Uniform Application for Physician Licensure

UA Username e759478
FCVS Status Applicant has an FCVS Packet

Date Submitted 4/9/2014

1. Name: Indicate your full legal name. If your name has changed at any time during your life and you are not using FCVS, you must submit a copy of the legal document (marriage certificate, divorce decree, etc.) supporting your name change.

1. Full Name (use no initials)

Last Name	Livingston
First Name	Kristin
Middle Name	Jeanne
Suffix	
Maiden Name	

M.D. [X] **D.O.** [ ]

All other names used

First	Middle	Last	Suffix

2. Address/Phone: Please complete all sections and indicate which address you wish to be used for public access and which is to be used for mailings from the medical board. Each state's law determines whether each address or phone number is a public record in the state in which you are applying. You may wish to contact the licensing authority for that state for further information. Many boards publish the "Public Access" address on their website, therefore you should consider what your preferred address is for these purposes.

2. Address/Phone

Business

[ ] **Public Access**
[X] **Mailing**

Street 6116 FOUNTAIN AVE

City LOS ANGELES **State/Province** CA **Zip Code** 90028-8316
Country USA
Telephone (530) 227-0132
Fax
Email
Alternate Phone

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Home

[X] **Public Access**
[ ] **Mailing**

Street 6116 FOUNTAIN AVE

City LOS ANGELES **State/Province** CA **Zip Code** 90028-8316
Country USA
Telephone (530) 227-0132
Fax
Email
Alternate Phone

3. Identification: If you are not using FCVS, you must submit either a notarized copy of your birth certificate or a notarized copy of your current, valid passport.

3. Identification

/1983		California	USA
Date of Birth (mm/dd/yyyy)	Birth City	Birth State/Province	Birth Country

F (Gender) | Social Security Number | NPI | Are you a U.S. Citizen? [X] Yes [ ] No

Your social security number is required to facilitate reporting to the federal Healthcare Integrity & Protection Data Bank (42 U.S.C. Sections 1320a-7e(b), 5 U.S.C. Section 552a, and 45 C.F.R. pt. 61) and for accurate identification under the federal and state child support enforcement law (42 U.S.C. Section 666 and applicable state law). It may also be used for reporting to the National Practitioner Data Bank (42 U.S.C. Section 11101 and 45 C.F.R. pt. 60) and for other investigative/enforcement purposes in compliance with state laws governing physician discipline or as otherwise required by state or federal law.

The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. For more information on the NPI, please go to http://www.cms.hhs.gov/NationalProvidentStand/.

4. Medical School: List all medical schools you have attended, even those from which you did not graduate, in chronological order. Attach an additional sheet if necessary. If you are not using FCVS, you must complete the attached "Medical Education Verification" form and send it to all medical schools you have attended. You must include a copy of your diploma to which the medical school must attach their seal prior to forwarding it to this Board. Additionally, the medical school must provide this Board with an official copy of your transcripts. The medical school must forward all documentation directly to this Board.

4. Medical School

1

School Name Drexel University College of Medicine
Address Queen Lane Medical Campus
2900 W. Queen Lane

City Philadelphia
State/Province PA
ZIP Code 19129
Country USA
Attendance Dates **From (mm/yyyy)** 08/2006 **To (mm/yyyy)** 05/2010
Graduation Date 5/21/2010
Degree MD

5. Fifth Pathway: If you attended a Fifth Pathway program and are not using FCVS, you must complete the attached "Fifth Pathway Verification" form and send it to your medical school and to the institution where you completed your rotations. You must include a copy of your diploma. The medical school and institution must forward all documentation directly to this Board.

5. Fifth Pathway (if applicable)

Medical School Name			
Address			
City			
State/Province			
ZIP Code			
Country			
Attendance Dates	**From (mm/yyyy)**	**To (mm/yyyy)**	**In Progress**
Graduation Date			
Degree			
Institution name where rotations performed			
Address			
City			
State/Province			
ZIP Code			
Country			
Rotation Dates	**From (mm/yyyy)**	**To (mm/yyyy)**	**In Progress**
Certification Date			

6. Postgraduate Training: List **all** postgraduate programs you have attended, even those you did not complete. Attach an additional sheet if necessary. If you are not using FCVS, you must complete the attached "Postgraduate Training Verification" form and send it to **all** postgraduate training programs you have attended. You must submit a copy of your certificate of program completion to this Board. The postgraduate program must forward all documentation directly to this Board.

