

12209

STATE OF NEVADA BOARD OF MEDICAL EXAMINERS APPLICATION FOR LICENSURE

1. Present Legal Name Gontomitros Anna Themis Gontomitros  
Last First Middle Maiden

List any other name ever used Not Applicable

2. Business and/or Mailing Address 24 Beaufort Rd #3, Jamaica Plain, MA 02130  
Street City State Zip

3. Home Address 24 Beaufort Rd #3, Jamaica Plain, MA 02130  
Street City State Zip

4. Telephone (617) 524-5536 (617) 524-6224  
area code Office area code Home

5. Date of Birth 11/12/1959 Place of Birth Greece  
City, state, country

RECEIVED  
FEB 11 1998

6. Citizenship: U.S. Citizen XX Alien Registration # \_\_\_\_\_ Other NEVADA PART OF  
**Submit a certified copy of birth certificate, an original Certificate of Naturalization or a copy of the front and back of your alien registration card.** MEDICAL EXAMINERS

7. Age 38 Height \_\_\_\_\_ Weight \_\_\_\_\_ Color of Eyes \_\_\_\_\_ Color of Hair \_\_\_\_\_

Social Security Number 278-74-3489

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.

8. Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? Yes XX No \_\_\_\_\_  
If Yes, separate attached explanation required.

9. If you have a medical condition which in any way impairs or limits your ability to practice medicine is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? Yes XX No \_\_\_\_\_ N/A  
If Yes, separate attached explanation required.

10. If you use chemical substances, does your use of chemical substance(s) in any way impair or limit your ability to practice medicine with reasonable skill and safety? \_\_\_\_\_ Yes \_\_\_\_\_ No XX N/A  
If yes, separate attached explanation required.

JAN 07 1998

11. Have you failed to initiate the performance of public service within one year after the date the public service is required to begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local government for your medical education? \_\_\_\_\_ Yes XX No  
 If yes, separate attached explanation required.

12. Have you been a defendant in a legal action involving professional liability (malpractice) or had a professional liability claim paid in your behalf or paid such a claim yourself? \_\_\_\_\_ Yes XX No.  
 If Yes, separate attached explanation required.

13. Have you ever been investigated for, charged with, convicted of, or plead guilty or nolo contendere to, any offense or violation of any federal, state or local law, including any foreign country, which is a misdemeanor, gross misdemeanor, or felony, excluding any minor traffic offense (Driving or in control of a motor vehicle while under the influence of any substance is **not** considered a **minor traffic offense**) or which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? \_\_\_\_\_ Yes XX No.  
 If Yes, separate attached explanation required.

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

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

Name	Address	Place Where Instruction Received	Dates of Attendance From (Mo./Yr.)	To (Mo./Yr.)
<u>George Washington</u>	<u>Washington DC 20052</u>		<u>8/83</u>	<u>5/87</u>
<u>University Medical School</u>				

If more space is needed, please attach separate sheet.

16. Doctor of Medicine Degree granted by:

Medical School Name	Medical School Address	Exact Date of Issuance
<u>George Washington University</u>	<u>GW School of Medicine</u> <u>2300 I street, NW, Washington, 20037</u>	<u>5/29/87</u>

17. List all ACGME\* approved graduate medical education you have received as an intern or resident in the United States or Canada.

\*Accreditation Council for Graduate Medical Education

Hospital/ Institution	Mailing Address	Type of Service or Specialty	Dates of Attendance From (Mo./Yr.)	To (Mo./Yr.)
<u>Beth Israel Hospital</u>	<u>330 Brookline</u> <u>Boston, MA 02215</u>	<u>OB-GYN</u>	<u>7/1/88</u>	<u>6/30/92</u>

If more space is needed, please attach separate sheet.

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

Institution	Mailing Address	Type of Fellowship	Dates of Attendance From (Mo./Yr.)	To (Mo./Yr.)
<u>Not Applicable</u>				

If more space is needed, please attach separate sheet.

19. Have any actions, restrictions, limitations, or probations ever been imposed on you while participating in any type of training program? \_\_\_\_\_ Yes XX No.  
 If Yes, separate explanation required.

20. If you graduated from a medical school located outside the United States of America or Canada, list your ECFMG# N/A

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

a. NATIONAL BOARDS:

Location	Part Taken	Date	Results (Scores)
washington DC	Part I	6/85	Have requested
Washington DC	Part II	4/87	Have requested
Boston MA	Part III	6/89	Have requested

b. FLEX (Federation Licensing Examination):

Location	Part Taken	Date	Result (Scores)
N/A			

c. USMLE (United States Medical Licensing Examination):

Location	Part Taken	Date	Result (Scores)
N/A			

d. State Written Examination:

Location	Part Taken	Date	Result (Scores)
N/A			

e. SPEX (Special Purpose Examination):

Location	Part Taken	Date	Result (Scores)
N/A			

22. State your area of specialty: Obstetrics and Gynecology

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

Specialty Board	Certification #	Dates of Certification/Recertification
American Board of Obstetrics and Gynecology	No # 31815	12/9/94

24. Account for all periods of time since graduation from medical school.

**ALL PERIODS OF TIME MUST BE ACCOUNTED FOR.**

City/State/Country	From (Mo./Yr.)	To (Mo./Yr.)
Boston Massachusetts	8/1987-	9/1996
Athens Greece	10/1996-	10/1997
Boston Massachusetts	11/1997-	currently

If more space is needed, attach separate sheet.

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

Hospital	Complete Mailing Address	Dates of Appointment	
		From (Mo./Yr.)	To (Mo./Yr.)
Brigham and Women's Hospital	75 Francis Street Boston MA 02115	8/7/92--	3/28/97

If more space is needed, attach separate sheet.

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

State/Territory Country	License #	Date of Issuance	Dates of Practice	
			From (Mo./Yr.)	To (Mo./Yr.)
Massachusetts	73988	5/1/91	5/91-	currently

If more space is needed, attach separate sheet.

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

If Yes, separate attached explanation required.

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

If yes, separate attached explanation required.

29. Have you ever voluntarily surrendered a license to practice a healing art in any state, country or U.S. territory?        Yes XX No.

If yes, separate attached explanation required.

30. Have you ever been denied membership or expelled from a medical society or other professional medical organization?        Yes XX No.

If yes, separate attached explanation required.

31. Have you ever been investigated for, charged with, or convicted of any violation of a statute, rule or regulation governing the practice of medicine by any medical licensing board, hospital, medical society, governmental entity or other agency?        Yes XX No  
 If Yes, separate attached explanation required.

32. Have you ever surrendered your state or federal controlled substance registration or had it revoked or restricted in any way?        Yes XX No  
 If yes, separate attached explanation required.

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

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

If more space is needed, attach separate sheet.

I, Anna Themis Contomitros being duly sworn, depose and say: That the answers to the foregoing questions and statements made in the above application as well as any and all further explanations contained on any separate attached pages are true and correct, that I am the person named in the credentials to be submitted, and that the same were procured in the regular course of instruction and examination without fraud or misrepresentation. I understand that if any of my responses on this application are false, fraudulent, misleading, inaccurate, or incomplete, my application for licensure will be denied.

