAMINERS |
|---------------|--------------------------|-----------------|--|-------------------|---|--|--|
| 1. Name | Last | | First | | Middle | | Maiden |
| | | | | | | | |
| If you hav | e ever used another | name, please | indicate | | · | | • |
| | | . ا سم س | th us c (cc. | | | 1 00. | |
| 2. Business | and/or Mailing Addr | ess 534 | - Ma 1291 | ISO, NCH | 7 2 1412 C 17 | , NV 891 | 4/ |
| | | - | | City | State | | Zip |
| 3. Home Ad | dress | | - • | i | | ······································ | |
| | | Street # | _ | City · | State | | Zip |
| 4. Telephon | e Number (<u>702)</u> _ | | | 7-0 | 4652 | - 3357 (| office |
| | | | Office | | | Home | |
| 5. Date of B | i ct h | 57 | Place of Bir | th ⁽ | | | LA |
| 5. Date of B | II (II | | Place of Bil | uı | _ | | - <u>- </u> |
| | M | م | | | | | |
| | ip: US Citizen | | Alien Registration #_ ertificate of Naturaliz | | | | etion |
| | | | | | riegistiation e | ara with this applic | auon. |
| 7. nave you | ever previously app | nea for meaic | al licensure in Nevada | ir 🗆 ies 🔎 | | .• | |
| | | | | | | | |
| | ve date of previous a | | * . | | | | |
| | | | iversities attended ot of directly to the board | | where profession | onal medical instru | ction was received. |
| nave eac | n school submit an c | inciai transcri | bt directly to the board | | | | |
| | Name | | | Address | | Dates of A | Attendance |
| • | | | | | | | To (Mo/Yr) |
| Univ o | f Calif, So | inta Ch | ue San | ta Craz, | Calif | 9/75 | 6/76 |
| | <u>u</u> | | • | | | 9177 | 1 10 4 |
| | | | | | | 717+ | 6180 |
| | | | | | | | |
| 9. List name | and address of all s | chools where | professional medical i | nstruction was re | ceived. Have e | ach school submit a | an official transcript |
| | the board. | · | | | | | |
| | | 1 | | Place W | here | Dates of A | Attendance |
| | Name | | Address | Instruction I | | From (Mo/Yr) | To (Mo/Yr) |
| Univ. of | Southern | | Zonal Hue | School o | f med. | 8/80 | 5/84 |
| 0.1110.01 | Calif | 1-A., | CA 90033 | | | 0,00 | |
| | | | | | | | |
| 10. Doctor of | Medicine Degree gr | anted by: | | | | | • |
| Name of | Medical School | _. | Address of Med | ical School | | Exact Date of Is | ssuance |
| Univ | er. of South | rn Cal. | see abo | ve | 81 | nay 1984 | |
| | | | pards? XYes □ No | | | <u>'</u> | s). Have certificate |
| of scores | submitted from Nati | onal Boards to | the board. | , | , | , ===2 ===3 ===10(| _,, |
| | Location | | Part Taken | D | ate | Result | (Score(s)) |
| | _ | - | | , , | | 1 _ | _ |
| Los Hv | ngeles, CA | | ! , | 1 418 | <u> </u> | PASS | 555 |
| 4 | | I | I | 4/8 | 34 | PASS | 425 |

工工

3185

PASS

450

| Location | Part Taken | Date | Result (S | Score(s)) |
|-------------------------------------|---|---|---|----------------------|
| | | | | |
| Have you taken any part of | ECFMG or FMGEMS? ☐ Yes | If YES, list part(s) taken, lo | cation, date and result(| s) of examina |
| Have certification of examin | nation(s) submitted from the ECFMG d | | Decult / | Saara(a)) |
| Location | Part Taken | Date | nesuit (s | Score(s)) |
| | | | | |
| requested below. | * approved postgraduate training in the Graduate Medical Education | United States or Canada? | [Yes □ No If YES, fill | in the inform |
| Hospital/ | Mailing | Type of Service | Dates of At | |
| Institution | Address | or Specialty Intern | From (Mo/Yr) | To (Mo/Y |
| niv. of Southern C A Co. Med Ctr | Los Angeles, CA 90033 | 03/Eyn | 6 184 | 6/85 |
| alley Med Ctr | 445 S. Cedar Ave Fresna CA 93702 | OB/Gy Resid | . 6 85° | ·6/89 |
| (UC5F) | | San are see | | |
| • | | الم المستواد المستوا المستواد المستواد الم | ी हैं। जिस्से राज तक प्रकारिक प्रकार हुन करने तक करने तक | |
| Have you completed any | ACGME*approved Fellowship progra | | , fill in the information | |
| Institution | Mailing Address | Type of Fellowship | Prom (Mo/Yr) | To (Mo/ |
| | 7,00,000 | | | |
| | | | | |
| List any other postgraduate | e medical education not accounted for | in questions 14 and 15 above | B | |
| Institution | Mailing | Type of Service or Specialty | Dates of A From (Mo/Yr) | ttendance To (Mo/ |
| | Address | of Opecially | | |
| | | | | |
| Area of Specialty: 08 | SSTET PLCS / EYN y a Board recognized by the America | NECOLOGY n Board of Medical Specialtic | es? □ Yes 🕱 No If | YES, comple |
| following: | | | Date | es of: |
| | | On with a ship of the | Date | |
| Specialty Bo | ard | Certification # | Certification | Recertific |

| 19. | Location of | f medical | practice since | graduation | (Include N | Ailitary Service) | |
|-----|-------------|-----------|----------------|------------|------------|-------------------|--|
| | | | | | | | |

| City/State | From (Mo/Yr) | To (Mo/Yr) |
|--------------------------|--------------|------------|
| NELLIS AFB LOSVEGAS NV 8 | 39191 8/89 | Present |
| | | |
| | | , |
| | | , |

20. List below the requested information for <u>all</u> hospitals of which you are, or have ever been a Staff Member at any level. If none, please indicate.

| Hospital | Complete Mailing Address | Date of A | ppointment |
|----------------------------------|--|--------------|--------------|
| поэрна | • | From (Mo/Yr) | To (Mo/Yr) |
| 554 th M.G. Support Hospitate | S54 OSW Hospital Nells AFB NV 89191 | 8/89 | Present |
| Hospitale | | | |
| | | | |
| | | | |
| | | | |
| | | | |

21. Have you been licensed to practice medicine in any state or country? Yes

No if YES, complete the following information:

| State or Country | License # | Date of Issuance | Dates of Practice in A | |
|---------------------------------------|-----------|------------------|------------------------|-------|
| CALIFORNIA | 660065 | 25 June 85 | From (Mo/Yr) | 6 /89 |
| | | | | |
| · · · · · · · · · · · · · · · · · · · | | | | |
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| | | | | 1 |

- 22. Have any disciplinary or administrative actions ever been taken against any healing arts license which you now hold or have ever held? Include any disciplinary and administrative actions by the U.S. Military, U.S. Public Health Service or other U.S. federal government entity.

 Yes No
- 23. Have you ever been denied a license, permission to practice medicine or any other healing arts, or permission to take an examination to practice medicine or any other healing art in any state, country or U.S. territory?
- 24. Have you ever had a medical license revoked, suspended, or limited in any state, country or U.S. territory?

 Yes XNo
- 25. Have you ever voluntarily surrendered a license to practice in the healing arts in any state, country or U.S. territory?

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

 Yes No
- 27. Have you ever had staff privileges in a hospital denied, suspended, limited, revoked or not renewed, or have you ever resigned from a medical staff in lieu of disciplinary or administrative action?

 No (PLEASE NOTE: THIS REQUIREMENT DOES NOT INCLUDE SUSPENSIONS OR RESTRICTIONS FOR FAILURE TO COMPLETE MODERNIA STEPPICAL RECORDS)

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

| | | | | | \ |
|---------------|-------------------------------------|------------------------|---|---------------------------|---|
| | | | | | cal society or other professional medical organization? |
| | | | c or psychologic tr | | |
| ☐ Yes | X 100 | | | | addiction, or acute or chronic substance, drug or alcohol abuse? |
| 32. Do you | regularly take ar | ny prescrip | tion drugs for thera | peutic purpo | oses? 🗆 Yes 🔊 No |
| | | | | | ance registration or had it restricted in any way? Yes No |
| 34. Are you | now or were yo | u in the pa | st, addicted to con | trolled substa | ances, including, but not limited to narcotics or alcohol? 🛘 Yes 💢 No |
| | | | | | r pled nolo contendere to a violation of any federal, state or local law ed substances, or to drug addiction? □ Yes No |
| | | | | | ted of, or pled nolo contendere to any offense, misdemeanot or felony tions of traffic laws resulting in fines of \$75 or less.) ☐ Yes No |
| NOTE: You | are required to | ist any coi | nviction that has be | en set aside | and dismissed under any other provision of law. |
| if you answe | | of question | ons 22 through 35 (| please explai | in the circumstances and disposition on a separate sheet(s) and attach |
| 37. If grante | ed a license, do | you intend | to practice in Neva | ada? X Yes | □ No . |
| If YES: | Location | as 1 | LEGAS | | Date_ASAP |
| 38. Persona | al Information | | | | |
| Age | Heigh | • | Weight. | Color of | Eyes |
| Color of | f Hair | _ Social S | Security Number_ | | |
| in the c | s to the foregoing redentials to be | submitted is unders | ns and statements ; and that the same tood by me, that if | made in the were procu | , being duly sworn, depose and say: That the above application are true and correct; that I am the person named ired in the regular course of instruction and examination without fraudhis application is found to be false or fraudulent, that I forfeit the right |
| At the | | amination, | I wish to be examin | | ea of my specialty as indicated in Number 17 of this application. ea of general medicine. |
| | | | | | ^ · · |
| | | | | |) × lm |
| | | | | | Signature of Applicant |
| | | | | | |
| | | | | | Subscribed and sworn to before me this 247# |
| | | | | | day of SEPTEMBER , 1990 |
| | | (Notary S | ieal) | | Notary Public for State of NEVADA |
| | ~~~~~ | | | | |
| | | COUNTY | State Of Nevada OF CLARK A. RUNKLE | | My Commission Expires 31 MARCH 1992 |
| | | My Appoint | ment Expires 31. 1992 | | Residing at 4535 W. SAMACA AVE. |
| | | | | | LAS UECAS ALL |



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

30 July 90

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

INSTRUCTIONS

The Application, and Form A, are to be completed by the applicant, notarized as indicated, and returned to the Nevada State Board of Medical Examiners.

Forms 1 thru 6, are to be completed by the agencies or individuals indicated. It is the responsibility of the applicant to see that these are promptly returned. The completed application must be received 45 days before any examination will be administered. The forms should be separated and mailed individually, then must be returned directly to the Nevada State Board of Medical Examiners by the agencies or individuals responsible for their completion. If additional copies of any forms are needed, please photocopy.

If additional space is required for answers, separate sheets may be attached to application.

No application will be processed prior to receipt of all required fees. See fee schedule on enclosed sheet.

Application fees are non-refundable.

Please submit the application and Form A along with all required fees to:

Nevada State Board of Medical Examiners P. O. Box 7238 Reno, NV 89510 (702) 329-2559

APPLICANT Do Not Write In This Box For Use At Time Of Interview

| I verify that all statements made on my application for |
|---|
| licensure in the State of Nevada received on |
| , are still true and |
| valid on, the date |
| of my oral examination |
| Signed |
| Witness: 4 Mourey |
| (Board Member) |

Nevada State Board of Medical Examiners

Renewal Responses Report



| License Number | Licensee | License Type |
|----------------|-------------------|----------------|
| 6135 | Adam Vincent LEVY | Medical Doctor |
| | | |
| | | |

| Question | Answer | Date |
|--|--------|------------|
| Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? If you do not have a medical condition, select No. | Z | 05/08/2013 |
| | | |
| | | |
| If you have a medical condition which in any way impairs or limits your ability to practice medicine, | Z | 05/08/2013 |

If you have a medical condition which in any way impairs or limits your ability to practice medicine, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? If you do not have a medical condition, select No. If you use chemical substances, does your use in any way impair or limit your ability to practice If you do not use chemical substances, select No. medicine with reasonable skill and safety?

05/08/2013

Z

| NSBME Renewal Responses Report | onses Report |
|---|--|
| 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? | s a defendant, or been requested to respond as a defendant, to a legal onal liability, malpractice, including any military tort claims if applicable? |

05/08/2013

10/1/2014

Z

Please include: who, what, where (provide state), and when in the textbox directly below this question. Ha acti

Have you had a professional liability, malpractice, claim paid on your behalf or paid such a claim If "Yes" during the time period July 1, 2011 - June 30, 2013 type an explanation in the textbox yourself including any military tort claims if applicable? directly below this question.

05/08/2013

z

misdemeanor, felony, violation of the Uniform Code of Military Justice, or synonymous thereto in a prescribing, or dispensing of controlled substances? Please note that you MUST disclose ANY 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 Justice), state or local law, or the laws of any foreign country, which is a misdemeanor, gross investigation or arrest, including those where the final disposition was dismissal, or contendere to any offense or violation of any federal (including the Uniform Code of Military Have you been arrested, investigated for, charged with, convicted of, or pled guilty or nolo minor traffic offense), or for any offense which is related to the manufacture, distribution, expungement.

Z

05/08/2013

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| NSBME Renewal Responses Report | 10/1/2014 | |
|---|-----------|------------|
| 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? | Z | 05/08/2013 |
| Have you had a medical license or license to practice any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory? | Z | 05/08/2013 |
| Have you voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory in lieu of any disciplinary action? | Z | 05/08/2013 |

Z

05/08/2013

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

NSBME Renewal Responses Report

from the federal government or a state or local government for your medical education?

Statutes and whose duties involve injection practices, has knowledge of and is in compliance with 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 physician in the future, and who is not licensed pursuant to chapter 630 of the Nevada Revised the guidelines of the Centers for Disease Control and Prevention concerning the prevention of also attest that any person who is currently, or will be under my control as their supervising injection practices, your answer should be "YES". I hereby attest to knowledge of and If you believe that you are in compliance with the Centers for Disease Control safe transmission of infectious agents through safe and appropriate injection practices. http://www.cdc.gov/hicpac/2007IP/2007isolationPrecautions.html

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

>

05/08/2013

z

05/08/2013

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| NSBME Renewal Responses Report | 10/1/2014 | |
|--|-----------|------------|
| 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.) | z | 05/08/2013 |
| Have you actively practiced medicine in Nevada within the past 12 months? | Y | 05/08/2013 |
| I hereby request my license to be placed on Inactive status, which means I will <u>not</u> physically | z | 05/08/2013 |

05/08/2013

doctors, whether in state, out of state, active or inactive status! THIS IS NOT OPTIONAL. have completed this action, you may proceed in answering the renewal attestations and website, click on the following link for instructions and complete the required form. Click on the questions. The online renewal site will retain your previous responses. Please go to the DO NOT answer this attestation until you have completed the requisite form. Once you The submission of the in-office surgery/procedure forms is required for <u>all</u> medical following link for the instructions and forms:

"YES". Nevada Revised Statutes (NRS) require the Nevada State Board of Medical Examiners to 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

Are you out of compliance with court ordered child support? If this does not apply to you,

05/08/2013

z

please answer "no".

If "Yes" during the time period July 1, 2011 - June 30, 2013 type an explanation in the textbox directly below this question.

understand that I may be included in a random audit. I agree to retain CME's taken between July have completed the required amount of AMA Category 1 CME within the current biennial. I 1, 2011 and June 30, 2013.