6. Postgraduate Training

1

Hospital Name Kaiser Permanente Southern California - Los Angele
Hospital Address 4900 Sunset Boulevard, 5A

City Los Angeles
State/Province California
ZIP Code 90027
Country USA

PGY: (e.g., 1, 2, 3, etc.) [X] **Internship** [X] **Residency** [ ] **Fellowship** [ ] **Research** [ ] **Other**

Department/Specialty Obstetrics and Gynecology

From: 07 /2010 **To:** 06 /2014 **Successfully Completed?** [ ] **Yes** [ ] **No** **In Progress** [X]

Month Year Month Year

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7. Examination History: If you are not using FCVS, you are responsible for contacting the appropriate examination entity and having a certified transcript of your scores sent directly to this Board.

7. Examination History

List each licensure examination, U.S. or international, you have taken (USMLE, NBME, NBOME, LMCC, Etc.).If additional space is necessary, please enclose a separate sheet with your application and include all the information below

Examination	State	Most Recent Date taken(Month/Year)	Passed (P) or Failed (F)		Number of attempts
USMLE Step 1		06/2008	[X] P	[ ] F	1
USMLE Step 2		07/2009	[X] P	[ ] F	1
USMLE Step2 CS		05/2009	[X] P	[ ] F	1
USMLE Step 3		06/2011	[X] P	[ ] F	1

8. ECFMG: If ECFMG is applicable and you are not using FCVS, you are responsible for contacting ECFMG and having a certified "Status Report" forwarded directly to this Board. There is a separate fee for this report. Reports can be obtained through the ECFMG web site at www.ecfmg.org.

8. ECFMG (if applicable)		
Certificate Number	Issue Date	Valid Through Date

9. State or Professional Licensure: List all state and Canadian provinces where you currently hold or have ever held any type of medical/osteopathic license. You must also complete the attached "Licensure Verification" form (Form #1) and forward it to all states in which you have held any health care license or certification. The verifying entity must forward all documentation directly to this Board. Some state boards charge a fee for this information. Contact the state board where you hold or held a license to determine their requirements.

9. State Licensure

1	**State/Province**	CA	**Practitioner Type (MD, DO, etc.)**	MD	**Type of License (Full, Temporary, etc.)**		
	License Number	A119369	**Status**	Active	**Issue Date**	12/1/2011	

10. Chronology of Activities: List ALL activities (medical, non-medical, and postgraduate training) in chronological order beginning with medical school graduation to the PRESENT date, using **MONTH** and **YEAR**. *For any non-working time, you MUST state on the form exactly what your activities were, such as "vacation" or "seeking employment," as well as your permanent address.* If you worked for a physician-staffing group or did locum tenens, you must list all facilities where you worked and include complete dates and addresses. **DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM.** Be sure to indicate the percentage of working time spent in clinical administrative duties.

10. Chronology of Activities

Dates: From/To	Practice/Employment
1 From: Month: 07 Year: 2010 To: Month: Year: In Progress ☒	**Practice/Employment Name** Kaiser Permanente Los Angeles Medical Center (or list non-working time as indicated above) **Practice/Employment Address** 4733 Sunset Blvd., 3rd Floor Center for Medical Education **City** Los Angeles **State/Province** California **ZIP Code** 90027 **Country** USA **Position and Department** OB/GYN Resident Physician-Continuing Medical Education **Percent Clinical:** 100% **Percent Administrative:** 0% **Employment** ☐ **Staff Privileges** ☐ **Affiliation** ☐ **Other** Post-Graduate Training

11. Malpractice: List of all claims or suits for medical malpractice made against you. A claim is any formal or informal demand for payment to any person or organization. If you do not have any such claims or suits, this section will be blank. Please have your information available before reviewing this section and contact the state board or FCVS to make changes.