Anna Themis Contomitros  
 Signature of Applicant

(Notary Seal)

Subscribed and sworn to before me this 2nd day of

February  
 Notary Public for State of Massachusetts

My Commission Expires 2002

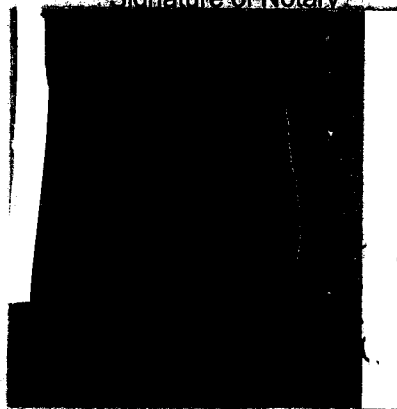
Residing at 335 Brookline Ave, Boston, MA

Danielle M. [Signature]  
 Signature of Notary

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

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

Proof photos and negatives are not acceptable



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

Anna Themis Contomitros  
 Signature of Applicant

1/30/98  
 Date

NOTICE

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

1. Have you taken Part III of the examination given by the National Board of Medical Examiners?

Yes  No

If answer is yes, indicate date taken.

6/89

2. Have you taken the Special Purpose Examination (SPEX)?

Yes  No

If answer is yes, indicate date taken.

\_\_\_\_\_

3. Have you taken Component II of the Federation Licensing Examination (FLEX)?

Yes  No

If answer is yes, indicate date taken.

\_\_\_\_\_

4. Have you taken Step III of the United States Medical Licensing Examination (USMLE)?

Yes  No

If answer is yes, indicate date taken.

\_\_\_\_\_

5. Have you received certification by a specialty board of the American Board of Medical Specialties?

Yes  No

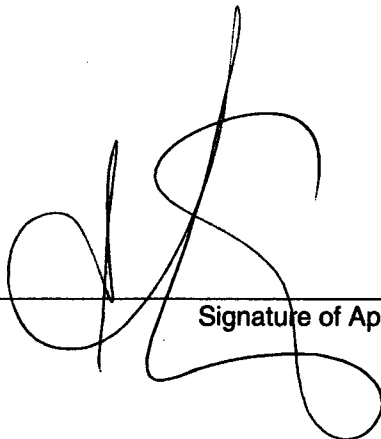
If answer is yes, indicate date of certification. *American Board of Obstetrics and Gynecology*

December 9, 1994

American Board of Obstetrics and Gynecology'

Date of certification: 12/9/94

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



Signature of Applicant

1/26/98  
Date

RECEIVED  
FEB 11 1995  
NEVADA STATE BOARD OF  
MEDICAL EXAMINERS

STATE OF NEVADA BOARD OF MEDICAL EXAMINERS APPLICATION FOR CHANGE OF STATUS

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

RECEIVED  
FEB 11 1998  
NEVADA STATE BOARD OF  
MEDICAL EXAMINERS

CHILD SUPPORT INFORMATION

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

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

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

PLACE AN X ON THE APPROPRIATE LINE

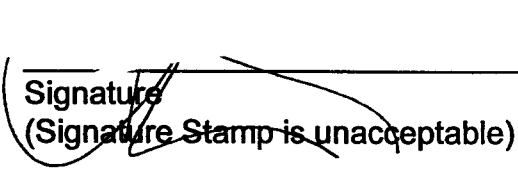
X I am not subject to a court order for the support of a child.

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

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

Anna V. Contomiro  
Type or print name

278.74.3489  
Social Security number

  
Signature  
(Signature Stamp is unacceptable)

1/25/98  
Date

PHYSICIAN  
APPLICATION FOR REGISTRATION RENEWAL  
FOR THE BIENNIAL REGISTRATION PERIOD 2005 - 2007  
NEVADA STATE BOARD OF MEDICAL EXAMINERS  
Post Office Box 7238 Reno, Nevada 89510 Phone (775) 688-2559  
Physical Address: 1105 Terminal Way, Suite 301 Reno, Nevada 89502

Date Received by Board

License No. 8564

JUN 16 2005

File No. 31298

(For Board Use Only)

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

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

File No. [redacted] License No. [redacted]  
Anna Themis CONTOMITROS M.D.  
5353 W. Desert Inn Rd., Suite 2124  
Las Vegas NV 89146-

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

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

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

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

Date N/A Signature (SIGNATURE STAMP UNACCEPTABLE) N/A

**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 N/A  
Street N/A  
City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone Number 702-221-6372 Fax Number 702-221-6372  
702-327-9291 mobile



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

Name \_\_\_\_\_  
 Street 7 N14  
 City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone Number \_\_\_\_\_

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

**SCOPES OF PRACTICE CODES**

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

Primary Scope of Practice Code 56      Secondary Scope of Practice Code 53

**PLEASE INDICATE AMERICAN BOARD OF MEDICAL SPECIALTIES BOARD CERTIFICATION & RECERTIFICATION**

Board American Board of Obstetrics and Gynecology      Date of Initial Certification 12/9/94      Date of Last Recertification 1/21/2005  
 (Mo./Yr.)      (Mo./Yr.)  
 Subboard N/A      (Mo./Yr.)      (Mo./Yr.)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**CHILD SUPPORT STATEMENT**

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

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

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

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

**CONTINUING MEDICAL EDUCATION (CME) STATEMENT**

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

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

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

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

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

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

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

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

**BY SIGNING ON THE SIGNATURE LINE BELOW:**

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

Date 6/13/05

Signature [Handwritten Signature]  
(SIGNATURE STAMP UNACCEPTABLE)

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

Date Received by Board

JUN 11 2003

License No. 9564

File No. \_\_\_\_\_

(For Board Use Only)

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

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

Anna T CONTOMITROS  
332 Bishops Forest Dr  
Waltham MA 02452

M.D.

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

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

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

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

Date \_\_\_\_\_

Signature (SIGNATURE STAMP UNACCEPTABLE) \_\_\_\_\_

**PLEASE NOTE:**

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

**PLEASE TYPE OR PRINT LEGIBLY**

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

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

Name Anna T Contomitros MD  
Street 1930 Blackwater Court  
City Las Vegas County \_\_\_\_\_ State NV Zip 89117  
Phone Number 702-360-2218 Fax Number 702-360-2218

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

Name \_\_\_\_\_  
Street \_\_\_\_\_  
City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone Number \_\_\_\_\_

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

### SCOPES OF PRACTICE CODES

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

Primary Scope of Practice Code 25

Secondary Scope of Practice Code

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

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

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

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

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

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

1. Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? Yes  No
2. If you have a medical condition which in any way impairs or limits your ability to practice medicine, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? Yes  No  N/A
3. If you use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety? Yes  No  N/A
4. Have you failed to initiate the performance of public service within one year after the date the public service is required to begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local government for your medical education? Yes  No  N/A
5. Have you been a defendant in a legal action involving professional liability (malpractice) or had a professional liability claim paid in your behalf or paid such a claim yourself? Yes  No
6. Have you ever been investigated for, charged with, convicted of, or plead guilty or nolo contendere to any offense or violation of any federal, state or local law, including any foreign country, which is a misdemeanor, gross misdemeanor, or felony, excluding any minor traffic offense (driving or in control of a motor vehicle while under the influence of any chemical substance is **not** considered a **minor traffic offense**) or which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? Yes  No
7. Have you ever been denied a license, permission to practice medicine or any other healing art, or permission to take an examination to practice medicine or any other healing art in any state, country or U.S. territory? Yes  No
8. Have you ever had a medical license or license to practice any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory? Yes  No
9. Have you ever voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory? Yes  No
10. Have you ever been denied membership or expelled from a medical society or other professional medical organization? Yes  No
11. Have you ever been: a) notified that you were under investigation for; b) investigated for; c) charged with; or d) convicted of any violation of a statute, rule or regulation governing your practice as a physician by any medical licensing board, hospital, medical society, governmental entity or other agency other than the Nevada State Board of Medical Examiners? Yes  No
12. Have you ever surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? Yes  No
13. List all hospitals where you have had staff privileges denied, suspended, limited, revoked or not renewed by the hospital. List any and all resignations from any medical staff in lieu of disciplinary or administrative action. **(Please Note: Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance).**

