

MEDICAL DOCTOR
STATE OF NEVADA BOARD OF MEDICAL EXAMINERS APPLICATION FOR LICENSE

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NOV 13 2002
NEVADA STATE BOARD OF
MEDICAL EXAMINERS

1. Present Legal Name Isaacson, Paul Allen
Last First Middle Maiden

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List any other name ever used _____

2. Business and/or Mailing Address 892 N. Sicily Dr., Chandler, AZ 85226
Street City State Zip

3. Home Address _____
Street City State Zip

4. Telephone (480) 225-8826 (_____)
area code Office area code Home

5. Date of Birth /59 Place of Birth Michigan
City, state, country

6. Citizenship: U.S. Citizen Alien Registration # _____ Work Authorization# _____
Visa Type and # _____

Submit a certified copy of birth certificate, or original Certificate of Naturalization or current U.S. passport or copy of front/ back of your alien registration card, work authorization or Visa.

7. Age _____ Height _____ Weight _____ Color of Eyes _____ Color of Hair _____
Social Security Number _____

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 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 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 N/A
If yes, separate attached explanation required.

8/22/02

11. Have you failed to initiate the performance of public service within 3 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 X 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? X Yes 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 X No.

If Yes, separate attached explanation required.

14. Have you previously applied for medical licensure in Nevada (including a residency program)? Yes X 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.)
Tufts University School of Medicine	145 Harrison Ave., Boston, MA 02111		9/87 to 5/91

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
Tufts University School of Medicine	145 Harrison Ave., Boston, MA 02111	5/4/91 5/12/91

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.)
Brigham and Women's Hospital	75 Francis St., Boston, MA 02115	Ob/Gyn	6/91 to 6/95 7/91 to 6/95

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.)
-------------	--------------------	-----------------------	--

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 X 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# _____

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.

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a. NATIONAL BOARDS:

Location	Part Taken	Date	Results (Scores)
Boston, MA	Part I	6/89	625 - Pass
Boston, MA	Part II	9/90	570 Pass
Boston, MA	Part III	3/92	625 Pass

NEVADA STATE BOARD OF
MEDICAL EXAMINERS

b. FLEX (Federation Licensing Examination):

Location	Part Taken	Date	Result (Scores)

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MEDICAL EXAMINERS

c. USMLE (United States Medical Licensing Examination):

Location	Part Taken	Date	Result (Scores)

d. State Written Examination:

Location	Part Taken	Date	Result (Scores)

e. SPEX (Special Purpose Examination):

Location	Part Taken	Date	Result (Scores)

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
The American Board of Obstetrics and Gynecology	# 951166	11/7/97

24. Account for all periods of **C**ie since graduation from medical school. **C**
ALL PERIODS OF TIME MUST BE ACCOUNTED FOR.

City/State/Country		From (Mo./Yr.)	To (Mo./Yr.)
Chelsea, MA USA	Residency 04/6yr	5/91	7/92
Brookline, MA USA	Residency 04/6yr	7/92	7/95
Chander, AZ USA	Private practice 04/6yr	7/95	to present

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.)
Please See Attachment		

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	77622	5/12/93	5/93 to 7/95
Arizona	23227	6/16/95	7/95 to present

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 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 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 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 No.
 If yes, separate attached explanation required.

Question 25

Desert Samaritan Medical Center
1400 S. Dobson Rd, Mesa, AZ 85202
8/95 to present

Paul A. Isaacson, M.D.
Additional Information
3

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NEVADA STATE BOARD OF
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Chandler Regional Hospital
475 S. Dobson Rd, Chandler, AZ 85224
7/95 to present

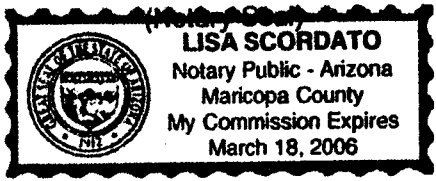
Mesa General Hospital
515 N Mesa Dr, Mesa, AZ 85201
9/95 to 7/97

Mesa Lutheran Hospital
525 W. Brown Road Mesa, AZ 85201
9/95 to 8/97

Valley Lutheran Hospital
6644 E. Baywood Ave, Mesa, AZ 85206
9/95 to 8/97

Tempe St. Luke's Hospital
1500 S Mill Ave, Tempe, AZ 85281
7/95 to 7/99

I, Paul Isaacson 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.



Signature of Applicant
Subscribed and sworn to before me this 22nd day of October, 2002
Notary Public for State of Arizona
My Commission Expires March 18, 2006
Residing at Bank of America
Lisa Scordato
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.