11. Malpractice Liability Claims Information

Name of patient involved:

In which state did the action take place? **Case number (if applicable)**

Which court?
(If private compromise or settled before initiation of civil action, state here)

Current status of claim:

☐ Open (pending) ☐ Closed (settled or judgment) ☐ Dismissed (no money paid out) ☐ Other

Amount of judgement or settlement $ **Amount paid on your behalf $**

Month and year of event precipitating claim:

Month and year of lawsuit:

Insurance carrier at time:

What is/or was your status? ☐ **Primary defendant** ☐ **Co-defendant** ☐ **Other**

Please provide specifics in reference to the adverse event including the allegations and your role in the event:

Federation of STATE MEDICAL BOARDS

Federation of State Medical Boards
UA Licensure History

Physician Identification

Name:	Kristin Jeanne Livingston
Alternate Names:	
DOB:	08/07/1983
Medical School:	Drexel University College of Medicine
Year of Graduation:	2010

Licensure History

State Board/Licensing Entity	License Number	Issue Date	Expiration Date
Medical Board of California	A-119369	12/14/2011	08/31/2015

Licensure History as of UA Submission Date: 04/09/2014
UA Submission ID: 70788
UA User Name: e759478

ADDENDUM 8 – REQUEST FOR LICENSURE BY A RESIDENT

(You must be currently enrolled in an approved postgraduate training program.)

ONLY complete this form if you are currently enrolled in a postgraduate training program, have completed at least 24 months of progressive postgraduate training and meet all requirements for an unlimited license in the state of Nevada, including having passed all 3 steps of USMLE within the time period allowed by NAC 630.080.

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Acknowledgement of statutory requirements NRS 630.160

I, Kristin Livingston (print your name), am a Resident who is enrolled in a progressive postgraduate training program in the United States or Canada, approved by the Board, the Accreditation Council for Graduate Medical Education or the Coordinating Council of Medical Education of the Canadian Medical Association, and have completed at least 24 months of the program, and now commit in writing to the Nevada State Board of Medical Examiners (Board) that I will complete the program; and I hereby acknowledge that I will provide or cause to be provided to the Board proof of satisfactory completion of the program within sixty (60) days after the scheduled completion of the program.

If, after issuing a license to practice medicine to me, the Board obtains information from a primary or other source of information, and that information differs from the information provided by me (the applicant) or otherwise received by the Board, or if I fail to provide or cause to be provided to the Board proof of satisfactory completion of the program within sixty (60) days after the scheduled completion of the program, the Board may take action pursuant to Sections 4 and 5 of NRS 630.160, as well as any other disciplinary action deemed appropriate.

Applicant Signature MD 5/8/14 Date

State of California County of Los Angeles

Subscribed and sworn to before me this 8th day of May, 2014.

Notary Public for the State of CA

My Commission Expires: Nov 19, 2015

Residing at: LA City CA State

Signature of Notary

(NOTARY SEAL)

JORGE AMEZQUITA
Commission # 1961016
Notary Public - California
Los Angeles County
My Comm. Expires Nov 19, 2015

ADDENDUM 2 – ADDITIONAL PHYSICIAN INFORMATION

CITIZENSHIP AND IDENTIFICATION

U.S. Citizen Yes ☒ No ☐ Alien Registration #_____

Employment Authorization #_____ Visa #_____

Color of Eyes: _____ Color of Hair: _____ Height: _____ Weight: _____

SPECIALTY CERTIFICATION

Scope of Practice/Specialty(ies): Obstetrics & Gynecology

List any and all certifications and re-certifications by a board or sub-board recognized by the **American Board of Medical Specialties.** ALSO INCLUDE ALL INFORMATION PERTAINING TO ANY AND ALL FAILED ATTEMPTS.

Board / Specialty Board	If you are Lifetime Board Certified, indicate "Lifetime"	Certification #	Dates of Certification/ Recertification (MM/YY)
Planning to sit for written boards (ABOG)			on 6/30/14

If you hold "lifetime or historical" ABMS Board certification, please provide a notarized statement agreeing to maintain Board certification for the duration of your licensure in the state of Nevada.

EXAMINATION SCORES

List all licensure examinations you have taken, whether U.S. or International, on the Examination History tab of the online Uniform Application. Also list below the score you received on each exam taken.

Examination Name	Score Received	Examination Name	Score Received
USMLE Step1	248		
USMLE Step2 CK	235		
USMLE Step2 CS	Pass		
USMLE Step3	223		

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Applicant Name: Kristin Livingston MD

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ADDENDUM 3 – ATTESTATION QUESTIONS

Applicant Name: Kristin Livingston, MD

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 condition or disorder.

"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 THIS ADDENDUM.