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

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

amcardinal
5/06/12

**CHILD SUPPORT STATEMENT**

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

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

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

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

**CONTINUING MEDICAL EDUCATION (CME) STATEMENT**

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

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

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

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

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

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

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

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

**BY SIGNING ON THE SIGNATURE LINE BELOW:**

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

Date 6/1/2003

Signature A. Shermans (SIGNATURE STAMP UNACCEPTABLE)

PHYSICIAN

RECEIVED By Board

APPLICATION FOR STATUS CHANGE TO ACTIVE REGISTRATION FOR THE BIENNIAL REGISTRATION PERIOD 2001- 2003 NEVADA STATE BOARD OF MEDICAL EXAMINERS

SEP 19 2001

License No. \_\_\_\_\_

File No. \_\_\_\_\_

Post Office Box 7238 Reno, Nevada 89510 Phone (775) 686-2559

NEVADA STATE BOARD OF MEDICAL EXAMINERS (Foreign Only)

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

- ACTIVE STATUS \$600.00
- INACTIVE STATUS \$200.00
- SUPERVISING/COLLABORATING PHYSICIAN \$200.00

Anna T. Contomitros, M.D.  
c/o Maria Mantzouranis  
15 Gavrilidou Street  
Patissia  
Athens Greece 11141

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

**PLEASE NOTE:**

- YOUR CURRENT INACTIVE STATUS M.D. LICENSE EXPIRES ON JUNE 30, 2003. THIS APPLICATION FOR STATUS CHANGE TO ACTIVE REGISTRATION FORM IS THE FORM TO BE COMPLETED FOR CHANGE OF INACTIVE STATUS TO ACTIVE STATUS MEDICAL LICENSURE IN THE STATE OF NEVADA.
- YOUR STATUS WILL NOT BE CHANGED UNLESS YOU ANSWER ALL QUESTIONS ON THIS APPLICATION FOR STATUS CHANGE TO ACTIVE REGISTRATION FORM. YOU MUST PROVIDE WRITTEN EXPLANATIONS FOR ALL QUESTIONS ANSWERED "YES."
- ALL INFORMATION YOU PROVIDE ON THIS APPLICATION FOR STATUS CHANGE TO ACTIVE REGISTRATION FORM IS PUBLIC INFORMATION.

**PLEASE TYPE OR PRINT LEGIBLY**

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

2. Active status registration requires the submission of proof of completion of 40 hours of AMA Category 1 continuing medical education (CME), which includes 2 hours of CME in medical ethics and 20 hours of CME in your scope of practice or specialty completed during the preceding 24-month time period of the date of your submission of this form. Submit your proof of completion of CME with your completed Application for Status Change to Active Registration form. (See last page of this form for CME statement.)

3. If your name and/or address has changed from that printed on this form above, 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 Anna T Contomitros M.D

Street 332 Bishops Forest Drive, Waltham

City Waltham County MA State Ma Zip 02452

Phone Number (781) 891-1715 Fax Number \_\_\_\_\_

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

Name N/A

Street \_\_\_\_\_

City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_



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

SCOPE OF PRACTICE SPECIALTY CODES

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

Primary Specialty Code 23 Secondary Specialty Code 47 Tertiary Specialty Code

All of the following questions refer to the preceding 24-month time period of the date of your submission of this form.

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.

**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.**

RECEIVED

SEP 19 2001

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**CHILD SUPPORT STATEMENT**

**RECEIVED**

**SEP 19 2001**

NEVADA STATE BOARD OF  
MEDICAL EXAMINERS

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 the following statement:

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 preceding 24-month time period of the date of my submission of this form.

- ATTACH COPIES OF PROOF OF YOUR COMPLETION OF CONTINUING MEDICAL EDUCATION (CME) HOURS.
- YOUR COPIES OF PROOF OF CME OR TRAINING COMPLETION WILL NOT BE RETURNED TO YOU.

*Attached are CME credit hrs from Arc Mesa, and up to date Educators*

**BY SIGNING ON THE SIGNATURE LINE BELOW:**

- 1) I HEREBY REPRESENT THAT I AM THE PERSON NAMED IN THIS APPLICATION FOR STATUS CHANGE TO ACTIVE REGISTRATION OF LICENSE TO PRACTICE MEDICINE IN THE STATE OF NEVADA AND THAT ALL STATEMENTS I HAVE MADE HEREIN ARE TRUE;
- 2) I UNDERSTAND THAT THIS APPLICATION FOR STATUS CHANGE TO ACTIVE REGISTRATION WILL BE DENIED IF I HAVE NOT PLACED A CHECK MARK NEXT TO (a), (b), OR (c) UNDER THE CHILD SUPPORT STATEMENT SECTION; AND
- 3) I UNDERSTAND THAT THIS APPLICATION FOR STATUS CHANGE TO ACTIVE REGISTRATION 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); (b) PAYMENT OF THE APPROPRIATE REGISTRATION FEE; AND (c) WRITTEN EXPLANATION(S) TO ANY "YES" ANSWER(S).

September 15, 2001  
Date

Anna Themis Contonich MD  
Signature (SIGNATURE STAMP UNACCEPTABLE)

**PHYSICIAN**  
**APPLICATION FOR REGISTRATION RENEWAL**  
**FOR THE BIENNIAL REGISTRATION PERIOD 2001- 2003**  
**NEVADA STATE BOARD OF MEDICAL EXAMINERS**

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

Date Received by Board

**JUN 28 2001**

License No. 8564

File No. \_\_\_\_\_

(For Board Use Only)

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

- ACTIVE STATUS \$600.00
  - INACTIVE STATUS \$200.00
  - RETIRED STATUS \$ 50.00
  - SUPERVISING/COLLABORATING PHYSICIAN \$200.00
- (RETIRED STATUS REQUIRES THAT THE APPLICANT NOT PRACTICE MEDICINE ANYWHERE)**

*Anna T Contomitros MD CN 6703*  
*24 Beaufort Rd #3*  
*Jamaica Plain, MA 02130*

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

**PLEASE NOTE:**

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

**PLEASE TYPE OR PRINT LEGIBLY**

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

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

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

Name Anna Themis Contomitros M.D  
Street 332 Bishops Forest Drive Waltham  
City Waltham County Mass State Mass Zip 02452  
Phone Number (781) 891-1715 Fax Number \_\_\_\_\_

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

Name N/A  
Street \_\_\_\_\_  
City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone Number \_\_\_\_\_

5. Indicate below the EXACT NAME AND LOCATION of the Medical School from which you graduated and your EXACT DAT

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

SCOPE OF PRACTICE SPECIALTY CODES

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

Primary Specialty Code 23      Secondary Specialty Code 47      Tertiary Specialty Code