If renewing to an <u>Inactive</u> status, CME is not required and "No" can be selected (Review CME information online at www.medboard.nv.gov)

05/08/2013

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MyLicense Transaction Reports

Reports Home Page

| | Renewal Questions for License Number 6135 | | *, | lyLicense [®] |
|--------------------------|--|---|--------|------------------------|
| License | e Question | | Answer | Date |
| LEVY, Adam Vincent | Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? If you do not have a medical condition, select No. | N | | 4/7/2011 |
| LEVY, Adam Vincent | Explanation 1: For the above question if your answer is "Yes" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box. | | | |
| LEVY, Adam Vincent | 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. | | | 4/7/2011 |
| LEVY, Adam Vincent | Explanation 2: For the above question if your answer is "Yes" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box. | | | |
| LEVY, Adam Vincent | If you use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety? If you do not use chemical substances, select No. | N | | 4/7/2011 |
| LEVY, Adam Vincent | 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. | | | |
| Adam | 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? | Y | | 4/7/2011 |
| Vincent | Please include: who, what, where (provide state), and when in the textbox directly below this question. | | | .,,,2011 |

Explanation 4: For the above question if your

| LEVY, Adam Vincent | 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. | 4/7/2011 |
|--------------------------|---|----------|
| LEVY, | 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? | |
| Adam Vincent | If "Yes" during the time period July 1, 2009 - June 30, 2011 type an explanation in the textbox directly below this question. $^{\rm Y}$ | 4/7/2011 |
| LEVY, Adam Vincent | 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. | 4/7/2011 |
| LEVY, Adam Vincent | 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 Ninfluence 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. | 4/7/2011 |
| LEVY, Adam Vincent | 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. | |
| LEVY, Adam Vincent | 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 N art in any state, country or U.S. territory? | 4/7/2011 |
| LEVY, Adam Vincent | Explanation 7: For the above question if your answer is "Yes" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box. | |

| LEVY, Adam Vincent | Have you had a medical license or license to practice an other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory? | y N | 4/7/2011 |
|--------------------------|--|--------|----------|
| LEVY, Adam Vincent | Explanation 8: For the above question if your answer is "Yes" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box. | | |
| LEVY, Adam Vincent | 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 | 4/7/2011 |
| LEVY, Adam Vincent | 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. | | |
| LEVY, Adam Vincent | Have you been denied membership, been asked to resign or expelled from a medical society or other professional medical organization (including the ABMS)? | N | 4/7/2011 |
| LEVY, Adam Vincent | Explanation 10: For the above question if your answer is "Yes" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box. | | |
| LEVY, Adam Vincent | 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 | 4/7/2011 |
| LEVY, Adam Vincent | 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. | | |
| LEVY, Adam Vincent | Have you surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? | N | 4/7/2011 |
| LEVY, Adam Vincent | Explanation 12: For the above question if your answer is "Yes" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box. | | |

Have you had hospital staff privileges denied, suspended, limited, revoked or not renewed by the hospital, including any and all resignations from any

| | medical staff in lieu of disciplinary or administrative action? | | |
|--------------------------|---|---|----------|
| LEVY, Adam Vincent | 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 | 4/7/2011 |
| LEVY, Adam Vincent | 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. | | |
| LEVY, | Are you out of compliance with court ordered child support? If this does not apply to you, please answer "no". | | |
| Adam Vincent | If "Yes" during the time period July 1, 2009 - June 30, 2011 type an explanation in the textbox directly below this question. | N | 4/7/2011 |
| LEVY, Adam Vincent | 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. | | |
| 1504 | 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. | | |
| LEVY, Adam Vincent | 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 | 4/7/2011 |
| LEVY, Adam Vincent | 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. | | |
| LEVY, Adam Vincent | 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 | 4/7/2011 |
| LEVY, Adam | Explanation 16: For the above question if your answer is "YES", please type your new scope of | | |

| Vincent | practice or specialty in this text box. | | |
|--------------------------|---|---|----------|
| LEVY, | Do you want to change your scope of practice or specialty? | | |
| Adam Vincent | If you answer "Yes" type your current scope of practice or specialty in the textbox directly below this question. | N | 4/7/2011 |
| LEVY, Adam Vincent | 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) | | |
| LEVY, Adam Vincent | 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. | Y | 4/7/2011 |
| | If renewing to an <u>Inactive</u> status, CME is not required and "No" can be selected. | | |
| LEVY, Adam Vincent | 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 | 4/7/2011 |

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|---|--|--|--|
| LEVY, Adam Vincent | LEVY, Adam Vincent | LEVY, Adam Vincent | LEVY, Adam Vincent |
| 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. | If you use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety? | If you 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? | Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? |
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| 5/7/2009 | 5/7/2009 | 5/7/2009 | 5/7/2009 |

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| m Vincent | m Vincent | m Vincent | LEVY, Adam Vincent | LEVY, Adam Vincent |
| 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? | 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? | Have you been arrested, investigated for, charged with, convicted of, or pled guilty or nolo contendere to any criminal offense other than a criminal offense listed in Question #6? Please note that you MUST disclose ANY investigation or arrest, including those where the final disposition was dismissal, sealing of a record, or expungement. | Have you been arrested, investigated for, charged with, convicted of, or pled guilty or nolo contendere to any criminal offense related to the manufacture, distribution, prescribing, or dispensing of controlled substances? Please note that you MUST disclose ANY investigation or arrest, including those where the final disposition was dismissal, sealing of a record, or expungement. | Have you had a professional liability (malpractice) claim paid on your behalf or paid such a claim yourself (including any military tort claims if applicable)? Please include: who, what, where (provide state), when and case number in the textbox directly below this question. Please fax a copy of the complaint, civil or otherwise to 775-688-2551. |
| Z | Z | z | Z | Z |
| 5/7/2009 | 5/7/2009 | 5/7/2009 | 5/7/2009 | 5/7/2009 |
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| | LEVY, Adam Vincent | LEVY, Adam Vincent | | LEVY, Adam Vincent | LEVY, Adam Vincent | LEVY, Adam Vincent |
| 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.) | substance registration or had it revoked or restricted in any way? Have you had hospital staff privileges denied, suspended. | practice as a physician? Have you surrendered your state or federal controlled | than the Nevada State Board of Medical Examiners), have you been: (a) Asked to respond to an investigation; (b) Notified that you were under investigation for; (c) Investigated for; (d) Charged with; or (e) Convicted of any | medical organization (including the ABMS)? Regarding any medical licensing board, hospital medical society, or other governmental entity or agency (other | Have you been denied membership, been asked to resign or expelled from a medical society or other professional | Have you voluntarily surrendered a license to practice medicine or any other healing art in any state, country or |
| | Z | z | | Z | Z | Z |
| | 5/7/2009 | 5/7/2009 | | 5/7/2009 | 5/7/2009 | 5/7/2009 |

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| LEVY, Adam Vincent | | LEVY, Adam Vincent | LEVY, Adam Vincent | LEVY, Adam Vincent | | LEVY, Adam Vincent |
| 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. | 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. | question. I have completed the required amount of AMA Category 1 CME within the current biennial. (Review CME | 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 | I hereby request my license to be placed on Inactive status, which means I will not physically practice in the state of Nevada. | support? If this does not apply to you, please answer "no". If "Yes" during the time period July 1, 2007- June 30, 2009 type an explanation in the textbox directly below this question | Are you out of compliance with court ordered child |
| ≺ | | ~ | Z | Z | | Z |
| 5/7/2009 | | 5/7/2009 | 5/7/2009 | 5/7/2009 | · | 5/7/2009 |
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| 6135 | | 6135 | 6135 | License Number Licensee Name 6135 LEVY, Adam Vin | |
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| LEVY, Adam Vincent | | LEVY, Adam Vincent | LEVY, Adam Vincent | Licensee Name LEVY, Adam Vincent | |
| 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? | 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? | in you use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety? Have you failed to initiate the performance of public | 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? | Question Text Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? | |
| Z | - | 2 2 | z | Answer N | |
| 3/29/2007 | 2/23/2007 | 3/29/2007 | 3/29/2007 | Date Answered 3/29/2007 | |

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| · | LEVY, Adam Vincent | LEVY, Adam Vincent | LEVY, Adam Vincent | LEVY, Adam Vincent | | LEVY, Adam Vincent |
| | Have you been denied membership or expelled from a medical society or other professional medical organization? | Have you voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory by the direct request of a medical board? | 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? | 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? | 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. | 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 |
| | z | Z | Z | z | | z |
| | 3/29/2007 | 3/29/2007 | 3/29/2007 | 3/29/2007 | | 3/29/2007 |
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| LEVY, Adam Vincent | LEVY, Adam Vincent | | LEVY, Adam Vincent | LEVY, Adam Vincent | LEVY, Adam Vincent |
| Is your license currently contingent upon maintaining certification by the American Board of Medical Specialties in the specialty of Family Practice, Emergency Medicine or Preventative medicine? | Is your license currently contingent upon compliance with the Diversion program also known as the Nevada Health Professionals Assistance Foundation? | 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.) | Have you had hospital staff privileges denied, suspended, limited, revoked or not renewed by the hospital? If you | Have you surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? | Have you been: a) notified that you were under investigation for; b) investigated for; c) charged with; or d) convicted of any violation of a statute, rule or regulation governing your practice as a physician by any medical licensing board, hospital, medical society, governmental entity or agency other than the Nevada State Board of Medical Examiners? |
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| LEVY, Adam Vincent | LEVY, Adam Vincent | LEVY, Adam Vincent | LEVY, Adam Vincent | LEVY, Adam Vincent | LEVY, Adam Vincent | LEVY, Adam Vincent | LEVY, Adam Vincent |
| 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. | I hereby request my license to be placed on Inactive status. I will not physically practice in the state of Nevada. | I have actively practiced medicine in Nevada within the past 12 months. | I have completed the required amount of AMA Category 1 CME within the current biennial. (Review CME information online at www.medboard.nv.gov) I understand that I may be included in a random audit following July 1st 2007 renewal. I agree to retain CME's taken between July 1, 2005 and June 30, 2007. | 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 | Do you want to change your scope of practice or specialty? If you answer "Yes" please email your request to elicensensbme@medboard.nv.gov | Are you out of compliance with court ordered child support? If this does not apply to you please answer "no". | 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? |
| ≺ | z | ~ | ~ | ~ | Z | Z | Z |
| 3/29/2007 | 3/29/2007 | 3/29/2007 | 3/29/2007 | 3/29/2007 | 3/29/2007 | 3/29/2007 | 3/29/2007 |

Date Received by Board **PHYSICIAN** License No. MAR 2 8 2005 APPLICATION FOR REGISTRATION RENEWAL FOR THE BIENNIAL REGISTRATION PERIOD 2005 - 2007 APR 1 5 2005 **NEVADA STATE BOARD OF MEDICAL EXAMINERS** Post Office Box 7238 Reno, Nevada 89510 Phone (775) 688-2559 (For Board Use Only) Physical Address: 1105 Terminal Way, Suite 301 Reno, Nevada 89502 I hereby apply for renewal of biennial registration and enclose the appropriate fee(s) as indicated below \$600.00 h ACTIVE STATUS \$300.00.....(INACTIVE STATUS DOES NOT PERMIT **INACTIVE STATUS** I REQUEST NON-RENEWAL OF MY LICENSE* THE PRACTICE OF MEDICINE INCLUDING THE WRITING OF PRESCRIPTIONS IN NEVADA) (*IF YOU ARE REQUESTING NON-RENEWAL, SEE BELOW) File No License No. 6135 Make checks payable to: Adam Vincent LEVY M.D. **NEVADA STATE BOARD OF MEDICAL EXAMINERS** 1670 E Flamingo Rd # C (Foreign checks must indicate "U.S. FUNDS") Las Vegas NV 89119-Request for NON-RENEWAL of License to Practice Medicine In Nevada I hereby represent that I am the person named in this APPLICATION FOR REGISTRATION RENEWAL of license to practice medicine in the state of Nevada. By signing on the signature line below, I am requesting that my license to practice medicine in Nevada NOT be renewed by the Nevada State Board of Medical Examiners. I will return this signed form to the Board office. Date Signature (SIGNATURE STAMP UNACCEPTABLE) PLEASE NOTE: YOUR CURRENT M.D. LICENSE EXPIRES ON JUNE 30, 2005. COMPLETED APPLICATION FOR REGISTRATION RENEWAL FORMS NOT RECEIVED AT THE BOARD OFFICE BY JULY 1, 2005 AT 5:00 P.M. ARE AUTOMATICALLY SUSPENDED FOR NON-PAYMENT. EXTENSIONS OF TIME ARE NOT ALLOWED FOR ANY REASON, AS NEVADA HAS NO GRACE PERIOD. (USE THE ENCLOSED ENVELOPE TO MAIL YOUR COMPLETED APPLICATION FOR REGISTRATION RENEWAL FORM.) YOUR LICENSE WILL NOT BE RENEWED UNLESS YOU ANSWER ALL QUESTIONS ON THIS APPLICATION FOR REGISTRATION RENEWAL FORM. YOU MUST PROVIDE WRITTEN EXPLANATIONS FOR ALL QUESTIONS ANSWERED "YES." ALL INFORMATION YOU PROVIDE ON THIS APPLICATION FOR REGISTRATION RENEWAL FORM IS PUBLIC INFORMATION. PLEASE TYPE OR PRINT LEGIBLY 1. Active status registration renewal requires the submission of proof of completion of 44 hours of AMA Category 1 continuing medical education (CME), which includes 2 hours of CME in medical ethics and 20 hours of CME in your scope of practice or specialty completed during the period July 1, 2003 through June 30, 2005. Additionally, pursuant to Nevada Revised Statutes (NRS) 630.253(2)(b), an applicant must complete a course of instruction relating to the medical consequences of an act of terrorism that involves the use of a weapon of mass destruction. "The course must provide at least 4 hours of instruction that includes instruction in the following subjects: (1) An overview of acts of terrorism and weapons of mass destruction; (2) Personal protective equipment required for acts of terrorism; (3) Common symptoms and methods of treatment associated with exposure to, or injuries caused by, chemical, biological, radioactive and nuclear agents; (4) Syndromic surveillance and reporting procedures for acts of terrorism that involve biological agents; and (5) An overview of the information available on, and the use of, the Health Alert Network." Submit your proof of completion of CME with your completed Application for Registration Renewal form. (See last page of this form for CME statement.) 2. If your name and/or address has changed from that printed on the label on this form, clearly indicate the change in the space provided below. Also, please indicate your current telephone and fax numbers. [Please note: a notarized or certified copy of the document authorizing your name change (marriage license, divorce decree, etc.) must be included.] Name

_____County_____State____Zip_

Phone Number_____ Fax Number____

Street

City__

| Name | | | | | |
|--------|---------------------------------------|----------|--|----------------|--|
| Stree | | | | | *** |
| City_ | Coı | nty | State | | _Zip |
| 2hon | e Number | | ary scopes of practice using the fo | | |
| l. In | dicate below your primary an | d second | ary scopes of practice using the fo | ollowing code | 9S: |
| | | | COPES OF PRACTICE CODES | • | • |
| | | | | OF DEDIATE | RIC, SURGERY |
| 1 | ADDICTION MEDICINE | | NEPHROLOGY NEUROLOGY | 86 PEDIATE | RIC, UROLOGY |
| 2 | ADOLESCENT MEDICINE | 44 | NEURO-OPHTHALMOLOGY | 87 PEDIATE | RICS |
| 3 | AEROSPACE MEDICINE | 46 | NEUROPATHOLOGY | 88 PHYSICA | L MEDICINE/REHABILITATIO |
| 4 | ALLERGY/IMMUNOLOGY | | NEURORADIOLOGY | | TIVE MEDICINE |
| 5 6 | AMBULATORY MEDICINE | | NEUROTOLOGY | 90 PSYCHIA | TRY |
| 7 | ANESTHESIOLOGY | 49 | NON-CONVENTIONAL MEDICINE | 91 PSYCHO | |
| 8 | BLOODBANKING | | NUCLEAR MEDICINE | | MATIC MEDICINE |
| 9 | BRONCO-ESOPHAGOLOGY | 51 | NUTRITION | 93 PUBLIC | |
| 10 | CARDIOVASCULAR DISEASES | 52 | OBSTETRICS | | IARY DISEASES |
| 11 | CATSCAN/ULTRASOUND | 53 | OBSTETRICS/GYNECOLOGY | | TIONAL MEDICINE |
| | CHILD NEUROLOGY | | OCCUPATIONAL MEDICINE | 96 RADIOLO | |
| 13 | CHILD PSYCHIATRY | 55 | ONCOLOGY | 97 RADIOLO | DGY, DIAGNOSTIC DGY, INTERVENTIONAL |
| | CLINICAL PHARMACOLOGY | 56 | ONCOLOGY, GYNECOLOGICAL | | OGY, NUCLEAR |
| | CRITICAL CARE | 57 | ONCOLOGY, HEMATOLOGY ONCOLOGY, RADIATION | | OGY, THERAPEUTIC |
| | DERMATOLOGY | | | | OGY, VASCULAR |
| 17 | | | ONCOLOGY, SURGICAL | 102 RHEUM | |
| | EMERGENCY MEDICINE | | OPHTHALMOLOGY OTOLARYNGOLOGY | 103 RHINOL | |
| | ENDOCRINOLOGY | | OTOLOGY | 104 SLEEP D | |
| | FAMILY PRACTICE | 62 | PAIN MANAGEMENT | 105 SPORTS | |
| 21 | | 64 | PATHOLOGY | | RY, ABDOMINAL |
| | GASTROENTEROLOGY CENERAL BRACTICE | 65 | PATHOLOGY, ANATOMIC | | RY, CARDIOTHORACIC |
| 23 | GENERAL PRACTICE GERIATRIC PSYCHIATRY | 66 | DATHOLOGY CLINICAL | 108 SURGER | RY, CARDIOVASCULAR |
| | GERIATRICS | 67 | PATHOLOGY, FORENSIC | 109 SURGER | RY, COLON/RECTAL |
| 26 | GYNECOLOGY | 68 | PEDIATRIC, ALLERGY | 110 SURGER | RY, CRANIOFACIAL |
| 27 | | 69 | PEDIATRIC, ANESTHESIOLOGY | 111 SURGER | RY, GENERAL |
| 28 | HEMATOLOGY | 70 | PEDIATRIC, CARDIOLOGY | 112 SURGER | |
| 29 | HOMEOPATHY | 71 | PEDIATRIC, CRITICAL CARE | 113 SURGER | RY, HEAD/NECK |
| 30 | | | PEDIATRIC, EMERGENCY MEDICINE | 114 SURGER | RY, MAXILLOFACIAL |
| 31 | IMMUNOLOGY | | PEDIATRIC, ENDOCRINOLOGY | 115 SURGER | RY, NEUROLOGICAL |
| 32 | INFECTIOUS DISEASES | 74 | PEDIATRIC, GASTROENTEROLOGY | | RY, ORTHOPEDIC |
| 33 | INFERTILITY | 75 | PEDIATRIC, HEMATOLOGY/ONCOLOGY | 117 SURGER | |
| 34 | INTÉRNAL MEDICINE | | PEDIATRIC, INFECTIOUS DISEASES | 118 SURGE | RY, THORACIC |
| 35 | LARYNGOLOGY | 77 | PEDIATRIC, INTENSIVIST | | RT, TRANSPLANT |
| 36 | LEGAL MEDICINE | | PEDIATRIC, NEPHROLOGY | | RY, TRAUMATIC RY, UROLOGIC |
| 37 | MATERNAL/FETAL MEDICINE | | PEDIATRIC, NEUROLOGY | | RY, VASCULAR |
| 38 | MEDICAL ACUPUNCTURE | | PEDIATRIC, OPHTHALMOLOGY | 123 TOXICO | |
| 39 | | | PEDIATRIC, PHYSIATRY | 124 TRANSF | |
| 40 | MEDICAL GENETICS | | PEDIATRIC, PULMONARY PEDIATRIC, RADIOLOGY | 125 URGEN | |
| 41 | NEO/PERINATAL MEDICINE | | PEDIATRIC, RADIOLOGY PEDIATRIC, RHEUMATOLOGY | 126 UROLO | |
| 42 | NEOPLASTIC DISEASES | Code | PEDIATRIO, MILLONIA (1929) | 1.8 | <u>Code</u> |
| | つ. | | | | |
| Pr | imary Scope of Practice $\frac{Z}{Z}$ | <u> </u> | Secondary Sco | pe of Practice | ···· |
| | • | | F MEDICAL SPECIALTIES BOARD | CERTIFICATI | ON & RECERTIFICATIO |
| ۲L | EASE INDICATE AMERICAN E | | Date of Initial Certification | ication | Date of Last Recertificati |
| Boa | rd () () 6 cm | | 12/31/91 | | 4 30 03 |
| | | | (Md./Yr.) | | (Mo./Yr.) |
| Sub | board | | | | (Mo./Yr.) |

July 1, 2003, through the present date only.