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Proof photos and negatives are not acceptable

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

Signature of Applicant
10/22/02
Date

**APPLICATION FOR INITIAL REGISTRATION
NEVADA STATE BOARD OF
MEDICAL EXAMINERS**

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

Date received by Board **RECEIVED**

MAY 15 2003

License No. _____

File No. _____

Paul A. Isaacson, M.D.
892 N. Sicily Drive
Chandler, AZ 85226

(NVS) NEVADA STATE BOARD OF
MEDICAL EXAMINERS

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

PLEASE PROVIDE ALL INFORMATION AS REQUESTED (TYPE OR PRINT LEGIBLY)

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

Name _____

Street _____

City _____ County _____ State _____ Zip Code _____

2. 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.

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

**SCOPE OF PRACTICE
SPECIALTY CODES**

- | | | |
|----------------------------|-----------------------------------|-------------------------------------|
| 102 ADDICTION MEDICINE | 31 NEOPLASTIC DISEASES | 62 PEDIATRIC, RADIOLOGY |
| 1 ADOLESCENT MEDICINE | 32 NEPHROLOGY | 63 PEDIATRIC, SURGERY |
| 2 AEROSPACE MEDICINE | 33 NEUROLOGY | 64 PEDIATRIC, UROLOGY |
| 3 ALLERGY/IMMUNOLOGY | 34 NEUROPATHOLOGY | 65 PEDIATRICS |
| 104 ALTERNATIVE MEDICINE | 35 NEURORADIOLOGY | 66 PHYSICAL MEDICINE/REHABILITATION |
| 4 ANESTHESIOLOGY | 36 NUCLEAR MEDICINE | 67 PREVENTIVE MEDICINE |
| 5 BLOODBANKING | 37 NUTRITION | 68 PSYCHIATRY |
| 6 BRONCO-ESOPHAGOLOGY | 38 OBSTETRICS/GYNECOLOGY | 69 PSYCHOANALYSIS |
| 7 CARDIOVASCULAR DISEASES | 39 OBSTETRICS | 70 PSYCHOMATIC MEDICINE |
| 8 CATSCAN/ULTRASOUND | 40 OCCUPATIONAL MEDICINE | 71 PUBLIC HEALTH |
| 9 CHILD NEUROLOGY | 41 ONCOLOGY | 72 PULMONARY DISEASES |
| 10 CHILD PSYCHIATRY | 45 ONCOLOGY, GYNECOLOGICAL | 73 RADIOLOGY |
| 11 CLINICAL PHARMACOLOGY | 42 ONCOLOGY, HEMATOLOGY | 74 RADIOLOGY, DIAGNOSTIC |
| 12 CRITICAL CARE | 43 ONCOLOGY, RADIATION | 75 RADIOLOGY, NUCLEAR |
| 13 DERMATOLOGY | 44 ONCOLOGY, SURGICAL | 76 RADIOLOGY, THERAPEUTIC |
| 14 EMERGENCY MEDICINE | 46 OPHTHALMOLOGY | 77 RHEUMATOLOGY |
| 15 ENDOCRINOLOGY | 47 OTOLARYNGOLOGY | 78 RHINOLOGY |
| 16 FAMILY PRACTICE | 48 OTOTOLOGY | 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>38</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 and Gynecology</u>	<u>11/97</u> (Mo./Yr.)	(Mo./Yr.)
Subboard _____	(Mo./Yr.)	(Mo./Yr.)
Board _____	(Mo./Yr.)	(Mo./Yr.)
Subboard _____	(Mo./Yr.)	(Mo./Yr.)

4. Form of employment is 1003. (Use one of the following codes.)

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

5. 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.

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

- a. Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? _____ Yes X No
- b. 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 X N/A
- c. 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 X N/A
- d. 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 X N/A
- e. 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? X Yes _____ No

f. Have you ever been investigated for, charged with, convicted of, or pleaded 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

g. 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

h. 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

i. 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

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

k. 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

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

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

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

(If more space is needed, attach 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

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.