**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 the 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 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, visual, speech, hearing, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, emotional or mental illness, HIV disease, tuberculosis, drug addiction, and alcoholism.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**CHILD SUPPORT STATEMENT**

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

- (a) I am not subject to a court order for the support of a child;
- (b) I am subject to a court order for the support of one or more children and am in compliance with the order or 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
- (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 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:

*Please see statement!*

- (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, 2000 through June 30, 2001;
- (b) I was initially licensed in Nevada during the time period January 1, 2000 through June 30, 2000, the second six months of the past biennial period, and completed a minimum of 30 hours of AMA Category I continuing medical education (CME), 2 hours of which were in medical ethics and 20 hours of which were in my scope of practice or specialty;
- (c) I was initially licensed in Nevada during the time period July 1, 2000 through December 31, 2000, the third six months of the past biennial period, and completed a minimum of 20 hours of AMA Category I continuing medical education (CME), 2 hours of which were in medical ethics and 18 hours of which were in my scope of practice or specialty;
- (d) I was initially licensed in Nevada during the time period January 1, 2001 through June 30, 2001, the fourth six months of the past biennial period, and completed a minimum of 10 hours of AMA Category I continuing medical education (CME), 2 hours of which were in medical ethics and 8 hours of which were in my scope of practice or specialty; OR
- (e) I am exempt from submitting proof of completion of continuing medical education (CME) because I have completed a full year of residency or fellowship training during the biennial period July 1, 1999 through June 30, 2001.

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

I HAVE \_\_\_\_\_ MONTHS. HAVE NOT  (CHECK ONE) ACTIVELY PRACTICED MEDICINE IN NEVADA WITHIN THE PAST

**BY SIGNING ON THE SIGNATURE LINE BELOW:**

*(twenty four)*

- 1) I HEREBY REPRESENT THAT I AM THE PERSON NAMED IN THIS APPLICATION FOR REGISTRATION RENEWAL AND THAT ALL STATEMENTS I HAVE MADE HEREON 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 NO 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 AN "YES" ANSWER(S).

**PHYSICIAN**  
**APPLICATION FOR RENEWAL REGISTRATION**  
**NEVADA STATE BOARD OF**  
**MEDICAL EXAMINERS**

Date Received by Board

License No. \_\_\_\_\_

**JUN 14 1999**

File No. \_\_\_\_\_

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

(Board Use Only)

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

ACTIVE STATUS <input checked="" type="checkbox"/>	\$600.00
INACTIVE STATUS	\$200.00
RETIRED STATUS	\$ 50.00
SUPERVISING/COLLABORATING PHYSICIAN	\$200.00

Anna T. Contomitros, MD  
24 Beaufort Rd #3  
Jamaica Plain MA 02130

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

**PLEASE NOTE**

**NEVADA HAS NO GRACE PERIOD - - - - - LICENSES NOT RENEWED BY JULY 1, 1999  
ARE AUTOMATICALLY SUSPENDED FOR NON-PAYMENT.**

**EXTENSIONS OF TIME ARE NOT ALLOWED FOR ANY REASON.**

**YOUR LICENSE WILL NOT BE RENEWED WITHOUT ANSWERING ALL QUESTIONS.**

**ALL YES ANSWERS MUST BE EXPLAINED.**

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

**ALL FEES MUST BE PAID AND ARE NON-REFUNDABLE.**

**DO NOT SEND CASH THROUGH THE MAIL.**

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

**PLEASE TYPE OR PRINT LEGIBLY**

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

Name \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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

Name \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_



7. Are you currently active in medicine?

a.  YES, in training.

c.  YES, working part-time

e.  NO, other (specify \_\_\_\_\_)

b.  YES, working full-time

d.  NO, retired.

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

**SCOPE OF PRACTICE  
SPECIALTY CODES**

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

Primary	Code <u>39 / 20</u>	Percent of Time <u>100%</u>	Board Certified (Indicate Yes/No) <u>Yes</u>
Secondary	_____	_____	_____
Tertiary	_____	_____	_____

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

	Date of Initial Certification	Date of Last Certification
Board <u>American Board of Obstetrics + Gynecology</u>	<u>Dec 9, 1994</u> (Mo./Yr.)	<u>12/9/94</u> (Mo./Yr.)
Subboard _____	(Mo./Yr.)	(Mo./Yr.)
Board _____	(Mo./Yr.)	(Mo./Yr.)
Subboard _____	(Mo./Yr.)	(Mo./Yr.)

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

**SELF-EMPLOYED:**

- 1001 Solo Practice  
1002 Partnership or Group Practitioners

**SALARIED, EMPLOYED BY:**

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

**SALARIED, EMPLOYED BY: (continued)**

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

1012 Other (specify \_\_\_\_\_)

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

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

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

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

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

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

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

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

1. Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? \_\_\_\_\_ Yes  No
2. If you have a medical condition which in any way impairs or limits your ability to practice medicine, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? \_\_\_\_\_ Yes  No \_\_\_\_\_ N/A
3. If you use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety? \_\_\_\_\_ Yes  No \_\_\_\_\_ N/A
4. Have you failed to initiate the performance of public service within one year after the date the public service is required to begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local government for your medical education? \_\_\_\_\_ Yes  No \_\_\_\_\_ N/A
5. Have you been a defendant in a legal action involving professional liability (malpractice) or had a professional liability claim paid in your behalf or paid such a claim yourself? \_\_\_\_\_ Yes  No
6. Have you ever been investigated for, charged with, convicted of, or plead guilty or nolo contendere to any offense or violation of any federal, state or local law, including any foreign country, which is a misdemeanor, gross misdemeanor, or felony, excluding any minor traffic offense (driving or in control of a motor vehicle while under the influence of any chemical substance is not considered a minor traffic offense) or which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? \_\_\_\_\_ Yes  No
7. Have you ever been denied a license, permission to practice medicine or any other healing art(s), or permission to take an examination to practice medicine or any other healing art(s) in any state, country or U.S. territory? \_\_\_\_\_ Yes  No
8. Have you ever had a medical license or license to practice any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory? \_\_\_\_\_ Yes  No
9. Have you ever voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory? \_\_\_\_\_ Yes  No
10. Have you ever been denied membership or expelled from a medical society or other professional medical organization? \_\_\_\_\_ Yes  No

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

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

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

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

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

**PLEASE CHECK ONE OF THE FOLLOWING:**

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

Signature  (SIGNATURE STAMP UNACCEPTABLE)

**PLEASE CHECK ONE OF THE FOLLOWING:**

- 1. I have earned a minimum of 40 hours approved AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics, and 20 hours of which were in my scope of practice or specialty during the biennial period July 1, 1997, through June 30, 1999.
- 2. I was initially licensed in Nevada during the second six months of the biennial period July 1, 1997, through June 30, 1999, and have earned a minimum of 30 hours approved AMA Category I continuing medical education (CME).
- 3. I was initially licensed in Nevada during the third six months of the biennial period July 1, 1997, through June 30, 1999, and have earned a minimum of 20 hours approved AMA Category I continuing medical education (CME).
- 4. I was initially licensed in Nevada during the fourth six months of the biennial period July 1, 1997, through June 30, 1999, and have earned a minimum of 10 hours approved AMA Category I continuing medical education (CME).
- 5. I am exempt from submitting proof of continuing medical education (CME) because I have completed a full year of residency or fellowship training during the biennial period July 1, 1997, through June 30, 1999.