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

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

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

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

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

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

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

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

| None | | | |
|--|--|--|---|
| List any and all resignations | from any medical staff for failure to complete | in lieu of disciplinary or hospital medical record | ed, limited, revoked or not renewed by the hospital administrative action. (<u>Please Note</u> : Do not include is, attend hospital department or staff meetings, or ch a separate sheet) Dates of Action From (Mo./Yr.) To (Mo./Yr.) |
| 12. Have you ever surrend way? | lered your state or fede | eral controlled substanc | e registration or had it revoked or restricted in any |
| any violation of a statute, remedical society, government | ule or regulation goverr ntal entity or other ager | ning your practice as a process of the Nevalor of t | o) investigated for; c) charged with; or d) convicted or onlysician by any medical licensing board, hospital and State Board of Medical Examiners? Yes No. |
| 10. Have you ever been de | enied membership or ex | xpelled from a medical s | society or other professional medical organization?YesNo |
| 9. Have you ever voluntaril territory? | y surrendered a license | e to practice medicine o | r any other healing art in any state, country or U.S YesNo |
| 8. Have you ever had a meany state, country or U.S. to | | to practice any other hea | aling art revoked, suspended, limited, or restricted inYesNo |
| 7. Have you ever been den examination to practice me | iled a license, permissi dicine or any other hea | ion to practice medicine ling art in any state, cou | or any other healing art, or permission to take are intry or U.S. territory?YesNo |
| violation of any federal, sta | ate or local law, including traffic offense (driving ed a minor traffic offe | ng any foreign country, i or in control of a motor | plead guilty or nolo contendere to any offense or which is a misdemeanor, gross misdemeanor, or vehicle while under the influence of any chemical to the manufacture, distribution, prescribing, orYesNo |
| 5. Have you been a defend paid in your behalf or paid s | ant in a legal action invo such a claim yourself? | olving professional liabil | ity (malpractice) or had a professional liability claimYesNo |
| 4. Have you failed to initiate begin to satisfy a requiren government for your medic | nent of your receiving | ublic service within one a loan or scholarship | year after the date the public service is required to from the federal government or a state or local YesNoN/A |
| 3. If you use chemical substill and safety? | stances, does your use | in any way impair or lim | nit your ability to practice medicine with reasonable YesNoN/A |
| 2. If you have a medical co- limitation reduced or amelia practice? | ondition which in any worated because of the | ray impairs or limits you field of practice, the se | r ability to practice medicine, is that impairment or tting, or the manner in which you have chosen to YesNoN/A |
| 1. Do you have a medical cosafety? | ondition which in any wa | ay impairs or limits your | ability to practice medicine with reasonable skill and YesNo |

CHILD SUPPORT STATEMENT

Date

| • | |
|---|--------|
| 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 compliance with a plan approved by the district attorney or other public agency enforcing the order for the repayment of amount owed pursuant to the order; OR | am in |
| (c) I am subject to a court order for the support of one or more children and am NOT in compliance with the order a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount opursuant to the order. | |
| CONTINUING MEDICAL EDUCATION (CME) STATEMENT | |
| (a) I completed a minimum of 44 hours of AMA Category 1 continuing medical education (CME), 2 hours of were in medical ethics and 20 hours of which were in my scope of practice or specialty, and an additional 4 hours of Category 1 continuing medical education in acts of terrorism, during the past biennial period of July 1, 2003 through Jun 2005; | AMA |
| (b) I was initially licensed in Nevada during the time period January 1, 2004 through June 30, 2004, the secon months of the past biennial period, and completed a minimum of 34 hours of AMA Category 1 continuing medical educ (CME), 2 hours of which were in medical ethics and 20 hours of which were in my scope of practice or specialty, ar additional 4 hours of AMA Category 1 continuing medical education in acts of terrorism; | catio |
| (c) I was initially licensed in Nevada during the time period July 1, 2004 through December 31, 2004, the thirmonths of the past biennial period, and completed a minimum of 24 hours of AMA Category 1 continuing medical educ (CME), 2 hours of which were in medical ethics and 18 hours of which were in my scope of practice or specialty, ar additional 4 hours of AMA Category 1 continuing medical education in acts of terrorism; | catio |
| (d) I was initially licensed in Nevada during the time period January 1, 2005 through June 30, 2005, the four months of the past biennial period, and completed a minimum of 14 hours of AMA Category 1 continuing medical educ (CME), 2 hours of which were in medical ethics and 8 hours of which were in my scope of practice or specialty, ar additional 4 hours of AMA Category 1 continuing medical education in acts of terrorism; OR | cation |
| (e) I am exempt from submitting proof of completion of continuing medical education (CME) because I have compa full year of residency or fellowship training during the biennial period July 1, 2003 through June 30, 2005. | oleted |
| ATTACH COPIES OF PROOF OF YOUR COMPLETION OF CONTINUING MEDICAL EDUCATION (CME) HOURS. IF YOU COMPLETED A FULL YEAR OF RESIDENCY OR FELLOWSHIP TRAINING DURING THE BIENNIAL PERIOD JULY 1, 2003 THROUGH JUNE 30, 2005, ATTACH A COPY OF PROOF OF COMPLETION OF YOUR TRAINING. YOUR COPIES OF PROOF OF CME OR TRAINING COMPLETION WILL NOT BE RETURNED TO YOU. | |
| I HAVE HAVE NOT (CHECK ONE) ACTIVELY PRACTICED MEDICINE IN NEVADA WITHIN THE PAST 12 MONTHS. | |
| BY SIGNING ON THE SIGNATURE LINE BELOW: 1) I HEREBY REPRESENT THAT I AM THE PERSON NAMED IN THIS APPLICATION FOR REGISTRATION RENE OF LICENSE TO PRACTICE MEDICINE IN THE STATE OF NEVADA AND THAT ALL STATEMENTS I HAVE M HEREIN ARE TRUE; | |
| 2) I UNDERSTAND THAT THIS APPLICATION FOR REGISTRATION RENEWAL WILL BE DENIED IF I HAVE NO 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 COPIES PROOF OF CONTINUING MEDICAL EDUCATION (CME), OR RESIDENCY OR FELLOWSHIP TRAIN COMPLETION; (b) PAYMENT OF THE APPROPRIATE REGISTRATION RENEWAL FEE; AND (c) WRITEXPLANATION(S) TO ANY "YES" ANSWER(S). | S OF |
| 2/3/05 | |

Signature (SIGNATURE STAMP UNACCEPTABLE)

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| APPLICATION F | PHYSICIAN OR REGISTRATION RENE | Date Receiv | eu by board | License No. | 6135 |
| | REGISTRATION PERIOD 20 | 03- 2005 ri | E8 2 1 2003 | 2100/100 110 | |
| NEVADA STATE R | CARD OF MEDICAL EXAM | INFRS | | File No. | |
| Post Office Box 7238 Reno | o, Nevada 89510 Phone (775) 68 | 8-2559 MAR 1 0 (For Boa | ard Use Only) | | |
| Physical Address: 1105 Ter | o, Nevada 89510 Phone (775) 68 rminal Way, Suite 301 Reno, Neva wal of biennial registration ar | da 89502''' | <i>f</i> /-> :d: | And balance | |
| hereby apply for rene ACTIVE STA | | \$400,00 | ree(s) as indica | ited below: | |
| INACTIVE S | | The state of the s | CTIVE STATUS | DOES NOT PE | RMIT |
| ~ | NON-RENEWAL OF MY LIC | | | MEDICINE INCL | |
| | REQUESTING NON-RENEWAL, SE | | | RESCRIPTIONS | |
| rieno. | License no: 6135 | | | | · · · · · · · · · · · · · · · · · · · |
| 73777-31 | | MD | | | |
| Adam V LEVY 1670 E Flaming | as Pd. # C | M.D. | | ecks payable to: RD OF MEDICAL | EVALUATE |
| Las Vegas NV | | NEVAD | | ust indicate "U.S. FU | |
| D | - NON DENEWAL | af Lineman to Dun | | aina In Nas | |
| <u>Request f</u> | <u>or NON-RENEWAL</u> | <u>of License to Pra</u> | <u>ctice Medi</u> | <u>cine in Nev</u> | <u>ada</u> |
| | | | | | |
| | hat Lam the person named | in this APPLICATION FO | 'H KEGISTHAT | ION HENEWAL | of license |
| practice medicine in t | | | | | NOT |
| | ignature line below, I am re | | | | |
| enewed by the Neva | da State Board of Medical | Examiners. I will return t | inis signed fori | m to the board | office. |
| | | | | | |
| Date | Signature (SIGNA | TURE STAMP UNACCEP | TABLE) | | |
| | | | *************************************** | | |
| <u>PLEASE NOTE</u> | * | | | | |
| REGISTRATION I YOUR LICENSE W REGISTRATION I ANSWERED "YES | | ILESS YOU ANSWER <u>ALI</u> JST <u>PROVIDE WRITTEN</u> | QUESTIONS (EXPLANATION | ON THIS <i>APPLI</i> IS FOR ALL QU | CATION F ESTIONS |
| INFORMATION. | N YOU PROVIDE ON THIS | APPLICATION FOR HEG | ISTRATION RE | | IS PUBLI |
| | PLEASE T | YPE OR PRINT | LEGIBLY | | |
| medical education (CM specialty completed d e | ation renewal requires the sul IE), which includes 2 hours of uring the period July 1, 200 ation for Registration Renewa | CME in medical ethics and through June 30, 2003. | d 20 hours of CN Submit your pr | ME in your scope oof of completion | of practice |
| roui compieted <i>Applica</i> | ation for Registration Renewa | arionni. (See last page of | una ioitti ioi Civ | iL Statement.) | |
| 2. If your name and/or | r address has changed from | that printed on the label o | n this form, clea | arly indicate the | change in |
| space provided below. | Also, please indicate your c | urrent telephone and fax n | umbers. [Pleas | <u>e note</u> : a notariz | ed or certif |
| | authorizing your name chang | | | | |
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| Phone Number | • | e de la companya de | | | |

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

SCOPES OF PRACTICE CODES

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

Code

Primary Scope of Practice

25

Secondary Scope of Practice

50

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 safety? | condition which in any way | y impairs or limits your abilit | y to practice medicine with reasonable skill andYesNo |
|--|--|---|---|
| 2. If you have a medical limitation reduced or ame practice? | condition which in any wa eliorated because of the fi | y impairs or limits your abil eld of practice, the setting | ity to practice medicine, is that impairment or, or the manner in which you have chosen toNoN/A |
| 3. If you use chemical su skill and safety? | bstances, does your use i | n any way impair or limit yo | ur ability to practice medicine with reasonableNoN/A |
| 4. Have you failed to inition begin to satisfy a require government for your med | ement of your receiving | blic service within one year a loan or scholarship fron | after the date the public service is required to the federal government or a state or localYesNoN/A |
| 5. Have you been a defer paid in your behalf or paid | ndant in a legal action invol d such a claim yourself? | lving professional liability (n | nalpractice) or had a professional liability claim YesNo |
| violation of any federal, s | state or local law, including nor traffic offense (driving a ered a minor traffic offe | g any foreign country, whic or in control of a motor veh | d guilty or nolo contendere to any offense or ch is a misdemeanor, gross misdemeanor, or icle while under the influence of any chemical the manufacture, distribution, prescribing, orYesNo |
| 7. Have you ever been d examination to practice n | enied a license, permissionedicine or any other heali | on to practice medicine or a ing art in any state, country | any other healing art, or permission to take an or U.S. territory? YesNo |
| 8. Have you ever had a many state, country or U.S | | o practice any other healing | art revoked, suspended, limited, or restricted inYesNo |
| 9. Have you ever volunta territory? | arily surrendered a license | to practice medicine or an | y other healing art in any state, country or U.SYesNo |
| 10. Have you ever been | denied membership or ex | pelled from a medical socie | ety or other professional medical organization?YesNo |
| any violation of a statute. | rule or regulation govern | ing your practice as a phys | restigated for; c) charged with; or d) convicted of ician by any medical licensing board, hospital, State Board of Medical Examiners? YesNo |
| 12. Have you ever surre way? | ndered your state or fede | ral controlled substance re | gistration or had it revoked or restricted in anyNo |
| I ist any and all resignation | ns from any medical staff ns for failure to complete t | in lieu of disciplinary or adm | imited, revoked or not renewed by the hospital. ninistrative action. (<u>Please Note</u> : Do not include ttend hospital department or staff meetings, or |
| | Mailing | Type of | Dates of Action |
| Ho sp ital | Address | Action | From (Mo./Yr.) To (Mo./Yr.) |
| | | 4 | |
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| | ्, । ।।।। more spa | ce is needed, attach a sep | arate sheet.) |

CHILD SUPPORT STATEMENT

| Please place a check mark next to one of the following statements: |
|--|
| (a) I am not subject to a court order for the support of a child; |
| (b) I am subject to a court order for the support of one or more children and am in compliance with the order or am in compliance with a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order; OR |
| (c) I am subject to a court order for the support of one or more children and am NOT in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order. |
| CONTINUING MEDICAL EDUCATION (CME) STATEMENT |
| Please place a check mark next to one of the following statements: |
| (a) I completed a minimum of 40 hours of AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics and 20 hours of which were in my scope of practice or specialty, during the past biennial period of July 1, 2001 through June 30, 2003; |
| (b) I was initially licensed in Nevada during the time period January 1, 2002 through June 30, 2002, the second six months of the past biennial period, and completed a minimum of 30 hours of AMA Category I continuing medical education (CME), 2 hours of which were in medical ethics and 20 hours of which were in my scope of practice or specialty; |
| (c) I was initially licensed in Nevada during the time period July 1, 2002 through December 31, 2002, the third six months of the past biennial period, and completed a minimum of 20 hours of AMA Category I continuing medical education (CME), 2 hours of which were in medical ethics and 18 hours of which were in my scope of practice or specialty; |
| (d) I was initially licensed in Nevada during the time period January 1, 2003 through June 30, 2003, the fourth six months of the past biennial period, and completed a minimum of 10 hours of AMA Category I continuing medical education (CME), 2 hours of which were in medical ethics and 8 hours of which were in my scope of practice or specialty; OR |
| (e) I am exempt from submitting proof of completion of continuing medical education (CME) because I have completed a full year of residency or fellowship training during the biennial period July 1, 2001 through June 30, 2003. |
| ATTACH COPIES OF PROOF OF YOUR COMPLETION OF CONTINUING MEDICAL EDUCATION (CME) HOURS. IF YOU COMPLETED A FULL YEAR OF RESIDENCY OR FELLOWSHIP TRAINING DURING THE BIENNIAL PERIOD JULY 1, 2001 THROUGH JUNE 30, 2003, ATTACH A COPY OF PROOF OF COMPLETION OF YOUR TRAINING. YOUR COPIES OF PROOF OF CME OR TRAINING COMPLETION WILL NOT BE RETURNED TO YOU. |
| HAVE NOT (CHECK ONE) ACTIVELY PRACTICED MEDICINE IN NEVADA WITHIN THE PAST 12 MONTHS. |
| BY SIGNING ON THE SIGNATURE LINE BELOW: |
| 1) I HEREBY REPRESENT THAT I AM THE PERSON NAMED IN THIS APPLICATION FOR REGISTRATION RENEWAL OF LICENSE TO PRACTICE MEDICINE IN THE STATE OF NEVADA AND THAT ALL STATEMENTS I HAVE MADE HEREIN ARE TRUE; |
| 2) I UNDERSTAND THAT THIS APPLICATION FOR REGISTRATION RENEWAL WILL BE DENIED IF I HAVE NOT PLACED A CHECK MARK NEXT TO (a), (b), OR (c) UNDER THE CHILD SUPPORT STATEMENT SECTION; AND 3) I UNDERSTAND THAT THIS APPLICATION FOR REGISTRATION RENEWAL WILL BE DENIED IF I HAVE NOT ANSWERED ALL QUESTIONS THEREON AND/OR ATTACHED THERETO: (a) THE APPROPRIATE COPIES OF PROOF OF CONTINUING MEDICAL EDUCATION (CME), OR RESIDENCY OR FELLOWSHIP TRAINING COMPLETION; (b) PAYMENT OF THE APPROPRIATE REGISTRATION RENEWAL FEE; AND (c) WRITTEN EXPLANATION(S) TO ANY "YES" ANSWER(S). |
| 2-7-03 |
| Date Signature (SIGNATURE STAMP UNACCEPTABLE) |