1.	Do you currently have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? If "Yes," attach an explanation on a separate sheet.	Yes ☐ No ☒
2.	If you currently have a medical condition which in any way impairs or limits your ability to practice medicine, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? If "Yes," attach an explanation on a separate sheet.	Yes ☐ No ☒
3.	If you currently use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety? If "Yes," attach an explanation on a separate sheet.	Yes ☐ No ☒
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? If "Yes," attach an explanation on a separate sheet.	Yes ☐ No ☒
5a.	Have you EVER been named as a defendant, or been requested to respond as a defendant, to a legal action involving professional liability, or malpractice, including any military tort claims if applicable? If "Yes," please describe in the space provided on the Malpractice Liability Claims Information page within the online Uniform Application. Also complete addenda 3 and 4.	Yes ☐ No ☒
5b.	Have you EVER 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," please describe in the space provided on the Malpractice Liability Claims Information page within the online Uniform Application. Also complete addenda 3 and 4.	Yes ☐ No ☒
6.	Have you EVER 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	Yes ☐ No ☒

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. If "Yes," attach an explanation on a separate sheet.

7. Have you previously applied for medical licensure in Nevada (including in a Residency program)? If "Yes," attach an explanation on a separate sheet. Yes ☐ No ☒

8. Have you EVER been the subject of an investigation (including matters that resulted in no adverse action or outcome to you), have you resigned, been dismissed, or have any actions, form of remediation(s), restrictions, limitations, probations, terminations or any other disciplinary actions ever been imposed on you while participating in any type of training program? If "Yes," attach an explanation on a separate sheet. Yes ☐ No ☒

9. Have you EVER been denied a license, permission to practice medicine or any other healing art, or permission to take an examination to practice medicine or any other healing art in any state, country or U.S. territory? If "Yes," attach an explanation on a separate sheet. Yes ☐ No ☒

10. Have you EVER had a medical license or license to practice any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory? If "Yes," attach an explanation on a separate sheet. Yes ☐ No ☒

11. Have you EVER voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory? If "Yes," attach an explanation on a separate sheet. Yes ☐ No ☒

12. Have you EVER been denied membership, asked to resign, or expelled from a medical society or other professional medical organization? If "Yes," attach an explanation on a separate sheet. Yes ☐ No ☒

13. Have you EVER 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? If "Yes," attach an explanation on a separate sheet. Yes ☐ No ☒

14. Have you EVER surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? If "Yes," attach an explanation on a separate sheet. Yes ☐ No ☒

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

(<u>Please Note</u>: Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance.)

Hospital	Mailing Address	Type of Action	Dates of Action (From MM/YY to MM/YY)
N/A			

Applicant Name: Kristin Livingston, MD

CHILD SUPPORT STATEMENT

The law of the state of Nevada requires that all applicants for issuance of a license be required to provide the following information concerning the support of a child. You are advised that this questions is part of your application, your response is given under oath, and any response hereto which is false, fraudulent, misleading, inaccurate or incomplete, may result in your application being denied. You must mark one of the following responses, and failure to mark one of the responses may result in denial of your application.

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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.

Signature of Applicant: _____ MD Date: 5/8/14

SAFE INJECTION PRACTICE ATTESTATION

ATTESTATION TO KNOWLEDGE OF AND COMPLIANCE WITH THE GUIDELINES OF THE CENTERS FOR DISEASE CONTROL AND PREVENTION FOR APPLICANT PHYSICIANS

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. http://www.cdc.gov/injectionsafety/IP07_standardPrecaution.html

Signature of Applicant: _____ MD Date: 5/8/14

COMMUNICATIONS AFFIRMATION

Consent to accept communications and service of process from the Nevada State Board of Medical Examiners (Board) by electronic mail, for physicians and physician assistants who practice medicine in the state of Nevada via telemedicine and whose physical presence exists outside the state of Nevada or the United States

I hereby agree that as a condition of obtaining or maintaining licensure with the Board, I am willing to accept Board communications to me, to include service of process as defined under Nevada Revised Statute (NRS) 630.344, via electronic mail (more commonly known as e-mail). Further, should the electronic mail address provided below change for any reason, I agree to apprise the Board in writing of my new electronic mail address within 30 days after the change, and that the failure to do so may subject me to a fine or disciplinary action as allowed in NRS 630.244.