**IMPORTANT**

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

Signature  (SIGNATURE STAMP UNACCEPTABLE)

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

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

(617) 524-6224 Business Telephone #  
Date 5/30/99  
(702) 382-2745

Signature  (SIGNATURE STAMP UNACCEPTABLE)

APPLICATION FOR INITIAL REGISTRATION NEVADA STATE BOARD OF MEDICAL EXAMINERS

MAR 12 1998

License No. 8564

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

NEVADA STATE BOARD OF MEDICAL EXAMINERS

File No.

Anna T. Contomitros, MD 24 Beaufort Rd #3 Jamaica Plain, MA 02130

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

issued 3-12-98

PLEASE PROVIDE ALL INFORMATION AS REQUESTED

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

Name Anna Themis Contomitros M.D. Street 24 Beaufort Rd #3 City Jamaica Plain County State Mass Zip Code 02130

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. [ v ] NO, other (specify Currently seeking employment)

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

SPECIALTY CODE:

- 1 ADOLESCENT MEDICINE 35 NEURORADIOLOGY 64 PED. UROLOGY 65 PEDIATRICS 66 PHYSICAL MED/REHAB 67 PREVENTIVE MED 68 PSYCHIATRY 69 PSYCHOANALYSIS 70 PSYCHOMATIC MEDICINE 71 PUBLIC HEALTH 72 PULMONARY DISEASES 73 RADIOLOGY 74 RADIOLOGY, DIAGNOSTIC 75 RADIOLOGY, NUCLEAR 76 RADIOLOGY, THERAPEUT 77 RHEUMATOLOGY 78 RHINOLOGY 79 SLEEP DISORDERS 100 SPORTS MEDICINE 80 SURGERY, ABDOMINAL 81 SURGERY, CARDIOVASC 91 SURGERY, COLON/RECTAL 82 SURGERY, GENERAL 83 SURGERY, HAND 84 SURGERY, HEAD/NECK 92 SURGERY, MAXILLOFAC 93 SURGERY, NEUROLOGICAL 85 SURGERY, ORTHOPEDIC 86 SURGERY, PLASTIC 87 SURGERY, THORACIC 88 SURGERY, TRAUMATIC 89 SURGERY, UROLOGIC 90 SURGERY, VASCULAR 94 UROLOGY

Table with 3 columns: Primary, Secondary, Tertiary; Code; Percent of Time; Board Certified (Indicate Yes/No). Values: Primary Code 38, Percent 100, Board Certified Yes; Secondary Code N/A; Tertiary Code N/A.

PLEASE INDICATE AMERICAN BOARD OF MEDICAL SPECIALTIES BOARD CERTIFICATION:

Board American College of Obstetrics and Gynecology Date of Initial Certification 12/9/94 Date of Last Certification N/A

3. Form of employment is N/A (Use the following codes) None currently. SELF-EMPLOYED: 1001 Solo Practice, 1002 Partnership or Group Practitioners. SALARIED, EMPLOYED BY: 1003 Individual Practitioner, 1004 Partnership or Group of Practitioners, 1005 Group Health Plan Facility (such as H.M.O.), 1012 Other (specify). SALARIED, EMPLOYED BY (continued): 1006 Other Non-Government Employer (hospital, school, etc.), 1007 Federal Government (armed services personnel only), 1008 Federal Government (civilian, P.H.S., etc.), 1009 State Government, 1010 County Government, 1011 Local Government.

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

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

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

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

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

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

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

1. Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety?  Yes  No
2. If you have a medical condition which in any way impairs or limits your ability to practice medicine is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice?  Yes  No  N/A
3. If you use chemical substances, does your use of chemical substance(s) in any way impair or limit your ability to practice medicine with reasonable skill and safety?  Yes  No  N/A
4. Have you failed to initiate the performance of public service within one year after the date the public service is required to begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local government for your medical education?  Yes  No
5. Have you been a defendant in a legal action involving professional liability (malpractice) or had a professional liability claim paid in your behalf or paid such a claim yourself?  Yes  No
6. Have you ever been investigated for, charged with, convicted of, or plead guilty or nolo contendere to, any offense or violation of any federal, state or local law, including any foreign country, which is a misdemeanor, gross misdemeanor, or felony, excluding any minor traffic offense (Driving or in control of a motor vehicle while under the influence of any substance is **not** considered a minor traffic offense) or which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances?  Yes  No
7. Have you ever been denied a license, permission to practice medicine or any other healing arts, or permission to take an examination to practice medicine or any other healing arts in any state, country or U.S. territory?  Yes  No
8. Have you ever had a medical license revoked, suspended, limited, or restricted in any state, country or U.S. territory?  Yes  No
9. Have you ever voluntarily surrendered a license to practice a healing art in any state, country or U.S. territory?  Yes  No
10. Have you ever been denied membership or expelled from a medical society or other professional medical organization?  Yes  No
11. Have you ever been investigated for, charged with, or convicted of any violation of a statute, rule or regulation governing the practice of medicine by any medical licensing board, hospital, medical society, governmental entity or other agency?  Yes  No
12. Have you ever surrendered your state or federal controlled substance registration or had it revoked or restricted in any way?  Yes  No
13. List all hospitals where you have had staff privileges denied, suspended, limited, revoked or not renewed by the hospital. List any and all resignations from any medical staff in lieu of disciplinary or administrative action. (Please Note: Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance).

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

If more space is needed, attach separate sheet.

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

(617) 524-6224  
Business Telephone #

3/8/98  
Date

Signature (SIGNATURE STAMP UNACCEPTABLE)

*Anna Antonikas MD*

## Renewal Questions for License Number 8564



Licensee	Question	Answer	Date
CONTOMITROS, Anna Themis	Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? <b>If you do not have a medical condition, select No.</b>	N	6/3/2015
CONTOMITROS, Anna Themis	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, the manner in which you have chosen to practice, or by any other reasonable accommodation? <b>If you do not have a medical condition, select No.</b>	N	6/3/2015
CONTOMITROS, Anna Themis	If you use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety? <b>If you do not use chemical substances, select No.</b>	N	6/3/2015
CONTOMITROS, Anna Themis	Have you been named as a defendant, or been requested to respond as a defendant, to a legal action involving professional liability, malpractice, including any military tort claims if applicable?  Please include: who, what, where (provide state), and when in the textbox directly below this question.	N	6/3/2015
CONTOMITROS, Anna Themis	Have you had a professional liability, malpractice, claim paid on your behalf or paid such a claim yourself including any military tort claims if applicable?  If "Yes" during the time period July 1, 2013 - June 30, 2015 type an explanation in the textbox directly below this question.	N	6/3/2015
CONTOMITROS, Anna Themis	Have you been arrested, investigated for, charged with, convicted of, or pled guilty or nolo contendere to any offense or violation of any federal (including the Uniform Code of Military Justice), state or local law, or the laws of any foreign country, which is a misdemeanor, gross misdemeanor, felony, violation of the Uniform Code of Military Justice, or synonymous thereto in a foreign jurisdiction, excluding any minor traffic offense (driving or being in control of a motor vehicle while under the influence of a chemical substance, including alcohol, is not considered a minor traffic offense), or for any offense which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? <b>Please note that you MUST disclose ANY investigation or arrest, including those where the final disposition was dismissal, or expungement.</b>	N	6/3/2015
CONTOMITROS, Anna Themis	Have you been denied a license, permission to practice medicine or any other healing art, or permission to take an examination to practice medicine or any other healing art in any state, country or U.S. territory?	N	6/3/2015
CONTOMITROS, Anna Themis	Have you had a medical license or license to practice any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory?	N	6/3/2015
CONTOMITROS, Anna Themis	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	6/3/2015