| | /UN |
|--|---|
| PHYSICIAN | Date Received by Board License No. 6 |
| APPLICATION FOR REGISTRATION RENEWAL FOR THE BIENNIAL REGISTRATION PERIOD 2001- 2003 | APR 0 6 2001 |
| NEVADA STATE BOARD OF MEDICAL EXAMINERS | File No |
| Post Office Box 7238 Reno, Nevada 89510 Phone (775) 688-2559 I hereby apply for renewal of biennial registration and enclose the | (For Board Use Only) |
| ACTIVE STATUS | \$600.00 |
| INACTIVE STATUS | \$200.00 (RETIRED STATUS REQUIRES THAT THE |
| RETIRED STATUS SUPERVISING/COLLABORATING PHYSICIAN | \$ 50.00 APPLICANT <u>NOT PRACTICE MEDICINE</u> \$200.00 ANYWHERE) |
| SUPERVISINGSCELABORATING | DECOUGH ANTWICKEY |
| UEDD: W COUGLEST TOXAGE | And the second second |
| Adam V LEVY M.D. | Make checks payable to: NEVADA STATE BOARD OF MEDICAL EXAMINERS |
| 2501 W Charleston Blvd | (Foreign checks must indicate "U.S. FUNDS") |
| Las Vegas NV 89102 | |
| DIFAOT NOTE. | |
| PLEASE NOTE: YOUR CURRENT M.D. LICENSE EXPIRES ON JUNE 30, 2 | 004 COMPLETED APPLICATION FOR REGISTRATION |
| RENEWAL FORMS NOT RECEIVED AT THE BOARD OFF | ICE BY JULY 1, 2001 AT 5:00 P.M. ARE AUTOMATICALLY |
| SUSPENDED FOR NON-PAYMENT. EXTENSIONS OF TI | ME ARE NOT ALLOWED FOR ANY REASON, AS NEVADA |
| HAS <u>NO GRACE PERIOD</u> . (USE THE ENCLOSED ENVEL REGISTRATION RENEWAL FORM.) | OPE TO MAIL YOUR COMPLETED APPLICATION FOR |
| - YOUR LICENSE WILL NOT BE RENEWED UNLESS YOU | ANSWER ALL QUESTIONS ON THIS APPLICATION FOR |
| REGISTRATION RENEWAL FORM. YOU MUST PROVIDE | <u>EWRITTEN EXPLANATIONS</u> FOR ALL QUESTIONS |
| ANSWERED "YES." ALL INFORMATION YOU PROVIDE ON THIS APPLICATION | ON FOR REGISTRATION RENEWAL FORM IS PUBLIC |
| INFORMATION. | |
| PLEASE TYPE OR | PRINT LEGIBLY |
| | |
| 1. To be eligible to act as a SUPERVISING PHYSICIAN FOR | A PHYSICIAN ASSISTANT, and/or as a COLLABORATING |
| PHYSICIAN FOR AN ADVANCED PRACTITIONER OF NURSINgou must complete the enclosed Application for Approval as | Supervising/Collaborating Physician and return it with your |
| payment in the amount of \$200.00 in the enclosed envelope. | |
| 2. Active status registration renewal requires the submission of p | proof of completion of 40 hours of AMA Category 1 continuing |
| medical education (CME), which includes 2 hours of CME in me | dical ethics and 20 hours of CME in your scope of practice or |
| specialty completed during the period July 1, 1999 through J | une 30, 2001. Submit your proof of completion of CME with |
| your completed Application for Registration Renewal form. (Se | e last page of this form for CME statement.) |
| 3. If your name and/or address has changed from that printed or | the label on this form, clearly indicate the change in the space |
| provided below. Also, please indicate your current telephone and | I fax numbers. [Please note: a notarized or certified copy of the |
| document authorizing your name change (marriage license, dive | orce decree, etc.) must be included. |
| Name | |
| Street | |
| CityCounty | |
| Phone Number Fax Num | |
| | |
| 4. IF YOU HAVE RETIRED OR MOVED YOUR PRACTICE, inc | licate the location of patient records below: |
| Name | |
| Street | |
| CityCounty | State Zip |
| Phone Number | |
| | |
| 5. Indicate below the EXACT NAME AND LOCATION of the Me | dical School from which you graduated and your EXACT DATE |
| of graduation: | D. r_& 1004 |
| Medical School Name and Location Jan According | form 3-0-1-10T |
| Medical School Name and Lecation | 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

| D-:- | s | 0 | andam: Chasialty | т. | ortion, Specialty |
|----------|----------------------------------|------------|----------------------------------|----------|-------------------------------------|
| | <u>Code</u> | | <u>Code</u> | | <u>Code</u> |
| 39 | NEPHROLOGY | 7 <u>8</u> | PEDIATRIC, SURGERY | | |
| 38 | NEOPLASTIC DISEASES | 77 | PEDIATRIC, RADIOLOGY | | |
| 37 | NEO/PERINATAL MEDICINE | 76 | PEDIATRIC, PULMONARY | 115 | UROLOGY |
| 36 | MEDICAL GENETICS | 75 | PEDIATRIC, PHYSIATRY | 114 | URGENT CARE |
| 35 | MEDICAL ETHICS | 74 | PEDIATRIC, OPHTHALMOLOGY | 113 | SURGERY, VASCULAR |
| 34 | MEDICAL ACUPUNCTURE | 73 | PEDIATRIC, NEUROLOGY | | SURGERY, UROLOGIC |
| 33 | MATERNAL/FETAL MEDICINE | 72 | PEDIATRIC, NEPHROLOGY | | SURGERY, TRAUMATIC |
| 32 | LEGAL MEDICINE | 71 | PEDIATRIC, INTENSIVIST | | SURGERY, TRANSPLANT |
| 31 | LARYNGOLOGY | | PEDIATRIC, INFECTIOUS DISEASES | | SURGERY, THORACIC |
| 30 | INTERNAL MEDICINE | 69 | PEDIATRIC, HEMATOLOGY/ONCOLOGY | | SURGERY, PLASTIC |
| 29 | INFERTILITY | 68 | PEDIATRIC, GASTROENTEROLOGY | | SURGERY, ORTHOPEDIC |
| 28 | INFECTIOUS DISEASES | 67 | PEDIATRIC, ENDOCRINOLOGY | | SURGERY, NEUROLOGICAL |
| 27 | IMMUNOLOGY | | PEDIATRIC, EMERGENCY MEDICINE | | 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 |
| 22 | GERIATRICS | 61 | PATHOLOGY, CLINICAL | 100 | SURGERY, CARDIOVASCULAR |
| 21 | GENERAL PRACTICE | 60 | PATHOLOGY, ANATOMIC | 99 | SURGERY, CARDIOTHORACIC |
| 20 | GASTROENTEROLOGY | | PATHOLOGY | 98 | SURGERY, ABDOMINAL |
| 19 | FAMILY PRACTICE | | PAIN MANAGEMENT | 97 | SPORTS MEDICINE |
| 18 | ENDOCRINOLOGY | 57 | OTOLOGY | 96 | SLEEP DISORDERS |
| 17 | EMERGENCY MEDICINE | 56 | OTOLARYNGOLOGY | 95 | RHINOLOGY |
| 16 | DERMATOPATHOLOGY | | OPHTHALMOLOGY | 94 | RHEUMATOLOGY |
| 15 | DERMATOLOGY | | ONCOLOGY, SURGICAL | 93 | RADIOLOGY, VASCULAR |
| 14 | CRITICAL CARE | 53 | ONCOLOGY, RADIATION | 92 | RADIOLOGY, THERAPEUTIC |
| 12 13 | CLINICAL PHARMACOLOGY | 52 | ONCOLOGY, HEMATOLOGY | 91 | RADIOLOGY, NUCLEAR |
| 11 | CHILD NEUROLOGY CHILD PSYCHIATRY | 51 | ONCOLOGY, GYNECOLOGICAL | 90 | RADIOLOGY, INTERVENTIONAL |
| 10 | CATSCAN/ULTRASOUND | | ONCOLOGY | 89 | RADIOLOGY, DIAGNOSTIC |
| 9 | CARDIOVASCULAR DISEASES | 48 49 | OCCUPATIONAL MEDICINE | 88 | RADIOLOGY |
| 8 | BRONCO-ESOPHAGOLOGY | | OBSTETRICS OBSTETRICS/GYNECOLOGY | 87 | PULMONARY DISEASES |
| 7 | BLOODBANKING | 46 47 | NUTRITION OBSTETRICS | 86 | PUBLIC HEALTH |
| 6 | ANESTHESIOLOGY | 45 46 | NUCLEAR MEDICINE | 85 | PSYCHOANALYSIS PSYCHOMATIC MEDICINE |
| 5 | ALLERGY/IMMUNOLOGY | 44 | NON-CONVENTIONAL MEDICINE | 83 84 | PSYCHIATRY PSYCHOANALYSIS |
| 4 | ALLERGY | 43 | NEURORADIOLOGY | 82 | PREVENTIVE MEDICINE |
| 3 | AEROSPACE MEDICINE | | NEUROPATHOLOGY | 81 | PHYSICAL MEDICINE/REHABILITATION |
| 2 | ADOLESCENT MEDICINE | 41 | NEURO-OPHTHALMOLOGY | 80 | PEDIATRICS |
| 1 | ADDICTION MEDICINE | 40 | NEUROLOGY | | PEDIATRIC, UROLOGY |
| | | 40 | NEUROL 00V | 70 | DEDIATRIC HOOLOGY |

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

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

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

- 1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments;
- 2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
- 3. The physical capability to perform medical tasks such as physician examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.
- "Medical condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to, orthopedic, vision, speech, hearing, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, emotional or mental illness, HIV disease, tuberculosis, drug addiction, and alcoholism.
- "Chemical substances" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction.

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

| Do you have a medical conditional safety? | on which in any way impairs or limits y | your ability to practice medicine with reasonable skill andYesNo |
|--|--|--|
| 2. If you have a medical condit limitation reduced or ameliorate practice? | on which in any way impairs or limited because of the field of practice, the | s your ability to practice medicine, is that impairment or ne setting, or the manner in which you have chosen to NoN/A |
| 3. If you use chemical substance and safety? | s, does your use in any way impair or | limit your ability to practice medicine with reasonable skillYesNoN/A |
| 4. Have you failed to initiate the begin to satisfy a requirement of for your medical education? | performance of public service within your receiving a loan or scholarship fr | one year after the date the public service is required to com the federal government or a state or local government YesNoN/A |
| 5. Have you been a defendant in paid in your behalf or paid such | | liability (malpractice) or had a professional liability claim YesNo |
| of any federal, state or local la excluding any minor traffic offens | w, including any foreign country, which is the country of a motor vehible for in control of a motor vehible. | plead guilty or nolo contendere to any offense or violation ich is a misdemeanor, gross misdemeanor, or felony, icle while under the influence of any chemical substance is manufacture, distribution, prescribing, or dispensing of |
| 7. Have you ever been denied a examination to practice medicine | a license, permission to practice med or any other healing art in any state | dicine or any other healing art, or permission to take an , country or U.S. territory?YesNo |
| 8. Have you ever had a medical any state, country or U.S. territor | · · · · · · · · · · · · · · · · · · · | er healing art revoked, suspended, limited, or restricted inYesNo |
| 9. Have you ever voluntarily suiterritory? | rendered a license to practice medic | cine or any other healing art in any state, country or U.S. YesNo |
| 10. Have you ever been denied | membership or expelled from a med | dical society or other professional medical organization? |
| any violation of a statute, rule o | r regulation governing your practice | for; b) investigated for; c) charged with; or d) convicted of as a physician by any medical licensing board, hospital, Nevada State Board of Medical Examiners? YesNo |
| 12. Have you ever surrendered | our state or federal controlled substa | ance registration or had it revoked or restricted in anyway? |
| any and all resignations from a | ny medical staff in lieu of disciplinary allure to complete hospital medical r | ended, limited, revoked or not renewed by the hospital. List or administrative action. (<u>Please Note</u> : Do not include ecords, attend hospital department or staff meetings, or |
| Mailing | Type of | Dates of Action |
| Hospital Addres | s Action | From (Mo./Yr.) To (Mo./Yr.) |
| None | | |
| | | |
| | | |
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| | | |

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; I am subject to a court order for the support of one or more children and am in compliance with the order or am in compliance with a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order; OR (c) I am subject to a court order for the support of one or more children and am NOT in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order. CONTINUING MEDICAL EDUCATION (CME) STATEMENT Please place a check mark next to one of the following statements: (a) I completed a minimum of 40 hours of AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics and 20 hours of which were in my scope of practice or specialty, during the past biennial period of July 1, 1999 through June 30, 2001) (b) I was initially licensed in Nevada during the time period January 1, 2000 through June 30, 2000, the second six months of the past biennial period, and completed a minimum of 30 hours of AMA Category I continuing medical education (CME), 2 hours of which were in medical ethics and 20 hours of which were in my scope of practice or specialty; (c) I was initially licensed in Nevada during the time period July 1, 2000 through December 31, 2000, the third six months of the past biennial period, and completed a minimum of 20 hours of AMA Category I continuing medical education (CME), 2 hours of which were in medical ethics and 18 hours of which were in my scope of practice or specialty; (d) I was initially licensed in Nevada during the time period January 1, 2001 through June 30, 2001, the fourth six months of the past biennial period, and completed a minimum of 10 hours of AMA Category I continuing medical education (CME), 2 hours of which were in medical ethics and 8 hours of which were in my scope of practice or specialty: OR (e) I am exempt from submitting proof of completion of continuing medical education (CME) because I have completed

ATTACH COPIES OF PROOF OF YOUR COMPLETION OF CONTINUING MEDICAL EDUCATION (CME) HOURS.

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

a full year of residency or fellowship training during the biennial period July 1, 1999 through June 30, 2001.

| I HAVE_ | HAVE NOT | (CHECK ONE) ACTIVELY PRACTICED MEDICINE IN NEVADA WITHIN THE PAST 12 |
|---------|----------|--|
| MONTHS. | | |

BY SIGNING ON THE SIGNATURE LINE BELOW:

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

3/30/2001

Signature (SIGNATURE STAMP UNACCEPTABLE)

PHYSICIAN APPLICATION FOR RENEWAL REGISTRATION NEVADA STATE BOARD OF MEDICAL EXAMINERS Post Office Box 7238 Reno, Nevada 89510 Phone (775) 688-2559 hereby apply for renewal of biennial registration and enclose the appropriate fee(s) as indicated below: ACTIVE STATUS S200.00 S200.00

Adam V. Levy, MD 2020 Goldring Ave #404 Las Vegas NV 89106

SUPERVISING/COLLABORATING PHYSICIAN

County

City

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

0008817

RETIRED STATUS

PLEASE NOTE

\$ 50.00

8200.00

NEVADA HAS NO GRACE PERIOD ----- LICENSES NOT RENEWED BY JULY 1, 1999
ARE AUTOMATICALLY SUSPENDED FOR NON-PAYMENT.
EXTENSIONS OF TIME ARE NOT ALLOWED FOR ANY REASON.
YOUR LICENSE WILL NOT BE RENEWED WITHOUT ANSWERING ALL QUESTIONS.
ALL YES ANSWERS MUST BE EXPLAINED.

YOU MUST INCLUDE PROOF OF 40 HOURS OF AMA CATEGORY 1 CME WHICH INCLUDES 2 HOURS IN MEDICAL ETHICS AND 20 HOURS IN YOUR SCOPE OF PRACTICE OR SPECIALTY.

ALL FEES MUST BE PAID AND ARE NON-REFUNDABLE.

DO NOT SEND CASH THROUGH THE MAIL.

PLEASE ALLOW SIXTY (60) DAYS FOR PROCESSING OF YOUR APPLICATION.