Printed Name of Applicant/Licensee: Kristin Jeanne Livingston

Signature of Applicant/Licensee: _____

Electronic Mail Address: _____ Date: 5/8/14

CHILD ABUSE ATTESTATION

ATTESTATION REGARDING THE REPORTING OF THE ABUSE OR NEGLECT OF A CHILD

I attest and affirm that I am aware and understand the reporting requirements found in Nevada Revised Statute 432B.220 regarding the abuse or neglect of a child.

www.leg.state.nv.us/NRS/NRS-432B.html#NRS432BSec220

Applicant signature _____ Date of signature 5/8/14

Kristin Livingston
Printed name of applicant

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APPLICATION AFFIRMATION

I, Kristin Jeanne Livingston,
(Print your full name)

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.

I am responsible to keep the Board informed of any circumstance or event that would require a change to my initial responses provided to the Board in my application for licensure, and which occurs prior to my being granted licensure to practice medicine in the state of Nevada.

_____ MD 5/8/14
Signature of applicant **Date**

(NOTARY SEAL)
JORGE AMEZQUITA
Commission # 1961016
Notary Public - California
Los Angeles County
My Comm. Expires Nov 19, 2015

State of California County of Los Angeles
Subscribed and sworn to before me this 8th day of May, 2014.
Notary Public for the State of CA
My Commission Expires: 11/19/2015
Residing at: LA CA
City State

_____
Signature of Notary

ADDENDUM 1 – RESPONSIBILITY STATEMENT

ATTENTION APPLICANT!

Please sign and return this statement with your application for licensure to:

The Nevada State Board of Medical Examiners
P.O. Box 7238, Reno, NV 89510
or
1105 Terminal Way, Ste 301, Reno, NV 89502

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

Via FBI fingerprinting and other investigative modalities, our licensing specialists are likely to discover if data you have submitted on your application is erroneous or incomplete; therefore, you must answer all questions truthfully and completely. Specifically, this includes any sanctions or disciplinary actions you may have experienced during medical school or your postgraduate training, or any involvement you may have had with the legal system, either civil or criminal — criminal to include charges that may have ultimately been expunged, lessened, or dismissed, and no matter how long ago the event(s) occurred.

Explaining and documenting a problem to your licensing specialist will be much less painful than discussing your veracity before the entire Board of Medical Examiners due to inconsistencies between your application and incongruent input from outside sources.

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

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

o o o o o

I have read this responsibility statement and understand that I alone am accountable for completing my application for medical licensure in Nevada.

Print your name Kristin Joanne Livingston

Sign your name _____

Date 5/8/14

Note: It is your responsibility to keep the Board informed of any circumstance or event that would require a change to your initial responses provided to the Board in your application for licensure, and which occurs prior to you being granted licensure to practice medicine in the state of Nevada.

UA | UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

Affidavit and Authorization for Release of Information

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Applicant: Send this form to the state board you are applying to. Do not send this to FSMB.

Applicant:

Securely tape or glue a recent (less than 6 month old) front-view 2" x 2" passport-type color photo of yourself in the square below.

Sign this form with attached photo in the presence of a notary public.

Send the notarized form to the board you are applying to for licensure.

DO NOT SEND THIS FORM TO FSMB.

Doing so will cause a delay with your state board application.

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor of and person named in the various forms and credentials furnished or to be furnished with respect to my application, and that all documents, forms, or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

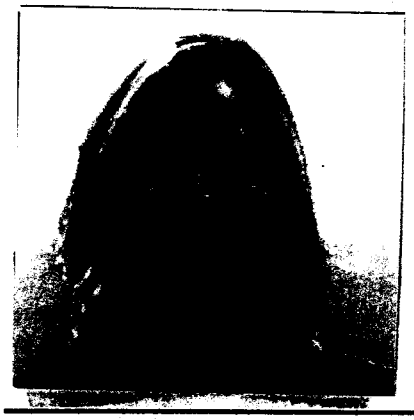
I acknowledge that I have read and understand the Uniform Application for Physician State Licensure and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me to furnish to the Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data, and to permit the Board or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

I hereby release, discharge, and exonerate the Board, its agents or representatives, and any person, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the Board.

I will immediately notify the Board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license to practice medicine being granted to me by the Board.

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my license or permit to practice medicine.



Applicant's signature (must be signed in the presence of a notary)

Livingston
Applicant's printed last name

Kristin Jeanne
Applicant's printed first name, middle initial, and suffix (e.g. Jr.)