CONTOMITROS, Anna Themis	Have you failed to initiate the performance of public service within one year after the date the public service is required to begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local government for your medical education?	N	6/3/2015
CONTOMITROS, Anna Themis	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 <u>other than</u> the Nevada State Board of Medical Examiners?	N	6/3/2015
CONTOMITROS, Anna Themis	Have you surrendered your state or federal controlled substance registration or had it revoked or restricted in any way?	N	6/3/2015
CONTOMITROS, Anna Themis	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.  <b>(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.)</b>	N	6/3/2015
CONTOMITROS, Anna Themis	Have you actively practiced medicine in Nevada within the past 12 months?	Y	6/3/2015
CONTOMITROS, Anna Themis	OPTION TO CHANGE LICENSE STATUS FROM ACTIVE TO INACTIVE:  NOTE: If you choose to drop to Inactive status during this renewal, your status will be changed to "Inactive" <b>as of the date of your renewal</b> . If you do NOT wish to change your status to "Inactive" as of today, DO NOT COMPLETE YOUR RENEWAL UNTIL SUCH TIME AS YOU ARE PREPARED TO HAVE YOUR STATUS CHANGED (prior to JULY 1ST). For your information, your answers to the questions that you've already completed will remain, but you should not complete the renewal and pay until such time as you are prepared to change your status to "Inactive."  I hereby request my license to be placed on Inactive status, which means I will <u>not</u> physically practice in the state of Nevada.  If you choose to place your license on Inactive status, make certain to select "Yes" to this question <b>AND</b> choose the Inactive status in the dropdown box located at the end of the questions.	N	6/3/2015
CONTOMITROS, Anna Themis	<b>If you believe that you are in compliance with the Centers for Disease Control safe injection practices, your answer should be "YES".</b>  I hereby attest to knowledge of and compliance with the guidelines of the Centers for Disease Control and Prevention concerning the prevention of transmission of infectious agents through safe and appropriate injection practices. I also attest that any person who is currently, or will be under my control as their supervising physician in the future, and who is not licensed pursuant to chapter 630 of the Nevada Revised Statutes and whose duties involve injection practices, has knowledge of and is in compliance with the guidelines of the Centers for Disease Control and Prevention concerning the prevention of transmission of infectious agents through safe and appropriate injection practices.  <a href="http://www.cdc.gov/injectionsafety/IP07_standardPrecaution.html">http://www.cdc.gov/injectionsafety/IP07_standardPrecaution.html</a>	Y	6/3/2015
CONTOMITROS, Anna Themis	I hereby attest that I am in compliance with the reporting requirements of NRS 630.30665, and am aware that failure to submit a report or filing false information in a report is grounds for disciplinary action under Nevada's	Y	6/3/2015

	<p>Medical Practice Act.</p> <p>I HAVE SUBMITTED A "FORM A" OR "FORM B" REPORT TO THE BOARD.</p> <p>Instructions and Forms A and B for in-office surgery/procedure reporting can be located on the Board's website by clicking the red "In-Office Surgery Reporting" link on the home page of the Board's website:  <a href="http://www.medboard.nv.gov">www.medboard.nv.gov</a>.</p> <p><b>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 "YES."</b></p>		
CONTOMITROS, Anna Themis	<p>Are you out of compliance with court ordered child support? <b>If this does not apply to you, please answer "no".</b></p> <p>If "Yes" during the time period July 1, 2013 - June 30, 2015 type an explanation in the textbox directly below this question.</p>	N	6/3/2015
CONTOMITROS, Anna Themis	<p>Once you have read the statute regarding the reporting of the abuse or neglect of a child, your answer to this question will be "YES".</p> <p><b>I attest and affirm that I am aware of and understand the reporting requirements found in Nevada Revised Statute 432B.220 regarding the abuse or neglect of a child.</b></p> <p><b><u><a href="http://www.leg.state.nv.us/NRS/NRS-432B.html#NRS432BSec220">www.leg.state.nv.us/NRS/NRS-432B.html#NRS432BSec220</a></u></b></p>	Y	6/3/2015
CONTOMITROS, Anna Themis	Have you ever served in the United States Military (to include National Guard or Reserves)?	N	6/3/2015
CONTOMITROS, Anna Themis	Do you hold a Nevada state business license issued <u>in your individual name</u> ?	N	6/3/2015
CONTOMITROS, Anna Themis	<p>I have completed the required amount of AMA Category 1 CME within the current biennial. I understand that I may be included in a random audit. I agree to retain CME's taken between July 1, 2013 and June 30, 2015. (Review CME information online at <a href="http://www.medboard.nv.gov">www.medboard.nv.gov</a>)</p> <p>If renewing to an <u>Inactive</u> status, CME is not required and "No" can be selected.</p>	Y	6/3/2015
CONTOMITROS, Anna Themis	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	6/3/2015



# Nevada State Board of Medical Examiners

Renewal Responses Report  
Monday, October 12, 2015



License Number Licensee License Type  
8564 Anna Themis CONTOMITROS Medical Doctor

Question	Answer	Date
Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? If you answer "Yes" during the time period July 1, 2005 - June 30, 2007 email to <a href="mailto:elicensbme@medboard.nv.gov">elicensbme@medboard.nv.gov</a>	N	06/05/2007

**NSBME Renewal Responses Report**

10/12/2015

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? **N**  
If you answer "Yes" during the time period July 1, 2005 - June 30, 2007 email to elicensesbme@medboard.nv.gov

06/05/2007

If you use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety? **N**  
If you answer "Yes" during the time period July 1, 2005 - June 30, 2007 email to elicensesbme@medboard.nv.gov

06/05/2007

**NSBME Renewal Responses Report**

10/12/2015

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

N

06/05/2007

Have you been named as a defendant, or been requested to respond as a defendant, to a legal action involving professional liability (malpractice), or had a professional liability claim paid on your behalf, or paid such a claim yourself?

N

06/05/2007

**NSBME Renewal Responses Report**

10/12/2015

Have you been investigated for, arrested for, charged with, convicted of, or plead guilty or nolo contendere to any offense or violation of any federal (including the U.S. Military), state or local law, including any foreign country, which is in a foreign jurisdiction equivalent to, a misdemeanor, gross misdemeanor, court martial, or felony, excluding any minor traffic offense (driving or being in control of a motor vehicle while under the influence of any chemical substance and/or including alcohol, is not considered a minor traffic offense), or for any offense which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? Please note that you MUST disclose ANY investigation or arrest, even if the ultimate disposition was dismissal or expungement.  
If you answer "Yes" during the time period July 1, 2005 - June 30, 2007 email to [elicensensbme@medboard.nv.gov](mailto:elicensensbme@medboard.nv.gov)

N

06/05/2007

Have you been denied a license, permission to practice medicine or any other healing art, or permission to take an examination to practice medicine or any other healing art in any state, country or U.S. territory? If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to [elicensensbme@medboard.nv.gov](mailto:elicensensbme@medboard.nv.gov).