PLEASE TYPE OR PRINT LEGIBLY

- 1. YOUR CURRENT M.D. LICENSE EXPIRES ON JUNE 30, 1999. THIS IS THE NOTICE TO RENEW YOUR M.D. LICENSE.
- 2. To be eligible to act as a supervising physician for a physician's assistant, or as a collaborating physician for an advanced practitioner of nursing, complete the enclosed Application for Approval as Supervising/Collaborating Physician.
- 3. ACTIVE STATUS REGISTRATION RENEWAL REQUIRES THE SUBMISSION OF PROOF OF 40 HOURS OF AMA CATEGORY 1 CONTINUING MEDICAL EDUCATION which includes 2 hours of medical ethics and 20 hours in your scope of practice or specialty completed during the period July 1, 1997 through June 30, 1999. Submit your proof of CME with your completed Application for Registration Renewal form.
- 4. In order to provide sufficient time for processing, please complete and return your Application for Registration Renewal form and Application for Approval as Supervising/Collaborating Physician form (if applicable) with your proof of 40 hours AMA Category I CME and the correct fee(s) BY JUNE 30, 1999. Use the enclosed self-addressed envelope to return your completed form(s) and fee(s).
- 5. If your name and/or address has changed from that printed on this form, clearly indicate the change in the space provided. A notarized or certified copy of the document authorizing your name change (marriage license, divorce decree, etc.) must be included.

| Name | | *************************************** | |
|---------------|-----------------------------|---|------------------------------|
| Street | | | |
| City | County | State | Zip |
| . IF YOU HAVE | RETIRED OR MOVED YOUR PRACT | TICE, INDICATE THE LOCATION | ON OF PATIENT RECORDS BELOW: |
| Name | | | |

State

Zip

| 7. Are you currently active in me a. [] YES, in training c. [] YES, working pe. [] NO, other (spe | g. part-time | b. [] | YES, working full-tin NO, retired. | ne | |
|---|---|--|--|--|--|
| 8. Please indicate your primar following codes: | y, secondary | SCOPE | specialties and perce OF PRACTICE IALTY CODES | ent of practice time sper | nt in each, using the |
| 102 ADDICTION MEDICINE 1 ADOLESCENT MEDICINE 2 AEROSPACE MEDICINE 3 ALLERGYIMMUNOLOGY 104 ALTERNATIVE MEDICINE 4 ANESTHESIOLOGY 5 BLOODBANKING 6 BRONCO-ESOPHAGOLOGY 7 CARDIOVASCULAR DISEASES 8 CATSCAN/ULTRASOUND 9 CHILD PSYCHIATRY 11 CLINICAL PHARMACOLOGY 12 CRITICAL CARE 13 DERMATOLOGY 14 EMERGENCY MEDICINE 15 ENDOCRINOLOGY 16 FAMILY PRACTICE 17 GASTROENTEROLOGY 18 GENERAL PRACTICE 19 GERIATRICS 20 GYNECOLOGY 21 HEMATOLOGY 21 HEMATOLOGY 22 HYPNOSIS 23 IMMUNOLOGY 24 INFECTIOUS DISEASES 25 INFERTILITY 26 INTERNAL MEDICINE 27 LARYNGOLOGY 28 LEGAL MEDICINE 29 MATERNAL/FETAL MEDICINE 106 MEDICAL ACUPUNCTURE 107 MEDICAL ETHICS 30 NEO/PERINATAL MEDICINE | 32 33 34 35 36 37 38 39 40 41 45 42 43 44 46 47 48 49 50 51 52 53 54 55 59 99 97 56 57 58 59 98 101 61 95 95 96 96 97 97 97 97 97 97 97 97 97 97 97 97 97 | ONCOLOGY, HI ONCOLOGY, RI ONCOLOGY, RI ONCOLOGY, SI OPHTHALMOLO OTOLARYNGOI OTOLOGY PAIN MANAGEN PATHOLOGY, A PATHOLOGY, A PATHOLOGY, C PATHOLOGY, C PATHOLOGY, C PEDIATRIC, CA PEDIATRIC, CA PEDIATRIC, EN PEDIATRIC, EN PEDIATRIC, INI PEDIATRIC, NE | LOGY LOGY ICINE SYNECOLOGY AL MEDICINE YNECOLOGICAL EMATOLOGY ADIATION URGICAL DGY LOGY MENT ANATOMIC CLINICAL FORENSIC LERGY RDIOLOGY ETICAL CARE MERGENCY MEDICINE MERCENCY | 62 PEDIATRIC, RADIOI 63 PEDIATRIC, SURGE 64 PEDIATRIC, UROLO 65 PEDIATRICS 66 PHYSICAL MEDICIN 67 PREVENTIVE MEDIC 68 PSYCHOANALYSIS 70 PSYCHOMATIC MEI 71 PUBLIC HEALTH 72 PULMONARY DISE 73 RADIOLOGY, DIAG 75 RADIOLOGY, THER 77 RHEUMATOLOGY 78 RHINOLOGY 79 SLEEP DISORDERS 100 SPORTS MEDICINE 80 SURGERY, CARDIO 81 SURGERY, CARDIO 81 SURGERY, CARDIO 91 SURGERY, CARDIO 91 SURGERY, CARDIO 91 SURGERY, HAND 82 SURGERY, HAND 83 SURGERY, HEAD/N 92 SURGERY, NEURO 93 SURGERY, NEURO 94 SURGERY, THORA 85 SURGERY, THORA 86 SURGERY, THORA 87 SURGERY, TRAUM 88 SURGERY, VASCUI 94 UROLOGY Board Certified (Indio | ERY OGY EE/REHABILITATION CINE DICINE ASES NOSTIC EAR APEUTIC INAL THORACIC EVASCULAR //ECTAL AL ECK DFACIAL LOGICAL PEDIC CIC ATIC GIC ATIC GIC LAR |
| Primary Secondary Tertiary | Code 3.8 | | | Yes | |
| PLEASE INDICATE ALL AMER | | D OF MEDIC | Ìn | Date of SUBBOARD Date of Sitial Certification | Date of Last Certification |
| | | | | (Mo./Yr.) | (Mo./Yr.) |
| SubboardBoard | | | | (Mo./Yr.) | (Mo/Yr.) |
| | | | | (Mo./Yr.) | (Mo./Yr.) |
| Subboard | | | | (Mo./Yr.) | (Mo./Yr.) |
| 9. Form of employment is | D BY: of Practitions | ers | 1006 Other Non-G 1007 Federal Gove | MPLOYED BY: (continuovernment Employer (he rement (armed services ernment (civilian, P.H.S., ment | ospital, school, etc.) personnel only) |

1012 Other (specify)_

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

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

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

- 1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments;
- 2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
- 3. The physical capability to perform medical tasks such as physician examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.
- "Medical condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to, orthopedic, vision, speech, hearing, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, emotional or mental illness, HIV disease, tuberculosis, drug addiction, and alcoholism.
- "Chemical substances" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction.
- "Currently" does not mean on the day of, or even in the weeks or months preceding the completing of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee.

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

| | · · · · · · · · · · · · · · · · · · · |
|----|---|
| | Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? YesNo |
| | 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? YesNoN/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? YesNoN/A |
| | 4. Have you failed to initiate the performance of public service within one year after the date the public service is required to begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local government for your medical education? Yes NoN/A |
| ď. | 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 |
| | Have you ever been investigated for, charged with, convicted of, or <u>plead guilty</u> 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? YesNo |
| | 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?YesNo |
| | 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? |
| | A Have you ever voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S |
| | 10. Have you ever been denied membership or expelled from a medical society or other professional medical organization?YesNo |

| 12. Have you ever su way? | ırrendered your state or t | federal controlled substance reg | istration or had it revoked or restricted in an |
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| List arry and air resignal | ions from any medical sta tions for failure to comple | att in lieu of disciplinary or admini | nited, revoked or not renewed by the hospital istrative action. (Please Note: Do not includend hospital department or staff meetings, of Dates of Action |
| | | Action | From (Mo./Yr.) To (Mo./Yr.) |
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| amount owed pursuant | to the order; or | | • • |
| plan approved by the | a court order for the sup district attorney or other | pport of one or more children and | d am NOT in compliance with the order or a der for the repayment of the amount owe |
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| pursuant to the order. | | | • • |
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| | | Date received by Board | |
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| APPLICATION FOR RENEWAL REGISTRA NEVADA STATE BOARD OF | TION | MAR 241907 | License No. <u>6135</u> |
| MEDICAL EXAMINERS | | | File No. |
| Post Office Box 7238 Reno, Nevada 89510 Phone (70 | 2) 688-2559 | (Board Use Only) | i ile No. |
| hereby apply for renewal of biennial registra | tion and enclo | se the appropriate fees as ir | ndicated below: |
| ACTIVE STATUSINACTIVE STATUS | \$600.00 | PLEASE NOTE: NEV | ADA HAS NO GRACE PERIOD. |
| RETIRED STATUS | \$150.00 \$ 50.00 | LICE | NSES NOT RENEWED BY |
| P.A. SUPERVISING PHYSICIAN | \$200.00 | JULY | 1, 1997 ARE AUTOMATICALL |
| | , | | PENDED FOR NON-PAYMENT |
| Adam V. Levy, MD | | | , |
| 2020 Goldring Ave #404 | | Make o | checks payable to: |
| Las Vegas, NV 89106 | | (Foreign checks | ARD OF MEDICAL EXAMINERS must indicate "U.S. FUNDS") |
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| INSTRUCT | TIONS - TY | PE OR PRINT LEGIBL | .Y |
| 1 VOLID CURRENT M.D. LIGENGE EVER | | - | |
| 1. YOUR CURRENT M.D. LICENSE EXPIR LICENSE. | CES ON JUN | E 30, 1997. THIS IS THE | NOTICE TO RENEW YOUR M.I |
| 2. To be eligible to act as a supervising physic | cian for a phys | sician assistant complete the | a analoged Application for a |
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| 3. ACTIVE STATUS REGISTRATION RENE | WAL REQUI | RES THE SUBMISSION OF | F PROOF OF 40 HOURS OF AM |
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YOUR LICENSE REGISTRATION WILL NOT BE RENEWED WITHOUT SUBMISSION OF THE CORRECT FEE(S),

PROPERLY COMPLETED FORM(S) AND PROOF OF 40 HOURS OF AMA CATEGORY I, CME'S

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

ALL FEES ARE NON-REFUNDABLE

DO NOT SEND CASH THROUGH THE MAIL

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

| | 1. 740 ye | a. [c. [e. [| YES, in training YES, working NO, other (sp | ng. part-time | b. d. | | YES, v NO, re | vorking ful tired. | I-time | | |
|---|--|--|--|--|--|--|--|--|---|---|----------------------------|
| | 2. Please | indica | te your primary, s | econdary | and tertia | ary sp | ecialties : | and perce | nt of t | ime spent in each, using the | e following codes. |
| | | | | | | SP | ECIALTY | CODE: | | | |
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| Subboard 3. Form | of employm | nent is | (v) | (Lis | e the folk | wina | rodes) | | | (Mo./Yr.) | (Mo./Yr.) |
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| | All of t | he fo | llowing quest | ions ref | er to th | ne tir | ne peri | od July | 1, 1 | 995, through the pre | sent date 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. 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 ATTACHE | D SHEET OF PARED |
|--|--|
| 1. Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable s | kill and safety?Yes No |
| 2. If you have a medical condition which in any way impairs or limits your ability to practice medicine is that impairment because of the field of practice, the setting, or the manner in which you have chosen to practice? | or limitation reduced or arceliorated Yes No N/A |
| if you use chemical substances, does your use of chemical substance(s) in any way impair or limit your ability to pra and safety? | ctice medicine with reasonable skill |
| 4. Have you failed to initiate the performance of public service within one year after the date the public service is required for your receiving a loan or scholarship from the federal government or a state or local government for your medical education. | |
| 5. Have you been a defendant in a legal action involving professional liability (malpractice) or had a professional liabilist such a claim yourself? | lity claim paid in your behalf or paid Yes No |
| 6. Have you ever been investigated for, charged with, convicted of, or plead guilty or nolo contendere to, any offense local law, including any foreign country, which is a misdemeanor, gross misdemeanor, or felony, excluding any minor of a motor vehicle while under the influence of any substance is not considered a minor traffic offense) or which is relative 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 or any other healing arts in any state, country or U.S. territory? | an examination to practice medicine YesNo |
| 8. Have you ever had a medical license revoked, suspended, limited, or restricted in any state, country or U.S. territo | nry? Yes No |
| 9. Have you ever voluntarily surrendered a license to practice a 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 organizations. | ration?YesNo |
| 11. Have you ever been investigated for, charged with, or convicted of any violation of a statute, rule or regulation go any medical licensing board, hospital, medical society, governmental entity or other agency? | verning the practice of medicine by Yes No |
| 12. Have you ever surrendered your state or federal controlled substance registration or had it revoked or restricted in | n any way?Yes : No |
| 13. List all hospitals where you have had staff privileges denied, suspended, limited, revoked or not renewed by the hospital staff in lieu of disciplinary or administrative action. (Please Note: Do not include suspensions or restrict medical records, attend hospital department or staff meetings, or maintain required malpractice insurance). Mailing Type of Dates of Action From (Mo./Yr.) To (Mo./Y | ons for failure to complete hospital |
| AND MAS OFFICE OF | |
| If more space is needed, attach separate sheet. | |
| PLEASE CHECK ONE OF THE FOLLOWING: | |
| I have earned a minimum of 40 hours approved AMA Category I continuing medical education (CME) for the to June 30, 1997. I was initially licensed in Nevada during the second six months of the biennial period July 1, 1995, through minimum of 30 hours approved AMA Category I continuing medical education (CME). I was initially licensed in Nevada during the third six months of the biennial period July 1, 1995, through minimum of 20 hours approved AMA Category I continuing medical education (CME). I was initially licensed in Nevada during the fourth six months of the biennial period July 1, 1995, through minimum of 10 hours approved AMA Category I continuing medical education (CME). I am exempt from submitting proof of continuing medical education (CME) because I have completed a full year during the biennial period July 1, 1999, through June 30 11997 | June 30, 1997 and have earned a June 30, 1997 and have earned a June 3, 1997 and have earned a |
| olgradite | |
| IMPORTANT: ATTACH COPIES OF PROOF OF DECLARED CME CREDITS. PROOF OF CME CRED | DITS WILL NOT BE RETURNED. |
| I HAVE NOT ACTIVELY PRACTICED IN NEVADA WITHIN THE PAST 12 MONTHS. (CHECK (| |
| | DNE) |
| I HEREBY CERTIFY THAT I AM THE PERSON NAMED IN THIS APPLICATION FOR REG LICENSE TO PRACTICE MEDICINE IN THE STATE OF NEVADA AND THAT ALL STATEMEN ARE TRUE. | STRATION RENEWAL OF |
| LICENSE TO PRACTICE MEDICINE IN THE STATE OF NEVADA AND THAT ALL STATEMEN | STRATION RENEWAL OF ITS I HAVE MADE HEREIN |

Date Received hy State Board APPLICATION FOR REGISTRATION RENEWAL License No. **NEVADA STATE BOARD OF** Pile No. MEDICAL EXAMINERS MAY 0 1 1995 Post Office Box 7238 Reno, Nevada 89510 Phone (702) 688-2559 This shaded section for BOARD USE ONLY ereby apply for renewal of biennial registration and enclose the appropriate fees as indicated below: **ACTIVE STATUS** \$420 PLEASE NOTE: NEVADA HAS NO GRACE PERIOD. INACTIVE STATUS \$150 (see attached NRS 630.255 & 630.257) LICENSES NOT RENEWED BY JULY RETIRED STATUS \$ 50 (see attached NRS 630.256 & 630.257) FRACTICHO MEDICINE DIAM STATE) A SUPERINGUE DIVINOUS D 1, 1995 ARE AUTOMATICALLY SUS-PENDED FOR NON-PAYMENT. P.A. SUPERVISING PHYSICIAN \$200 Adam V. Levy, MD Make cheeks payable to NETADA STATE BUARD OF MEDICAL SEASONERS Foreign checks must indicate "1/8", FUNDS" 2010 Goldring #302 Las Vedas NV 89106-0000 INSTRUCTIONS - TYPE OR PRINT LEGIBLY 1. YOUR CURRENT M.D. LICENSE EXPIRES ON JUNE 30, 1995. THIS IS THE NOTICE TO RENEW YOUR M.D.

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

| Name |
|--|
| street 2020 Goldring Ave Ste 404 |
| City Las Vegas county State NV zip Code 89106 |
| F YOU HAVE RETIRED OR MOVED YOUR PRACTICE, PLEASE INDICATE THE LOCATION OF FORMER PATIENT RECORDS BELOW: |
| Name |
| Street |
| City County State Zip Code |
| ; ; ! ! |

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

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

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

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

PLEASE PROVIDE ALL INFORMATION AS REQUESTED.

| 1. | Are you currently active in medicine' a. () YES, in training. b. () YES, working full-time. c. () YES, working part-time. d. () NO, retired. e. () NO, other (specify | • | | | | |
|----------------------------|---|--|--|---|---|--|
| 2. | Please indicate your primary, seconds codes. | | | | it of time spent in e | ach, using the followin |
| | codes. | SPEC | CIALTY (| CODE: | | |
| 1 2 3 4 | AEROSPACE MEDICINE ALLERGY / IMMUNOLOGY | 36 NUC 37 NUT | | | 65 66 | PED, UROLOGY PEDIATRICS PHYSICIAN MED / REHAB |
| 5 6 7 8 | BLOODBANKING BRONCO-ESOPHAGOLOGY CARDIOVASC DISEASES CATSCAN / ULTRASOUND | 39 OBS 40 OCC 41 ONC | TETRICS UPATIONA OLOGY | | 67 68 69 | PHYSICIAN ASSISTANT PREVENTIVE MED PSYCHIATRY PSYCHOANALYSIS PSYCHOMATIC MEDICINE |
| 9 10 11 12 13 | CHILD NEUROLOGY CHILD PSYCHIATRY CLINICAL PHARMACOL CRITICAL CARE DERMATOLOGY | 43 ONC 44 ONC 46 OPH | OLOGY, RA OLOGY, SU THALMOL | TRGICAL OGY | 71 72 73 74 | PUBLIC HEALTH PULMONARY DISEASES RADIOLOGY RADIOLOGY, DIAGNOSTIC |
| 14 15 16 17 | EMERGENCY MEDICINE ENDOCRINOLOGY FAMILY PRACTICE GASTROENTEROLOGY | 48 OTO 49 PAIN 50 PAT | Laryngoi Logy I Managei Hology Hology, A | MENT | 75 76 77 78 79 | RADIOLOGY, THERAPEUT RHEUMATOLOGY RHINOLOGY |
| 18 19 20 21 22 | General practice Geriatrics Gynecology Hematology Hypnosis | 52 PATI 53 PATI 54 PED 55 PED | HOLOGY, C HOLOGY, F ALLERGY CARDIOL CRITICAL | Linical Orensic Ogy | 100 80 | SPORTS MEDICINE SURGERY, ABDOMINAL SURGERY, CARDIOVASC SURGERY, COLON/RECTAL |
| 26 27 28 | IMMUNOLOGY INFECTIOUS DISEASES INFERTILITY INTERNAL MEDICINE LARYNGOLOGY LEGAL MEDICINE MATERNAL / FETAL MED | 97 PED 56 PED 57 PED 58 PED 59 PED 60 PED | EMERGE! ENDOCRI | NCY MED NOLOGY DNCOLOGY US DIS IST OGY | 83 84 92 93 85 86 | SURGERY, HAND SURGERY, HEAD/NECK SURGERY, MAXILLOFAC SURGERY, NEUROLOGICAL SURGERY, ORTHOPEDIC SURGERY, PLASTIC |
| 30 31 | NEO / PERINATAL MED NEOPLASTIC DISEASES NEPHROLOGY NEUROLOGY NEUROPATHOLOGY | 101 PED 61 PED 95 PED 62 PED | | MOLOGY IY IRY GY | 88 89 | SURGERY, THORACIC SURGERY, TRAUMATIC SURGERY, UROLOGIC SURGERY, VASCULAR UROLOGY |
| | imary condary | code 38 | Pe / | rcent of Time | Board Cert | ified (Indicate Yes/No) |
| | rtiary | | | | | |
| | PLEASE INDICATE AMERICAN I | | MEDIC | AL SPECIA | | CERTIFICATION: Date of Last Recertification |
| | | | + (|) | (Me/Ye.) | (Mo/Yr.) |
| Sul | bboard | | | | {Mo/Yr.} | (Mo/Yr.) |
| 3. Z | How many hours per week do you spe hours Patient care or services hours Administration (schools, a Chours Teaching medical courses hours Research hours Other (specify | gencies, asso | ciations, | • | 7 | |
| 4. | Form of employment ts / 507 . (Un SELF-EMPLOYED | se the followin | | | | |
| | 1001 Solo Practice 1002 Partnership or Group Practition SALARIED, EMPLOYED BY 1003 Individual Practitioner 1004 Partnership or Group of Practition 1005 Group Health Plan Facility (successive) | tioners | 1006 1007 1008 1009 1010 1011 1012 | Federal Gove | rnment (armed serv rnment (civilian, P.) ment rnment ment | r (hospital, school, et vices personnel only) H.S., etc.) |