5/8/14
Date of signature (must correspond to date of notarization)

JORGE AMEZQUITA
Commission # 1961016
Notary Public - California
Los Angeles County
My Comm. Expires Nov 19, 2015

Notary

State of California, County of Los Angeles,

I certify that on the date set forth below, the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document.

The statements on this document are subscribed and sworn to before me by the applicant on this 8th day of May, 2014.

Notary Public Signature:

My Notary Commission Expires: Nov 19, 2015

NOTARY PUBLIC SEAL
JORGE AMEZQUITA
Commission # 1961016
Notary Public - California
Los Angeles County
My Comm. Expires Nov 19, 2015

System Automation

MyLicense Transaction Reports

Reports Home Page

Renewal Questions for License Number 15432

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Licensee	Question	Answer	Date
LIVINGSTON, Kristin Jeanne	Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? **If you do not have a medical condition, select No.**	N	6/23/2015
LIVINGSTON, Kristin Jeanne	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? **If you do not have a medical condition, select No.**	N	6/23/2015
LIVINGSTON, Kristin Jeanne	If you use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety? **If you do not use chemical substances, select No.**	N	6/23/2015
LIVINGSTON, Kristin Jeanne	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	6/23/2015
LIVINGSTON, Kristin Jeanne	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	6/23/2015
LIVINGSTON, Kristin Jeanne	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	6/23/2015
LIVINGSTON, Kristin Jeanne	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	6/23/2015
LIVINGSTON, Kristin Jeanne	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	6/23/2015
LIVINGSTON, Kristin Jeanne	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	6/23/2015

LIVINGSTON, Kristin Jeanne	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	6/23/2015
LIVINGSTON, Kristin Jeanne	Have you been: a) asked to respond to an investigation; b) notified that you were under investigation for; c) investigated for; d) charged with; or e) convicted of any violation of a statute, rule or regulation governing your practice as a physician by any medical licensing board, hospital, medical society, governmental entity or agency other than the Nevada State Board of Medical Examiners?	N	6/23/2015
LIVINGSTON, Kristin Jeanne	Have you surrendered your state or federal controlled substance registration or had it revoked or restricted in any way?	N	6/23/2015
LIVINGSTON, Kristin Jeanne	Have you had hospital staff privileges denied, suspended, limited, revoked or not renewed by the hospital, including any and all resignations from any medical staff in lieu of disciplinary or administrative action? If the answer is "Yes," type the name of the hospital, the hospital's mailing address, the type of action taken, and the date or dates of the actions taken in the textbox directly below this question. **(Please Note: Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance.)**	N	6/23/2015
LIVINGSTON, Kristin Jeanne	Have you actively practiced medicine in Nevada within the past 12 months?	Y	6/23/2015
LIVINGSTON, Kristin Jeanne	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" **as of the date of your renewal.** 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 not physically practice in the state of Nevada. If you choose to place your license on Inactive status, make certain to select "Yes" to this question **AND** choose the Inactive status in the dropdown box located at the end of the questions.	N	6/23/2015
LIVINGSTON, Kristin Jeanne	**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. **http://www.cdc.gov/injectionsafety/IP07_standardPrecaution.html**	Y	6/23/2015

LIVINGSTON, Kristin Jeanne	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. I HAVE SUBMITTED A "FORM A" OR "FORM B" REPORT TO THE BOARD. 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: www.medboard.nv.gov. **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."**	Y	6/23/2015
LIVINGSTON, Kristin Jeanne	Are you out of compliance with court ordered child support? **If this does not apply to you, please answer "no".** If "Yes" during the time period July 1, 2013 - June 30, 2015 type an explanation in the textbox directly below this question.	N	6/23/2015
LIVINGSTON, Kristin Jeanne	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". **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.** **www.leg.state.nv.us/NRS/NRS-432B.html#NRS432BSec220**	Y	6/23/2015
LIVINGSTON, Kristin Jeanne	Have you ever served in the United States Military (to include National Guard or Reserves)?	N	6/23/2015
LIVINGSTON, Kristin Jeanne	Do you hold a Nevada state business license issued in your individual name?	N	6/23/2015
LIVINGSTON, Kristin Jeanne	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 www.medboard.nv.gov) If renewing to an Inactive status, CME is not required and "No" can be selected.	Y	6/23/2015
LIVINGSTON, Kristin Jeanne	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	6/23/2015