N

06/05/2007

**NSBME Renewal Responses Report**

10/12/2015

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

06/05/2007

If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to [elicensensbme@medboard.nv.gov](mailto:elicensensbme@medboard.nv.gov).

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? **N**

06/05/2007

If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to [elicensensbme@medboard.nv.gov](mailto:elicensensbme@medboard.nv.gov).

**NSBME Renewal Responses Report**

10/12/2015

Have you been denied membership or expelled from a medical society or other professional medical organization?  
If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov.

N

06/05/2007

Have you been:

- a) notified that you were under investigation for;
- b) investigated for;
- c) charged with; or
- d) convicted of

any violation of a statute, rule or regulation governing your practice as a physician by any medical licensing board, hospital, medical society, governmental entity or agency other than the Nevada State Board of Medical Examiners?

If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov.

N

06/05/2007

**NSBME Renewal Responses Report**

10/12/2015

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

N

06/05/2007

If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to [elicensensbme@medboard.nv.gov](mailto:elicensensbme@medboard.nv.gov).

Have you had hospital staff privileges denied, suspended, limited, revoked or not renewed by the hospital?

N

06/05/2007

*If you have answered "Yes" you will be required to submit a list of any and all resignations from any medical staff in lieu of disciplinary or administrative action via email to [elicensensbme@medboard.nv.gov](mailto:elicensensbme@medboard.nv.gov) (Please Note: Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance.)*  
If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to [elicensensbme@medboard.nv.gov](mailto:elicensensbme@medboard.nv.gov).

**NSBME Renewal Responses Report**

10/12/2015

Is your license currently contingent upon compliance with the Diversion program also known as the Nevada Health Professionals Assistance Foundation?  
If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to [elicensbme@medboard.nv.gov](mailto:elicensbme@medboard.nv.gov).

N

06/05/2007

Was your license issued contingent upon maintaining certification by the American Board of Medical Specialties in the specialty of Family Practice, Emergency Medicine or Preventative medicine?  
If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to [elicensbme@medboard.nv.gov](mailto:elicensbme@medboard.nv.gov).

N

06/05/2007



**NSBME Renewal Responses Report**

10/12/2015

Are you a foreign medical doctor, who holds a Conditional Resident Alien Card, Employment Authorization Card, or Visa with the Department of Homeland Security, Immigration and Naturalization Services?  
If "yes" please fax a copy of proof to (775) 688-2551 ATTN:Online License Renewal.

N

06/05/2007

Are you out of compliance with court ordered child support? If this does not apply to you please answer "no".

N

06/05/2007

If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to [elicensbme@medboard.nv.gov](mailto:elicensbme@medboard.nv.gov).

**NSBME Renewal Responses Report**

10/12/2015

Do you want to change your scope of practice or specialty?  
if you answer "Yes" during the time period July 1, 2005 - June 30, 2007 email your request to  
elicensbme@medboard.nv.gov

N

06/05/2007

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 [elicensbme@medboard.nv.gov](mailto:elicensbme@medboard.nv.gov)

N

06/05/2007

**NSBME Renewal Responses Report**

10/12/2015

I have completed the required amount of AMA Category 1 CME within the current biennial.

(Review CME information online at [www.medboard.nv.gov](http://www.medboard.nv.gov))

I understand that I may be included in a random audit following July 1st 2007 renewal. I agree to retain CME's taken between July 1, 2005 and June 30, 2007.

Y

06/05/2007

I have actively practiced medicine in Nevada within the past 24 months.

Y

06/05/2007

**NSBME Renewal Responses Report**

10/12/2015

N

I hereby request my license to be placed on Inactive status. I will not physically practice in the state of Nevada.

06/05/2007

Y

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.

06/05/2007

**NSBME Renewal Responses Report**

10/12/2015

N

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

05/05/2009

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

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

**Explanation 2: For the above question if your answer is "Yes" for the time period July 1, 2007 - June 30, 2009, please type your explanation in this text box.**

**ISBME Renewal Responses Report**

10/12/2015

If you use chemical substances, does your use in any way impair or limit your ability to practice medicine N

05/05/2009

**Explanation 3: For the above question if your answer is "Yes" for the time period July 1, 2007 - June 30, 2009, please type your explanation in this text box.**

**NSBME Renewal Responses Report**

10/12/2015

Have you been named as a defendant, or been requested to respond as a defendant or potential defendant, to a legal action involving professional liability (malpractice)?  
Please include: who, what, where (provide state), and when in the textbox directly below this question.

N

05/05/2009

**Explanation 4: For the above question if your answer is "Yes" for the time period July 1, 2007 - June 30, 2009, please type your explanation in this text box.**



Have you had a professional liability (malpractice) claim paid on your behalf or paid such a claim yourself **N**

05/05/2009

including any military tort claims if applicable)?  
Please include: who, what, where (provide state), when and case number in the textbox directly below  
his question.

Please fax a copy of the complaint, civil or otherwise to 775-688-2551.

**Explanation 5: For the above question if your answer is "Yes" for the time period July 1, 2007 - June 30, 2009, please type your explanation in this text box.**

Please fax a copy of the complaint, civil or otherwise to 775-688-2551.

10/12/2015

**NSBME Renewal Responses Report**

N

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.**

05/05/2009

**Explanation 6: For the above question if your answer is "Yes" for the time period July 1, 2007 - June 30, 2009, please type your explanation in this text box.**

**NSBME Renewal Responses Report**

10/12/2015

Have you been arrested, investigated for, charged with, convicted of, or pled guilty or nolo contendere to any criminal offense other than a criminal offense listed in Question #6? Please note that you **MUST** disclose **ANY** investigation or arrest, including those where the final disposition was dismissal, sealing of a record, or expungement. N

05/05/2009

**Explanation 7: For the above question if your answer is "Yes" for the time period July 1, 2007 - June 30, 2009, please type your explanation in this text box.**

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

N

**Explanation 8: For the above question if your answer is "Yes" for the time period July 1, 2007 - June 30, 2009, please type your explanation in this text box.**

**JSBME Renewal Responses Report**

10/12/2015

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

05/05/2009

**Explanation 9: For the above question if your answer is "Yes" for the time period July 1, 2007 - June 30, 2009, please type your explanation in this text box.**

**VBME Renewal Responses Report**

10/12/2015

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

N

05/05/2009

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

10/12/2015

**ISBME Renewal Responses Report**

N

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

05/05/2009

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

**NSBME Renewal Responses Report**

10/12/2015

N

Regarding any medical licensing board, hospital medical society, or other governmental entity or agency

05/05/2009

(other than the Nevada State Board of Medical Examiners), have you been:

- (a) Asked to respond to an investigation;
  - (b) Notified that you were under investigation for;
  - (c) Investigated for;
  - (d) Charged with; or
  - (e) Convicted of
- any violation of a statute, rule or regulation governing your practice as a physician?

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



**NSBME Renewal Responses Report**

10/12/2015

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

N

05/05/2009

**Explanation 13: For the above question if your answer is "Yes" for the time period July 1, 2007 - June 30, 2009, 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? **N**  
 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.)

**Explanation 14: For the above question if your answer is "Yes" for the time period July 1, 2007 - June 30, 2009, please type your explanation in this text box.**

**ISBME Renewal Responses Report**

10/12/2015

Are you out of compliance with court ordered child support? If this does not apply to you, please answer "no".

N

05/05/2009

If "Yes" during the time period July 1, 2007- June 30, 2009 type an explanation in the textbox directly below this question.