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

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

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

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

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

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

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

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|--------|--|--|--|-------------------------------|---------------|-----|
| 1. | Community of the same of the s | ordance with the terms of the loan, any | direct loan or loan which is insured or gu | ranteed by the Pede | rai | |
| | development of a state of local | government which you received to final | ice all or any part of your medical education | m? | ~ as and | No |
| 2. | no you mave a medical condido | n which in any way impairs or limits yo | ur ability to practice medicine with reason | ما درمان فالبابد ودواله مراطم | ? OYes 2 | No. |
| 3. | noce your use of chemical sub | stance(s) in any way impair or limit you | r ability to practice medicine with engage | hla =1.550 | ☐ Yes 5 | he. |
| 4. | we are nunswoons of unbantitie | nus caused by your medical condition i | educed or ameliorated because of the field | of practice, the | ~ · · · · × | 140 |
| | secting, or the mainter in which | you have chosen to practice? | | | O Yes & | Na |
| 5. | Have you been diagnosed as ha | ving, or have you been treated for pedoj | hilia, exhibitionism, or voveurism? | | O Yes 2 | NO. |
| ь. | Are you currently engaged in th | e illegal use of controlled dangerous su | ibstances? | | /. 1 | |
| 7. | Have you been a defendant in a | legal action involving professional liab | lity (malpractice) or had a professional liat | at bice micio wille | C) Yes | Í40 |
| | Anny neurit of baid ancu a civil | i yourseir? | | | 17 see - 30 | Ł. |
| 8. | Have you been investigated for, | charged with or convicted of, or pied no | olo contendere to a violation of any federal, | state or total | ☐ Yes 🏋 | ÍΛΟ |
| | law relating to the manufacture | distribution, prescribing, or dispensin | d of controlled substances? | State of focal | n. Y | L. |
| 9. | Have you been arrested, investig | rated for, charged with or convicted of | or pled noto contendere to any offense, mis | | Q Yes | ho |
| | felony in any state, the United S | tates, or a foreign country? | p no containdere to any onemse, mis | WEINGROOL OL | , | Z. |
| | Have you previously applied for | medical licensure in Nevada (including | a residency programia A . A | 0.0 | O Yes | - |
| n. | Have you failed to initiate the pe | rformance of public service within one | year after the date the public service is rec | enewax | Co Xes 🗅 | |
| | satisfy a requirement of your re- | ceiving a loan or scholarship from the f | gear after the date the public service is rec ederal government or a state or local gover | juired to begin to | Please | CC |
| | medical education? | and a real of conormaly nom the | edetal Rosettiment of a state of local gover. | ament for your | ٧ ، | c* |
| 12. | | permission to practice medicine or on- | other healing arts, or permission to take : | | O Yes | .Vo |
| | examination to practice medicin | e or any other healing arts in any state | other healing arts, or permission to take | ın | 1. | |
| 13. | Have you had a medical license | covered evenended limited an activity | country or U.S. territory? | | ☐ Yes X | No |
| 14. | Have you voluntarily surrenders | d a license to escale a in the best of | ed in any state, country or U.S. territory? | | 🔾 Yes 🕱 | }o |
| | Have you been dealed manhand | u a neense to practice in the healing ar | ts in any state, country or U.S. territory? | | □ Yes 🕅 | yo. |
| 16 | List all hospitals where was her | in or expensed from a medical society of | r other professional medical organization? | | ☐ Yes X(1 | Vo |
| 10. | all and making from the sale | e nad stall privileges denied, suspended | , limited, revoked or not renewed by the he | ospital. List any and | | |
| | an resignations from any medica | il stall in lieu of disciplinary or adminis | trative action. (Please Note: Do not include | suspensions or | | |
| | restrictions for miture to comple | te hospital medical records, attend hosp | ital department or staff meetings, or mainta | in required malpract | ice insuranc | e.) |
| | | Mailing | Type of | Dates of A | | |
| | Hospital | Address | Action | | To (Mo./Yr.) | |
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| 17. | Have you been investigated for. o |) harged with, or convicted of any violatio | on of a statute, rule or regulation governing | | , | - |
| | medicine by any medical licensis | ig board, hospital, medical society, gove | emmental antity of other agence? | me bractice of | ~~ | 1 |
| 18. | Have you surrendered your state | or federal controlled substance center | ation or had it revoked or restricted in any | | U Yes O | 0 |
| | , | The state of the s | adon or ned it revoked or restricted in any | way" | U Yes S | 0 |
| | | | | | - | |

CONTINUING MEDICAL EDUCATION

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

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

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

- (b) Be approved by the board; and
- (c) Be sponsored in whole or in part by an organization accredited or deemed to be an equivalent organization to offer such programs by the American Medical Association or the Lizison Committee on Continuing Medical Education.
 - 2. Any holder of a license who has completed a full year of residency or fellowship any time during the period for biennial registration immediately

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

- 3. If the holder of a license fails to submit evidence of his completion of continuing medical education within the time and in the manner prescribed by subsection 1, his license will not be renewed. Such a person may not resume the practice of medicine unless, within 2 years after the end of the biennial period of registration, he:
 - (a) Pays a fee to the board which is twice the fee for biennial registration otherwise prescribed by subsection 1 of NRS 630.290;
- (b) Submits to the board, in such form as it requires, evidence that he has completed 40 full hours of continuing medical education in addition to that otherwise required by subsection 1 or NAC 630.157; and
 - (c) Is found by the board to be otherwise qualified for active status pursuant to the provisions of this chapter and chapter 630 of NRS. [Added to NAC by Bd. of Medical Exam'rs, 7-31-85, eff. 8-1-85; A 6-23-86; 11-21-88; 9-12-91]

| ĸ | EASE | CHRCK | ONE | OF | THE | FOI | LOWING: | |
|----|------|-------|-----|-----|------|------|-----------|--|
| Æ. | | CHECK | UNG | Or. | 1115 | I UL | LUUWIING: | |

- 1. I have earned a minimum of 40 hours approved AMA Category I continuing medical education (CME) for the biennial period July 1, 1993 through June 30, 1995.
- 2. I was initially licensed in Nevada during the second six months of the biennial period July 1, 1993, through June 30, 1995 and have earned a minimum of 30 hours approved AMA Category I continuing medical education (CME).
- 3. I was initially licensed in Nevada during the third six months of the biennial period July 1, 1993, through June 30, 1995 and have earned a minimum of 20 hours approved AMA Category I continuing medical education (CME).
- 4. I was initially licensed in Nevada during the fourth six months of the biennial period July 1. 1993, through June 30, 1995 and have earned a minimum of 10 hours approved AMA Category I continuing medical education (CME).
- 5. I am exempt from submitting proof of continuing medical education (CME) because I have completed a full year of residency or fellowship training during the biennial period July 1, 1993 through June 30, 1995.

Signature

ISIGNATURE STAMP UNACCEPTABLE

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

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

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

If you have not practiced medicine in the State of Nevada during the period July 1, 1994, through June 30, 1995, please contact the Board office for further instruction.

Signature (SIGNATURE STMMP U

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

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

- 2. When a holder of a license fails to pay the fee for biennial registration after it becomes due, his license to practice medicine in this state is automatically suspended. The holder may, within 2 years after the date his license is suspended, upon payment of twice the amount of the current fee for biennial registration to the secretary-treasurer, and after he is found to be in good standing and qualified under the provisions of this chapter, be reinstated to practice.
 - 3. The board shall notify a licensee:
 - (a) At least once that his fee for biennial registration is due; and
- (b) That his license is suspended for nonpayment of the fee. A copy of this notice must be sent to the Drug Enforcement Administration (.e United States Department of Justice or its successor agency.

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

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

- 1. Any licensee who changes the location of his practice of medicine from this state to another state or country, has never engaged in the practice of medicine in this state after licensure or has ceased to engage in the practice of medicine in this state for 12 consecutive months must be placed on inactive status.
 - 2. Before resuming the practice of medicine in this state, the inactive registrant shall:
 - (a) Notify the board of his intent to resume the practice of medicine in this state:
 - (b) File an affidavit with the board describing his activities during the period of his inactive status;
 - (c) Complete the form for registration for active status;
 - (d) Pay the applicable fee for biennial registration; and
 - (e) Satisfy the board of his competence to practice medicine.
- 3. If the board determines that the conduct or competence of the registrant during the period of inactive status would have warranted denial of an application for a license to practice medicine in this state, the board may refuse to place the registrant on active status.

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

- 630.256 Retired licensees: Duties; requirements for reinstatement.
- 1. If a licensee retires from the practice of medicine, he shall notify the board in writing of his intention to retire, and the board shall record the fact of retirement. A licensee who is retired may not engage in the practice of medicine. Any licensee who is retired and desires to return to the practice of medicine, must, before resuming the practice of medicine in this state:
 - (a) Notify the board of his intent to resume the practice of medicine in this state;
 - (b) File an affidavit with the board describing his activities during the period of his retired status;
 - (c) Complete the form for registration for active status;
 - (d) Pay the applicable fee for biennial registration; and
 - (e) Satisfy the board of his competence to practice medicine.
- 2. If the board determines that the conduct or competence of the registrant during the period of retirement would have warranted denial of an application for a license to practice medicine in this state, the board may refuse to place the registrant on active status. (Added to NRS by 1985, 2222; A 1987, 195)

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

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

APPLICATION FOR REGISTRATION

NEVADA STATE BOARD OF **MEDICAL EXAMINERS**

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



License No. File No. New 🖸

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

ACTIVE STATUS ☐ INACTIVE STATUS

\$320.009 \$150.00

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

O RETIRED STATUS

\$ 50.00

Adam V. Levy, ND 2010 Goldring #302 Las Vegas

NV 89186-4666

Make checks payable to: BOARD OF MEDICAL EXAMINERS (Foreign checks must indicate 'U.S. PLNDS'

INSTRUCTIONS - TYPE OR PRINT LEGIBLY

- 1. YOUR CURRENT LICENSE EXPIRES ON JUNE 30, 1993. This is the notice to renew your M.D. license. You may apply for your license renewal upon receipt of this notice.
- 2. IN ORDER TO PROVIDE SUFFICIENT TIME FOR PROCESSING, PLEASE RETURN THIS RENEWAL APPLICATION WITH THE CORRECT RENEWAL FEE PRIOR TO JULY 1, 1993.
- 3. Use the enclosed self-addressed envelope to return this renewal notice and registration fee. ACTIVE registration requires submission of proof of 40 hours AMA Category I CME. If you register your license INACTIVE or RETIRED, you may not practice medicine in Nevada, including the writing of prescriptions.
- 4. All fees are non-refundable. Do not send cash through the mail.
- 5. If your name and/or address has changed from that printed on this notice, clearly indicate that change in the space provided. A NOTARIZED or CERTIFIED copy of the document authorizing your name change (marriage license, divorce decree, etc.) must be included.

| Name | |
|--------|--|
| | |
| Street | |

State _____Zip Code _____ __ County ___

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

ACTIVE REGISTRANTS MUST SUBMIT PROOF OF 40 HOURS AMA CATEGORY I CONTINUING MEDICAL EDUCATION (CME). 6-30-93

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

| 1 | I. Are you currently active in med | dicine? | | |
|----|--|---|---|---|
| | a. () YES, in training. | | | |
| | b. () YES, working full-tim | e. | | |
| | c. () YES, working part-tim | | | |
| | d. () NO, retired. | | | |
| | | | | , |
| | (), 1.5, 62161 (specify | | | |
| 2 | Please indicate your primary, se codes: | econdary and tertiary spec | cialties and percent of tim | , e spent in each, using the followin |
| | | SPECIAL | TY CODE: | |
| | 1 ADOLESCENT MEDICINE 2 AEROSPACE MEDICINE 3 ALLERGY/IMMUNOLOGY 4 ANESTITESIOLOGY 5 BLOODBANKING 6 BRONCO ESOPHAGOLOGY 7 CARDIOVASC DISEASES 8 CATSCAN/ULTRASOUND 9 CHILD NEUROLOGY 10 CHILD PSYCHIATRY 11 CLINICAL PHARMACOL 12 CRITICAL CARE 13 DERMATOLOGY 14 EMERGENCY MEDICINE 15 ENDOCRINOLOGY 16 FAMILY PRACTICE 17 GASTROENTEROLOGY 18 GENERAL PRACTICE 19 GERIATRICS 20 GYNECOLOGY 21 HEMATOLOGY 21 HEMATOLOGY 22 HYPNOSIS 23 IMMUNOLOGY 24 INFECTIOUS DISEASES | 25 INFERTILITY 26 INTERNAL MEDICINE 27 LARYNGOLOGY 28 LEGAL MEDICINE 29 MATERNAL/FETAL MED 30 NEO/PERINATAL MED 31 NEOPLASTIC DISEASES 32 NEPHROLOGY 33 NEUROLOGY 34 NEUROPATHOLOGY 35 NEURORADIOLOGY 36 NUCLEAR MEDICINE 37 NUTRITION 38 OBSTETRIC/GYNECOLOGY 39 OBSTETRICS 40 OCCUPATIONAL MED 41 ONCOLOGY 42 ONCOLOGY, GYNECOLOGIC 43 ONCOLOGY, HEMATOLOGY 44 ONCOLOGY, RADIATION 45 ONCOLOGY, SURGICAL 46 OPHTHALMOLOGY 47 OTOLARYNGOLOGY | 49 PAIN MANAGEMENT 50 PATHOLOGY 51 PATHOLOGY, ANATOM 52 PATHOLOGY, CLINICAI 53 PATHOLOGY, CLINICAI 53 PATHOLOGY, FORENSI 54 PED, CARDIOLOGY 55 PED, ENDOCRINOLOG 57 PED, ENDOCRINOLOG 58 PED, INTENSIVIST 60 PED, INTENSIVIST 60 PED, NEPHROLOGY 61 PED, PHYSIATRY 62 PED, RADIOLOGY 63 PED, SURGERY 64 PED, UROLOGY 65 PEDIATRICS 66 PHYSICAL MED/REHAI 67 PREVENTATIVE MED 68 PSYCHOANALYSIS 70 PSYCHOMATIC MEDICI 71 PUBLIC HEALTH | 75 RADIOLOGY, NUCLEAR 76 RADIOLOGY, THERAPEUT 77 RHEUMATOLOGY 78 RHINOLOGY 79 SLEEP DISORDERS GY 80 SURGERY, ABDOMINAL 81 SURGERY, CARDIOVASC 82 SURGERY, COLON/RECTAL 83 SURGERY, GENERAL 84 SURGERY, HAND 85 SURGERY, HEAD/NECK 86 SURGERY, MAXILLOFAC 87 SURGERY, NEUROLOGICAL 88 SURGERY, NEUROLOGICAL 88 SURGERY, PLASTIC 90 SURGERY, THORACIC 91 SURGERY, TRAUMATIC 92 SURGERY, UROLOGIC NE 93 SURGERY, VASCULAR 94 UROLOGY |
| | Code | Percent of Time | Board Certifled (Indicat | e Yes/No) |
| | Primary 38 | 100 % | *** | |
| | Secondary | · | | |
| | Tertiary | *************************************** | | |
| | PLEASE INDICATE AMERICAN Board | | CIALTIES BOARD CERT | IFICATION: |
| 3. | How many hours per week do your 18 hours Patient care or so 20 hours Administration (so 20 hours Research hours Other (specify | ervices schools, agencies, associa l courses | tion, etc.) | }} |
| 4. | Form of employment is 1001. | Use the following codes.) | | |
| | SELF-EMPLOYED 1001 Solo Practice 1002 Partnership or Group Practitioners SALARIED, EMPLOYED BY 1003 Individual Practitioner 1004 Partnership or Group of Practitioners 1005 Group Health Plan Facility (such as F 1006 Other Non-Government Employer (ho Federal Government (armed services.) | H.M.O.) spital, school, etc.) | 1008 Federal Government (c) 1009 State Government 1010 County Government 1011 Local Government 1012 Other (specify | vilian P.H.S., etc.) |

| . I | All of the following questions refer to the time period of July 1, 1991, through the present date on RESPONSES, PLEASE EXPLAIN ON A SEPARATE SHEET AND RETURN WITH THE RENEWAL APPLICATION OF THE PROPERTY O | ly. FOR A | LL YES |
|----------|---|--------------------------------|----------------------------------|
| 5 | o. Have you been rejected for membership by any medical society? | | , |
| | Have you been denied a license to practice medicine? | Yes 🔾 | No X |
| 1 | Have you been denied staff membership with any licensed hospital, nursing home or other hospital care facility with an organized medical staff? | Yes 🖸 | ио/С |
| 8 | 3. Have you been censured, reprimanded, disciplined, had privileges limited, had privileges suspended, been put on probation, or been requested to withdraw from any licensed hospital, nursing home, clinic, or other hospital care facility with an organized medical staff, in which you trained, have been a staff member, have been a partner, or have held hospital privileges? | Yes 🔾 | фои |
| 9 | Have you lost American Board certification because of disciplinary action? | Yes 🖸 | No 🗷 |
| 1 | 0. Have any U.S. state and/or Canadian provincial licensing or disciplinary agencies limited, restricted, suspended or revoked a license you have held or taken any other disciplinary action against you? | Yes 🔾 | По О |
| 1 | 1. Have you voluntarily surrendered a license issued to you by any state and/or Canadian provincial licensing agency while an investigation or other disciplinary action was pending? | Yes 🔾 | No Q |
| 1 | 2. Have you been notified of any current/pending charges or complaints filed against you with any state and/or Canadian provincial licensing or disciplinary agency? | Yes 🔾 | No S |
| 1 | 3. Have you been diagnosed or treated for any physical illness that would serve to hinder your ability to practice medicine? | Yes 🔾 | No 💆 |
| 1 | 4. Have you been diagnosed or treated for mental illness? | Yes 🔾 | No |
| 1 | 5. Have you been chemically dependent? | Yes 🔾 | No S |
| | 6. Have you interrupted your training because of illness or impairment? | Yes 🗀 | No Q |
| 13 | 7. Have you been unable to practice medicine because of illness or impairment? | Yes 🔾 | No Q |
| 16 | Administration (DEA) or State Board of Pharmacy or other lawful authority concerned with controlled substances or been censured. reprimanded, restricted, voluntarily surrendered, placed on probation or had such authority revoked? | Yes 🗅 | Nosq |
| 19 | Have you been indicted, arrested, charged with, convicted, pled guilty or nolo contendere in any criminal prosecution under the laws of any state or of the United States, for any offense reasonably related to the qualifications, functions or duties of a physician, for any offense an essential element of which is fraud, dishonesty or an act of violence, or for any offense involving moral turpitude? | | No |
| 20 | Have you been a defendant in a legal action involving professional liability (malpractice) or had | Yes 🔾 | No 🕽 |
| | processional habitity claim paid in your behalf of paid such a claim yourself? | Yes 🗓 | No S |
| 21 | . Have you been denied provider participation in any State Medicaid or Federal Medicare Program? | Yes 🔾 | No S |
| 22 | Have you been terminated from, sanctioned or penalized by, or had to repay monies to any State Medicaid or Federal Medicare Program as a result of administrative or criminal action? | Yes 🖸 | No D |
| | PLEASE LIST CURRENT HOSPITAL AFFILIATION(S): How has address Name Address Vally Hospital Name Address Vally Hospital Address | 1, NV 1, NV 1, N 1, N | 18910 18910 18910 18910 |
| | CONTINUING MEDICAL EDUCATION | | |

CONTINUING MEDICAL EDUCATION

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

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

(a) Offer, upon successful completion of the program, a certificate of Category 1 credit as recognized by the American

edical Association to the holder of the license;

,b) Be approved by the board; and

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

registration immediately preceding the submission of the application for biennial registration is exempt from the requirements set forth in subsection 1. 3. If the holder of a license fails to submit evidence of his completion of continuing medical education within the time and in the manner prescribed by subsection 1, his license will not be renewed. Such a person may not resume the practice of medicine unless, within 2 years after the end of the biennial period of registration, he: (a) Pays a fee to the board which is twice the fee for biennial registration otherwise prescribed by subsection 1 of NRS 630.290: (b) Submits to the board, in such form as it requires, evidence that he has completed 40 full hours of continuing medical education in addition to that otherwise required by subsection 1 or NAC 630.157; and (c) Is found by the board to be otherwise qualified for active status pursuant to the provisions of this chapter and chapter 630 of NRS. (Added to NAC by Bd. of Medical Exam'rs, 7-31-85, eff. 8-1-85; A 6-23-86; 11-21-88; 9-12-91) PLEASE CHECK ONE OF THE FOLLOWING: 1. I have earned a minimum of 40 hours approved AMA Category I continuing medical education (CME) for the period July 1, 1991, through June 30, 1993. 2. I am exempt because I have completed a full year of residency or fellowship training during the period for biennial registration immediately preceding the submission of this application. 3. I am exempt as I am applying for INACTIVE or RETIRED status. Signature IMPORTANT: ATTACH COPIES OF CERTIFICATES OF DECLARED CME CREDITS PROOF OF CME CREDITS WILL NOT BE RETURNED. Date of Birth: Social Security Number: month/day/year DEA Number: _ Medical School: Residency: City City State City State Fellowship: City State I hereby certify that I am the person named in this application for renewal of license to practice medicine in the state of Nevada: that all statements I have made herein are true; that I am the original and lawful possessor of and person named in the various documents and credentials furnished to the Board in connection with this renewal application. I HAVE XI HAVE NOT ACTIVELY PRACTICED IN NEVADA WIPHIN THE PAST Signature (SIGNATURE STAMP UNACCEPTABLE)

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

APPLICATION FOR REGISTRATION

NEVADA STATE BOARD OF MEDICAL EXAMINERS

Post Office Box 7238 Reno, Nevada 89510 Phone (702) 329-2559

Date Received by State Board

12/190

License No. 6/35

File No.___

New 🗆

Renewal []

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

WACTIVE STATUS

\$300.00 150, and

HINACTIVE STATUS

\$150.00

ė =0.00

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

This shaded section for BOARD USE ONLY

| GRETIRED STATUS \$ 50.00 | IRS630 explanation of status on reverse side |
|---|--|
| [T | Make checks payable to: BOARD OF MEDICAL EXAMINERS (Foreign checks must indicate "U.S. FUNDS") |
| L | |
| TYPE OR P | RINT LEGIBLY |
| NAME LEVY Adam V | Social Security Adddle Business Phone () |
| BUSINESS OR MAILING ADDRESS 6038 E Mirro Street Address or P.O. Box | r Lake Dr. Las Vegas NV 89110 Sulle No. City Las Vegas NV 89110 |
| If you have retired or moved your practice, please indicate the location of former patient's records below: | BOARD OF CERTIFICATION |
| NAME | YesNo |
| aDDRESS | AM. Bd. of |
| PHONE # () | Date of Certification or Recertification |
| Primary Specialty (List only one) | |
| I certify that within the past 24 months. I have completed a minimum of in my files documentation of such. I understand that the CME requirem | 40 hours of Continuing Medical Education, AMA-Category 1 and that I have ent is mandated by NRS 630.253 and NAC 630.153. |
| Signed: | |
| (No rubber stamps) SINCE YOUR LAST PEGISTRATION. (If a second to be seen to | |
| SINCE YOUR LAST REGISTRATION: (If any question is answered "yes," atta 1. Have you been investigated, charged or convicted of unprofessional conduct, professional incompetence or gross or repeated malpractice by any medical licensing board or other agency, hospital or medical society? Yes No Da | 4. Have you been denied a medical license or surrendered your license to practice in another jurisdiction or had your medical license revoked. suspended or limited in another jurisdiction. Yes □ No □ |
| 2. Have you been arrested, fined (over \$100), charged with or convicted of a crime, indicted, imprisoned or placed on probation? Yes \Box No \boxtimes | 5. Have you had staff privileges in a hospital denied, suspended, limited, revoked or not renewed, or have you resigned from a medical staff in lieu of disciplinary or administrative action, excluding failure to complete |
| 3. Have you been investigated, arrested, charged or convicted for the possession, use of, or illegal sale or dispensing of controlled substances? Yes □ No □ | medical records? Yes □ No ⊠ 6. Have any malpractice settlements, awards or judgments been made against you in any jurisdiction? Yes □ No ⊠ |
| STAFF PRIVILEGES: List all Nevada Hospitals in which you have any staf | XC3 C3 110 C3C |
| 1 | 4 |
| | 5 |
| | 6 |
| ertify that all the above statements are true and that I have actively pra | |
| | taken in Nevada within the past 12 months. |
| Sterioture | 420 00 |
| (N) rabber stamps: | Date 1 Dec 90 |

Nevada Medical Professional Liability Closed Claim Report

| I. Background | | | | | | | | | |
|--|-------------------------------|--|----------------|----------------|--------------------------------------|------------------------|--------------|---------------------------------------|--|
| 1. Name of Insurer T | he Doctors' C | ompany | | | 2. | Insurer C | laim N | p: 106364 | A |
| 3. Injury Date (Date of | f Loss) 5/17/ | 95 | 4. Repo | rt Da | te 8/15/96 | | 5. 0 | Closure Dat | te 3/1/07 |
| 6. Policy Type (choos | ea,b,orc) | a) O o | curren | ce | b) Claims mad | le c) X | Tail/Re | porting En | dorsement |
| 7. Policy Limits (Per C | laim/Aggrega | te) \$1M/\$ | 3M | | | Date This 30/07 | Closed | d Claim Re | port Submitted |
| 9. Type of Report (che | oose a or b) | a) X I nitial | Report | : b) | Updated R | eport | | | |
| II. Defendant & C | | ants | | | | | | | |
| 1. Defendant's Name | Last Levy | | | First | Adam | M.I. | Cred M.D. | | g. MD, DO, DMD, DDS) |
| 2. License Number | - | 3. Specialty Obstetrics/G | Descri | ption ogist | | <u> </u> | 111.0. | | efendant(s)? |
| 5. Number of Co-Defe | ndant(s): 3 | | | | | | | | |
| 6. Name, License Num Kenneth Turner, M.D. Rogers Diagnostics — St. Anna Birthing Cent Shelly Hooper, CNMW | – PULIC 🤝 FDC er | rer of Each Co | -Defen | dant, | if known, | | | NEVADO. | APP 2 2007 AST TO STATE OF THE |
| III. Injured & Inj 1. Injured Party's Nam | | | | | F: | | | · | Cty Son |
| | | | | | First | M. | 1. | 1. Sex Fe | male Control |
| 3. Age Date of | Birth - | | . Malpri 1P | actice | code (per Appe | endix 1): | 6. In | jury Code (| per appendix 2): |
| 7. Description of Allege | ed Malpractic | e and Injuries | (Attacl | h Add | litional Sheet(| s) if Nece | essarv | .) | |
| Brain damaged inf | ant as a re | esult of a m | isinter | pret | ation of son | ogram f | inding | s, result | ing in clearance to |
| deliver the patient 8. City Where Injury O | | | | 10 | Name of Tool | - Al (76) | | | |
| of city where figury o | | | | S | . Name of Instit t. Anna Birthing | Center | injury (| occurred in | Institution) |
| IV. Medical/Denta | al Screenin | ng Panel (H | ereaft | er, F | Panel) | | | | |
| 1. Case Filed with Pane | | | | | | NS 2 AND | 3) | | |
| 2. Panel Case Number | | | | | | | | · · · · · · · · · · · · · · · · · · · | |
| L96-07-1197 | | | | | | | | | |
| 3. Panel Decision: Is that a) Yes b) X No c) Una | ere Reasonal ble to Decide | ole Probability | of Malp | raction | e? Other - withdray | wn hefore | nanel | met | |
| 4. Court Case Filed After | | | | | | | parici | | |
| | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | _ 110 _ | | INTOWN | | | | |
| V. Court Case | | | | | | | | | |
| 1. Court Case Filed? X | Yes,No,L | Jnknown (IF Y | ES, ANS | SWER | QUESTIONS 2 | - 7) | | | |
| 2. Court Case Number A361891 | | 3. Cour | | | : | 4 | . Court | Departme | nt Number |
| 5. Date Court Case Was 9/19/97 | 1 | Eighth Date Verdict /23/01 | | | | 7. Date S | ettleme | ent Offer A | ccepted, if Applicable |
| I/I Pagamaga (Ama | 1 | | | | | | | | |
| 1. Reserves | unts Attril | buted to thi \$100,000 | s Def | enda Hio | nt Only, If Notes that \$1,000,000 | <i>fultiple</i> | | | 000 |
| 0.00 | | | | _ '"g | | | | st \$1,000, | 000 |
| VII. Claim Disposit | tion (Attrib | nuted to thi | c Def | | nt Only | | | | |
| Claim Disposition | | ecided By | | | ed By Trial in | b) Deci | ded by | - | c) Decided by |
| (check one) | Trial in Fa Plaintiff | vor of | Favo | or of [| Defendant | Arbitrato Plaintiff | or in Fa | | c) Decided by Arbitrator in Favor of Defendant |
| d) Settled w/o Court or | e) Claim | Denied | f) C | laim l | Inactive | g) Clain | n Witho | irawn | h) Other |

Form NDOI-1102 Page 1 of 3

| ว | T6 CI=: | D: | |
|----------|---------|--|---|
| ۷. | u uaim | Disposition is e, f, g or j, Please Explain | • |
| | | - 10 position, 10 c, 1, g or j, Flease Explain | |

| Derendant's Name (Last, First, M.I.) Levy, Adam | Insurer Claim No. 106364A Date This Closed Claim Report Submitted 3/30/07 |
|---|--|
| VIII. Vardict Information (1) | Claim report Submitted 3/30/07 |

VIII. Verdict Information (Attributed to All Defendants in Case)

| TALL VEI UICE IN | rormation | (Attributed to All Dofordant : |
|-------------------------------------|-----------|--|
| Verdict Awarded | 6,000,000 | (Attributed to All Defendants in Cas |
| | | , and the second |

IX. Claim Information (Amounts Attributed to this Defendant Only, If Multiple Defendants) 1. Settlement Awarded 2. Settlement Paid 3. Reasons for Amount Awarded (1) Not Being Equal to Amount Paid (2), if Applicable (Check More than One, if Applicable) a) ____ Post Verdict Settlement b) ____ Award Reduced to Present Value c) __ Interest Awarded d) __ Court Costs Awarded e) ____ Non-economic damages limited by Judge to \$350,000 f) ____ Award Capped by Judge at Policy Limit g) X Other (Explain) Judgment Paid, plus interest, costs and fees 4. How Will/Did Plaintiff Receive a) X Lump Sum Payments? b) _X_ Periodic Payments 5. If Periodic Payments, What is the Present Value (as of Date of Award) of the Payments? \$951,953.32 N/A 6. Sources of Award Company X b) Defendant \$ **Payments** c) Other (describe) \$ 7. Allocated Loss Adjustment Expenses Total \$840,782 Attorney's Fees Other \$90,282 \$750,500

XI. Closed Claim Report Information

- Contact Person's Name (Last, First) Davis, Rosalind
- 2. Contact Person's Phone Number (702) 396-3872
 - 2. Contact Person's Address The Doctors' Company 3157 N. Rainbow Blvd., Suite 522 Las Vegas, NV 89108

| Name of Person Responsible for Report (Last, First) Davis, Rosalind |
|--|
| Signature of Person Responsible for Report |

Form NDOI-1102

Nevada Medical Professional Liability Closed Claim Report 15 2013 I. Background 1. Name of Insurer National Fire & Marine Insurance Company 2. Insurer Claim No. 3. Injury Date (Date of Loss) 1005300 MEVADA STATE BOARD OF 4. Report Date 11/3/2007 5. Closure Date MEDICAL EXAMINERS 10/31/2008 6. Policy Type (choose a, b, or c) 4/6/2011 **O**ccurrence b) X Claims made Tail/Reporting Endorsement 7. Policy Limits (Per Claim/Aggregate) \$1,000,000/\$3,000,000 8. Date This Closed Claim Report Submitted 11/1/2013 Revised/Updated Report 9. Type of Report (choose a or b) Initial Report b) X Updated Report II. Defendant & Co-Defendants 1. Defendant's Name Last First M.I. Credentials (e.g. MD, DO, DMD, DDS) Adam 2. License Number 3. Specialty 6135 4. Co-Defendant(s)? Description _ Gynecology ISO Code 80277 _Yes <u>X</u> No __ Unknown 6. Name, License Number and Insurer of Each Co-Defendant, if known: N/A III. Injured & Injury 1. Injured Party's Name First 2. Sex: __Male _X_Female 3. Age 4. Date of Birth (MM/DD/YY) 5. Malpractice code (per Appendix 1): 6. Injury Code (per appendix 2): 7. Description of Alleged Malpractice and Injuries (Attach Additional Sheet(s) if Necessary.) Pregnancy termination. Suffered hemorrhage from both uterine atony & uterine wall separation and died more than five hours after care was transferred to the hospital. Alleged improper performance of procedure. Negligence was expressly denied & expert support was obtained for all aspects of the treatment at issue. Modest settlement was reached to avoid further costs of litigation. 8. City Where Injury Occurred -9. Name of Institution (If Injury Occurred in Institution) Las Vegas A-Z Women's Center IV. Medical/Dental Screening Panel (Hereafter, Panel) 1. Case Filed with Panel? __Yes, _X_ No, ___ Unknown (IF YES, ANSWER QUESTIONS 2 AND 3) 2. Panel Case Number: 3. Panel Decision: Is there Reasonable Probability of Malpractice? a)__ Yes b) __ No c) ___ Unable to Decide d) __ Case Dismissed e) ___ Other [case settled/withdrawn before panel met] 4. Court Case Filed After Panel Decision ____ Yes ___ No ___ Unknown V. Court Case 1. Court Case Filed? X Yes, No, Unknown (IF YES, ANSWER QUESTIONS 2 - 7) 2. Court Case Number 3. Court Name A-10-631369-C 4. Court Department Number Clark Co. District Court 5. Date Court Case Was Filed 6. Date Verdict Was Filed, if Applicable 7. Date Settlement Offer Accepted, if Applicable 12/10/2010 VI. Reserves (Amounts Attributed to this Defendant Only, If Multiple Defendants) Initial \$300,000 Highest \$300,000 Last \$300,000 VII. Claim Disposition (Attributed to this Defendant Only) 1. Claim Disposition a) ___ Decided By Trial Decided By Trial b) (check one) Decided by in Favor of Plaintiff __ Decided by in Favor of Defendant Arbitrator in Favor of Arbitrator in Favor of Plaintiff e) X Settled w/o Defendant f)___ Claim Denied g) ___ Claim Inactive h) __ Claim Withdrawn Court or Prior to Trial i) Other 2. If Claim Disposition is e, f, g, h or i, Please Explain - Case settled as a result of mediation.