**Explanation 15: For the above question if your answer is "YES" for the time period July 1, 2007 - June 30, 2009, please type your explanation in this text box.**

**NSBME Renewal Responses Report**

10/12/2015

hereby request my license to be placed on Inactive status, which means I will not physically practice in the state of Nevada.

05/05/2009

N

**Explanation 16:** For the above question, if your answer is "Yes" and you want to change to Inactive status for the next biennial July 1, 2009 – June 30, 2011, please provide a brief explanation in this text box.

Do you want to change your scope of practice or specialty?  
if you answer "Yes" type your current scope of practice or specialty in the textbox directly below this question.

N

05/05/2009

**Explanation 17:** For the above question if your answer is "YES" , please type your new scope of practice or specialty in this text box.

**MSBME Renewal Responses Report**

10/12/2015

have completed the required amount of AMA Category 1 CME within the current biennial.  
Review CME information online at [www.medboard.nv.gov](http://www.medboard.nv.gov)  
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.

Y

05/05/2009

I SWEAR OR AFFIRM UNDER THE PENALTY OF PERJURY THAT I PERSONALLY ANSWERED ALL  
OF THE QUESTIONS IN THIS APPLICATION AND THAT THE ANSWERS I HAVE PROVIDED ARE  
TRUE AND CORRECT.

Y

05/05/2009

**NSBME Renewal Responses Report**

10/12/2015

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

N

06/06/2011

**If you do not have a medical condition, select No.**

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

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

06/06/2011

**Explanation 2: For the above question if your answer is "Yes" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box.**



If you use chemical substances, does your use in any way impair or limit your ability to practice medicine N

06/06/2011

with reasonable skill and safety?

If you do not use chemical substances, select No.

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.

**SBME Renewal Responses Report**

10/12/2015

Have you been named as a defendant, or been requested to respond as a defendant, to a legal action involving professional liability, malpractice, including any military tort claims if applicable?  
Please include: who, what, where (provide state), and when in the textbox directly below this question.

N

06/06/2011

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

**JSBME Renewal Responses Report**

10/12/2015

Have you had a professional liability, malpractice, claim paid on your behalf or paid such a claim yourself **N**

06/06/2011

including any military tort claims if applicable?  
If "Yes" during the time period July 1, 2009 - June 30, 2011 type an explanation in the textbox directly below this question.

**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.**

**USBME Renewal Responses Report**

10/12/2015

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

N

06/06/2011

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

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

N

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

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

06/06/2011

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

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

N

06/06/2011

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

**USBME Renewal Responses Report**

10/12/2015

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

N

06/06/2011

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



**MSBME Renewal Responses Report**

10/12/2015

N

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?

06/06/2011

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

**NSBME Renewal Responses Report**

10/12/2015

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

N

06/06/2011

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

Have you had hospital staff privileges denied, suspended, limited, revoked or not renewed by the hospital, including any and all resignations from any medical staff in lieu of disciplinary or administrative action? N  
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.)

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

Are you out of compliance with court ordered child support? If this does not apply to you, please answer "no".

N

06/06/2011

If "Yes" during the time period July 1, 2009 - June 30, 2011 type an explanation in the textbox directly below this question.

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

**ISBME Renewal Responses Report**

10/12/2015

N

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

06/06/2011

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

s your license contingent upon maintaining certification with the American Board of Medical Specialties

ABMS) in the specialty of Family Practice, Emergency Medicine, or Preventative Medicine?

N

06/06/2011

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

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

N

06/06/2011

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

**ISBME Renewal Responses Report**

10/12/2015

have completed the required amount of AMA Category 1 CME within the current biennial.  
Review CME information online at [www.medboard.nv.gov](http://www.medboard.nv.gov)  
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.  
renewing to an Inactive status, CME is not required and "No" can be selected.

Y

06/06/2011

SWEAR OR AFFIRM UNDER THE PENALTY OF PERJURY THAT I PERSONALLY ANSWERED ALL  
OF THE QUESTIONS IN THIS APPLICATION AND THAT THE ANSWERS I HAVE PROVIDED ARE  
TRUE AND CORRECT.

Y

06/06/2011



**ISBME Renewal Responses Report**

10/12/2015

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

N

06/04/2013

If you do not have a medical condition, select No.

Do 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?

N

06/04/2013

If you do not have a medical condition, select No.

**MSBME Renewal Responses Report**

10/12/2015

If you use chemical substances, does your use in any way impair or limit your ability to practice medicine N

06/04/2013

with reasonable skill and safety?  
If you do not use chemical substances, select No.

Have you been named as a defendant, or been requested to respond as a defendant, to a legal action N

06/04/2013

involving professional liability, malpractice, including any military tort claims if applicable?  
Please include: who, what, where (provide state), and when in the textbox directly below this question.

**NSBME Renewal Responses Report**

10/12/2015

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

06/04/2013

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

06/04/2013

**ISBME Renewal Responses Report**

10/12/2015

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

06/04/2013

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

06/04/2013

**MSBME Renewal Responses Report**

10/12/2015

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

N

06/04/2013

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

N

06/04/2013

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

Y

06/04/2013

[http://www.cdc.gov/injectionsafety/IP07\\_standardPrecaution.html](http://www.cdc.gov/injectionsafety/IP07_standardPrecaution.html)

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

N

06/04/2013

**JSBME Renewal Responses Report**

10/12/2015

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.)**

06/04/2013

N

Have you actively practiced medicine in Nevada within the past 12 months?

Y

06/04/2013

N

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

06/04/2013

Y

The submission of the in-office surgery/procedure forms is required for all medical doctors, whether in state, out of state, active or inactive status! THIS IS NOT OPTIONAL. DO NOT answer this attestation until you have completed the requisite form. Once you have completed this action, you may proceed in answering the renewal attestations and questions. The online renewal site will retain your previous responses. Please go to the website, click on the following link for instructions and complete the required form. Click on the following link for the instructions and forms: [http://medboard.nv.gov/New\\_In\\_Office\\_Surgery\\_Forms.htm](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 "YES". Nevada Revised Statutes (NRS) require the Nevada State Board of Medical Examiners to obtain from each applicant who seeks renewal of his or her license to practice medicine, a report stating the number and type of surgeries requiring conscious sedation, deep sedation or general anesthesia performed by the holder of the license at his or her office or any other facility, excluding any surgical care performed at a medical facility as defined in NRS 449.0151, or outside the state of Nevada. I hereby attest that I am in compliance with the reporting requirements of NRS 630.30665, and am aware that failure to submit a report or filing false information in a report is grounds for disciplinary action under Nevada's Medical Practice Act.

06/04/2013



**NSBME Renewal Responses Report**

10/12/2015

Are you out of compliance with court ordered child support? If this does not apply to you, please answer "no".

N

06/04/2013

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

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

Y

06/04/2013

(Review CME information online at [www.medboard.nv.gov](http://www.medboard.nv.gov))

If renewing to an inactive status, CME is not required and "No" can be selected.

**NSBME Renewal Responses Report**

10/12/2015

I SWEAR OR AFFIRM UNDER THE PENALTY OF PERJURY THAT I PERSONALLY ANSWERED ALL OF THE QUESTIONS IN THIS APPLICATION AND THAT THE ANSWERS I HAVE PROVIDED ARE TRUE AND CORRECT.

Y

06/04/2013