| Name of Insurer Name (I | not First of Pidell | ic mourance Cor | npany | In | surer Clai | m No. 1005300 | |
|--|---------------------------|----------------------------|----------------------|------------------------------|-------------------|-------------------------------------|----------------------|
| Defendant's Name (L Levy, Adam V. | ast, First, M.I.) | | | Da 11 | te This C | losed Claim Report Revised/Updat | Submitted |
| VIII. Verdict Info 1. Verdict Awarded | Ormation (Attr | ibuted to Au | Dofo | | , -, | xevised/Upda | ea Report |
| Verdict Awarded | \$ | or X N/A | Derendan | ts in Cas | se) | | |
| IX. Claim Inform | ation (Amanus | | | | | | |
| IX. Claim Inform1. Verdict or Settleme3. Reasons for Amoun | nt Awarded \$20, | <i>s Attributed</i> and on | to this De N/A 2. | <i>fendant</i> Verdict or | Only, I | f Multiple Defe | endants) |
| 3. Reasons for Amoun a) Post Verdict Sett e) Non-economic | t Awarded (1) Not | Being Equal to A | Amount Paid | (2) if An | -U | TIL Paid \$20,000 | or N/A |
| a) Post Verdict Seti e) Non-economic g) Other (Explain) | damages limited b | vard Reduced to | Present Valu | (2), II Apj Ie c) | Interest A | heck More than O warded d) | ne, if Applicable) |
| e) Non-economic g) Other (Explain) 1. How Will/Did Plainti | f Doggi | | | | , | - and a de louich fil | nit |
| Payments? | receive | a) <u>X</u> Lum | p Sum | (b) | Poriodia | Day | _ N/A |
| . If Periodic Payments | , What is the Pres | ent Value (as of | Date of Awa | rd) of the | Paymente | 2 ¢ | |
| . Sources of Award ayments | a) Company \$20 | ,000 | b) Defend | | | | |
| . Allocated Loss Adjus | | | i | ant \$ | | c) Other (de | escribe) \$ |
| | | Total \$13,884. | 65 | | y's Fees | Other | \$350.37 |
| . Claim Informat | | | | \$13,53 | | | |
| Co-Defendant's Name | on (Amounts A | ttributed to | Other Def | endants | | _ | |
| License Number | 3. Specialty | | First | | M.I. | Credentials (e. | g. M.D., D.O) |
| _ | Description | | ICO C | | 4. \ | /erdict Awarded | |
| Settlement Made | | | 150 0 | ode | a) _ | Yes_b) N | o c) Unknown |
| Yes b)No | c) Unknown | | 0. Ve | uict or Se | ttlement / | Awarded \$ | or N/A |
| Co-Defendant's Name | Last | | First | | T | | |
| License Number | 3. Specialty | | 11150 | | M.I. | Credentials (e.g | . M.D., D.O) |
| 2-117 | Description | | ISO Co | de | 4. Ve | erdict Awarded | c) Unknown |
| Settlement Made Yesb)No_c |) Unknown | | 6. Ver | dict or Set | tlement A | No warded \$ | c) Unknown or N/A |
| o-Defendant's Name | Last | | F: | | | | |
| icense Number | 2 Specially | | First | | M.I. | Credentials (e.g. | M.D., D.O) |
| | Specialty Description | | ISO Co | _ | 4. Ve | rdict Awarded | |
| ettlement Made Yes_b) No_c) | | | ISO Cod | | _ (a) | Yes b) No | |
| | Unknown | | | | AV | varued \$ | or N/A |
| o-Defendant's Name | Last | | First | | M.I. | Conde | |
| cense Number | 3. Specialty | | | | | Credentials (e.g. | M.D., D.O) |
| ttlement Made | Description | | _ ISO Code | 1 | 4. Ver | dict Awarded | -> |
| Yes b) No c) | Unknown | | | | ement Aw | Yes b) No arded \$ | |
| ach Additional Sh | | ssarv) | | | | | or N/A |
| | | | | | | | |
| Closed Claim Rentact Person's Name (| Last, First) | TION |] | | | ···· | |
| ow, Pameia | | | Nai | ne of Pers dlow, Pan | son Respo nela | nsible for Report (| Last, First) |
| ntact Person's Phone N 463-3776 X6370 | | 9-9999} | Sign | nature of I | Person Re | sponsible for Repo | ort |
| ntact Person's Address | | | | | 47 | | |
| Reed Road | | | | - | | | |

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Page 2 of 3

Appendix 1

Cause of loss for Question III. 5.

| Code | Description |
|---------|--|
| Proced | ure Related Causes |
| MP | Mistake in Performance, Improperly Performed |
| DP | Delayed Delayed |
| NP | Not Performed |
| WP | Wrong Procedure, Procedure Not Indicated |
| BP | Better Alternative Available |
| OP | Other Procedural Errors, Including Misprescription of Medication |
| Diagno | sis Related Causes |
| FD | Failure to Diagnose |
| DD | Delayed Diagnosis |
| WD | Wrong Diagnosis |
| OD | Other Diagnostic Frrors |
| Other C | auses |
| IO | Failure to Inform, Lack of Informed Consent |
| SO | Lack of Supervision |
| PO | Failure to Prevent Harm |
| 00 | Other Cause(s) not Listed Above |

Appendix 2

Injury Codes for Question III.6. (if multiple injuries, select code most applicable to primary injury)

Code Description

| Code | Description Description | | | | | | |
|---------|--|--|--|--|--|--|--|
| Death | | | | | | | |
| DTH | Death (e.g., fetal death, death of patient) | | | | | | |
| Non-Pl | ysical/Emotional Injury | | | | | | |
| NPh | Non-Physical (e.g. abandonment breach of | | | | | | |
| | Non-Physical (e.g., abandonment, breach of contract, deposition, emotional distress, defamation, negligent referral, subrogation loss of consortium. | | | | | | |
| Physica | defamation, negligent referral, subrogation, loss of consortium, sexual misconduct) I Injury without Death | | | | | | |
| BnD | Bone Damage (e.g., fracture) | | | | | | |
| Bth | Birth Injury (e.g. complications brain descriptions | | | | | | |
| Crc | Birth Injury (e.g., complications, brain damage to new born, abortion problems) Circulatory Injury (e.g., heart failure, hemorrhage) | | | | | | |
| Dis | Disease (e.g., AIDS, cancer) | | | | | | |
| DLE | Diminished Life Expectancy (e.g., usually from a failure to diagnose) | | | | | | |
| Dsf | Disfigurement (e.g., scars) | | | | | | |
| Drm | Dermal Injury (e.g., burns) | | | | | | |
| Dnt | Dental Injury (e.g., broken tooth) | | | | | | |
| DLU | Diminished Use/Loss of Use (e.g., disablement of the time) | | | | | | |
| FnB | Diminished Use/Loss of Use (e.g., disablement of a limb, but not loss of the limb) Foreign Body (e.g., left after surgery) | | | | | | |
| Inf | Infection (e.g., usually resulting from surgery) | | | | | | |
| LLO | LOSS OF LIMD/Organ (e.g., amputation, romoval) | | | | | | |
| MLI | Muscular/Limb Injury (e.g. atrophy) | | | | | | |
| Nrv | Nervous System (e.g., paralysis, nerve damage) | | | | | | |
| Org | Organ Injury (e.g., perforation, rupture) | | | | | | |
| Opt | Optical/Sensory Injury (e.g., vision, hearing) | | | | | | |
| Pan | Pain | | | | | | |
| Prl | Prolonged (e.g., additional care, delayed recovery) | | | | | | |
| Rpr | Reproductive System (e.g., infertility) | | | | | | |
| SdE | Side Effects (e.g., reactions) | | | | | | |
| Vrg | Wrong Organ Removed, Injury Caused by Unnecessary Treatment | | | | | | |
| Note: | If Other Injury, select one of the above codes that has the closest match | | | | | | |

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RECEIVED

Nevada Medical Professional Liability Closed Claim Report OCT 2 0 2004 NEVADA STATE BOARD OF I. Background 1. Name of Insurer 2. Insurer Claim No. American Physicians Assurance Corporation 19155-01 3. Injury Date (Date of Loss) 4. Report Date 3/19/2002 8/22/2002 6. Policy Type (choose a, b, or c) **O**ccurrence b) _x_ Claims made ail Reporting Endorsement 7. Policy Limits (Per Claim/Aggregate) 8. Date This Closed Claim Report Submitte \$_1M___/\$_3M 8/6/2004 9. Type of Report (choose a or b) a) X Initial Report Updated Report II. Defendant & Co-Defendants 1. Defendant's Name Last First M.T. Credentials (e.g. MD, DO, DMD, DDS) Levy Adam 2. License Number 3. Specialty 6135 4. Co-Defendant(s)? Description _OB/GYN ISO Code _X_ Yes __ No _ Unknown 5. Number of Co-Defendant(s): _2_ or _ Unknown 6. Name, License Number and Insurer of Each Co-Defendant, if known: Shayna H. Hollingsworth, DO - Unknown University Medical Center - Unknown III. Injured & Injury 1. Injured Party's Name Last First M.I. 2. Sex: __ Male _X_ Female 3. Age 4. Date of Birth (MM/DD/YY) 5. Malpractice code (per Appendix 1): 6. Injury Code (per appendix 2): PΩ 7. Description of Alleged Malpractice and Injuries (Attach Additional Sheet(s) if Necessary.) The patient suffered 2nd and 3rd degree burns to her labia and perenium from a hot weighted speculum used in surgery. 8. City Where Injury Occurred 9. Name of Institution (If Injury Occurred in Institution) Las Vegas University Medical Center IV. Medical/Dental Screening Panel (Hereafter, Panel) 1. Case Filed with Panel? _X_Yes, _ No, ___Unknown (IF YES, ANSWER QUESTIONS 2 AND 3) 2. Panel Case Number 3. Panel Decision: Is there Reasonable Probability of Malpractice? a) Yes b) No c) Unable to Decide d) Case Dismissed e) X Other [case settled/withdrawn before panel met] 4. Court Case Filed After Panel Decision ____ Yes _X__ No ___ Unknown V. Court Case 1. Court Case Filed? __Yes, _X__ No, ___Unknown (IF YES, ANSWER QUESTIONS 2 - 7) 2. Court Case Number 3. Court Name 4. Court Department Number 5. Date Court Case Was Filed 6. Date Verdict Was Filed, if Applicable 7. Date Settlement Offer Accepted, if Applicable VI. Reserves (Amounts Attributed to this Defendant Only, If Multiple Defendants) 1. Reserves Initial Highest Last \$7001.00 \$8,750.00 \$7,500.00 VII. Claim Disposition (Attributed to this Defendant Only) 1. Claim Disposition Decided By Trial a) _ [b) ___ Decided By Trial c) Decided by (check one) Decided by in Favor of Plaintiff in Favor of Defendant Arbitrator in Favor of Arbitrator in Favor of Plaintiff Defendant e) _X__ Settled w/o Claim Denied __ Claim Inactive Claim h) ___ Court or Prior to Trial _ Other Withdrawn 2. If Claim Disposition is e, f, g, h or i, Please Explain: Settlement was negotiated before the panel answer was even prepared.

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|--|---------------------|-------------------|---|----------------|-----------------|---------------------------------|---------------|---------|
| Name of Insurer | | | | Incur | er Claim No. | | | EIVEL |
| American Physic | <u>ians Assurar</u> | ice Corporat | ion | 1 1915 | 5-01 | በርፕ ላ | _ | |
| Defendant's Name (La Levy, Adam | st, First, M.I.) | | | Data | 76:- C' | | 001 2 | 0 2004 |
| Levy, Adam | | | | O/C | ITTEMEVADA OF A | | | |
| 1777 | - | | | 1 0/0/ | 04 | Claim Report Subm | MEDICAL E | BOARD O |
| VIII. Verdict Info 1. Verdict Awarded \$ | rmation (Attr | ibuted to All | Defendant | te in Casa | • | | | MINERS |
| Verdict Awarded \$ | or | X N/A | - Ci Ciidaii | S III Case | <u>'</u> | | | |
| <u></u> | | | | | | | | |
| IX. Claim Informa | tion (4 | | | | | | | |
| 1. Verdict or Settlemen | t Awarded A | 's Attributed | to this Def | fendant O | nly. If Mu | ltinle Dofondon | 4-1 | |
| | | | | | | | | |
| Reasons for Amount Post Verdict Set Non-economic of | Awarded (1) Not | Reina Faunt to | | | | | r N/A | |
| a) Post Verdict Set e) Non-economic d g) Other (Explain) | tlement b) A | Ward Reduced to | Amount Paid | (2), if Applic | able (Check | More than One, if A | pplicable) | |
| e) Non-economic d g) Other (Explain) | amages limited b | y Judge to \$350 | 0.000 ft | ue c) Ir | iterest Awar | ded d) Court C | Costs Awarded | |
| a) Onler (Explain) | | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | . Awaru Capp | bea by Judge | at Policy Limit | | |
| 4. How Will/Did Plaintiff | Receive | 1 . | | _ | | | | |
| Payments? | | a) _X Lum | Sum | b) Pe | riodic Payme | ents c)N/A | | |
| 5. If Periodic Payments, | What is the Pres | ent Value (ac of | Data Ci | | | () N/A | ` | |
| 6 Courses () | | cite value (as or | Date of Awar | rd) of the Pa | yments? \$ | | | |
| 6. Sources of Award Payments | a) Company \$7,5 | 00.00 | b) Defenda | | | | | |
| 7. Allocated Loss Adjusti | mont F | T |) = diena | uric p | 1 | c) Other (describe) | \$42,500.00 | |
| | nent Expenses | Total \$0 | | Attorney's | Fees \$0 | was paid by co-def Other \$0 | endants | |
| | | L | | <u> </u> | ——— | Other \$0 | | |
| X. Claim Information I. Co-Defendant's Name | on (Amounts | **** | | | | | | |
| . Co-Defendant's Name | Last | Attributed to | Other Defe | endants) | | | | |
| | Hollingsworth | | First | | M.I. Cr | edentials (e.g. M.D. | D(0) | |
| . License Number | 3. Specialty | | Shayna | | <u> </u> |) | , 5.0) | |
| | Description | | ISO Co | de | 4. Verdic | t Awarded | | |
| . Settlement Made | | | | | Unknown | es b) X_ No c) | | |
| |)_X Unknown | | 6. Ver | dict or Settle | ment Award | - 4 4 | | |
| | Z_Z_ OHKHOWIT | | N/A | | | ec φ | or _X | |
| . Co-Defendant's Name | Last | | T == | | | | | |
| . License Number | | | First | N | 1.I. Cre | dentials (e.g. M.D., | D.O) | |
| License Number | 3. Specialty | | | | | | | |
| Settlement Made | Description | | ISO Cod | le _ | 4. Verdict | Awarded | | |
| Yes b) No c) | 14.1 | | | | ment Awarde | s b) No c) | | |
| | Unknown | | | Or Octue | HELIT WASTO | ±a \$ 6 | orN/A | |
| Co-Defendant's Name | Last | | | | | | | |
| | Last | | First | М | .I. Cred | dentials (e.g. M.D., | 0.0 | |
| License Number | 3. Specialty | | | | _ 1 | | 0.0) | |
| | Description | | ISO Code | ا | 4. Verdict | Awarded | | |
| Settlement Made | | | | | a) Yes | b) No c) | Unknown | |
| Yes b)No c) | Unknown | | o. verdi | ct or Settlen | nent Awarde | d \$ OI | N/A | |
| Co-Defendant's Name | | | | | | | | |
| | Last | | First | M.1 | I Cont | | | |
| icense Number | 3. Specialty | | | | i. Crea | entials (e.g. M.D., D | 0.0) | |
| ļ i | Description | | | | 4. Verdict A | warded | | |
| ettlement Made | | | ISO Code | | a) Yes | b) No c) | l Inknown | |
| Yes_b)No_c)_ | Unknown | | 6. Verdic | t or Settleme | ent Awarded | | N/A | |
| | | | | | | · U | N/A | |
| tach Additional Sh | eet(s) if Neces | ssarv 1 | | | | | | |
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| Closed Claim Re | port Informa | ation | | | | | | |
| Product i CISUII S NAME II | ast, First) | |] [| | · | | | |
| ten, Suzannah | - | | Nan | ne of Person | Responsible | for Report (Last, F | irst) | |
| ontact Person's Phone N | umber {(999) 000 | 9-99901 | ! L | C60 21 | ren | > CO Con u so b | | |
| 7777 | · ((222) 335 | , 2223} | Sign | lature of Per | son Respons | sible for Report | | |
| ontact Person's Address | | | L | Aure | | Dont | | |
|) Jefferson Street NF. Su | ite 410 | | | | | | | |
| querque, New Mexico 87 | 109 | | | | | | | |
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