480-855-9090 5/9/03
 Business Telephone # Date Signature (SIGNATURE STAMP UNACCEPTABLE)

PHYSICIAN

Date Received by Board

APPLICATION FOR REGISTRATION RENEWAL FOR THE BIENNIAL REGISTRATION PERIOD 2003- 2005

JUN 20 2003

License No. ~~104~~

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

(For Board Use Only)

File No. _____

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

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

Paul A. Isaacson, M.D.
892 N. Sicily Drive
Chandler, AZ 85226

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

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

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

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

Date _____ Signature (SIGNATURE STAMP UNACCEPTABLE) _____

PLEASE NOTE:

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

PLEASE TYPE OR PRINT LEGIBLY

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

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

Name _____

Street _____

City _____ County _____ State _____ Zip _____

Phone Number _____ Fax Number _____

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

Name _____

Street _____

City _____ County _____ State _____ Zip _____

Phone Number _____

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

SCOPES OF PRACTICE CODES

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

Code

Code

Primary Scope of Practice 51

Secondary Scope of Practice _____

**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.)

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

CHILD SUPPORT STATEMENT

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

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

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

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

CONTINUING MEDICAL EDUCATION (CME) STATEMENT

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

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

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

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

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

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

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

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

BY SIGNING ON THE SIGNATURE LINE BELOW:

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

6/16/03
Date

Signature (SIGNATURE STAMP UNACCEPTABLE)

PHYSICIAN

Date Received by Board

License No. 10490

**APPLICATION FOR REGISTRATION RENEWAL
FOR THE BIENNIAL REGISTRATION PERIOD 2005 - 2007**

FEB 24 2005

File No. _____
5/19/03

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

(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)



Paul Allen ISAACSON
2900 E. Desert Inn Road, Suite 209
Las Vegas NV 89121-

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

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

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

Date Signature (SIGNATURE STAMP UNACCEPTABLE)

PLEASE NOTE:

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

PLEASE TYPE OR PRINT LEGIBLY

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

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

Name _____

Street _____

City _____ County _____ State _____ Zip _____

Phone Number _____ Fax Number _____

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 | 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 OBSTETRICS/GYNECOLOGY | 95 OCCUPATIONAL MEDICINE |
| 12 CHILD NEUROLOGY | 54 OCCUPATIONAL MEDICINE | 96 RADIOLOGY |
| 13 CHILD PSYCHIATRY | 55 ONCOLOGY | 97 RADIOLOGY, DIAGNOSTIC |
| 14 CLINICAL PHARMACOLOGY | 56 ONCOLOGY, GYNECOLOGICAL | 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 SURGERY, 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 |

Code

Code

Primary Scope of Practice 53

Secondary Scope of Practice _____

PLEASE INDICATE AMERICAN BOARD OF MEDICAL SPECIALTIES BOARD CERTIFICATION & RECERTIFICATION

Board American Board of OBSTETRICS and Gynecology Date of Initial Certification 11/97 Date of Last Recertification _____
 (Mo./Yr.) (Mo./Yr.)

Subboard _____ (Mo./Yr.) (Mo./Yr.)

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

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

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

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

3. The physical capability to perform medical tasks such as physician examination and surgical procedures, with or without the use 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.)

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).

2/19/05

Date

Signature (SIGNATURE STAMP UNACCEPTABLE)

License Number	Licensee Name	Question Text	Answer	Date Answered
10490	ISAACSON, Paul Allen	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 elicensbme@medboard.nv.gov	N	5/5/2007
10490	ISAACSON, Paul Allen	If you have a medical condition which in any way impairs or limits your ability to practice medicine, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? If you answer "Yes" during the time period July 1, 2005 - June 30, 2007 email to elicensbme@medboard.nv.gov	N	5/5/2007
10490	ISAACSON, Paul Allen	If you use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety? If you answer "Yes" during the time period July 1, 2005 - June 30, 2007 email to elicensbme@medboard.nv.gov	N	5/5/2007
10490	ISAACSON, Paul Allen	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	5/5/2007
10490	ISAACSON, Paul Allen	Have you been named as a defendant, or been requested to respond as a defendant, to a legal action involving professional liability (malpractice), or had a professional liability claim paid on your behalf, or paid such a claim yourself?	Y	5/5/2007

10490	ISAACSON, Paul Allen	<p>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 elicensbme@medboard.nv.gov</p>	N	5/5/2007
10490	ISAACSON, Paul Allen	<p>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 elicensbme@medboard.nv.gov.</p>	N	5/5/2007
10490	ISAACSON, Paul Allen	<p>Have you had a medical license or license to practice any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory? If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensbme@medboard.nv.gov.</p>	N	5/5/2007

10490	ISAACSON, Paul Allen	Have you voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory by the direct request of a medical board? If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov.	N	5/5/2007
10490	ISAACSON, Paul Allen	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	5/5/2007
10490	ISAACSON, Paul Allen	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	5/5/2007
10490	ISAACSON, Paul Allen	Have you surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov.	N	5/5/2007

10490	ISAACSON, Paul Allen	Have you had hospital staff privileges denied, suspended, limited, revoked or not renewed by the hospital? If you have answered "Yes" you will be required to submit a list of any and all resignations from any medical staff in lieu of disciplinary or administrative action via email to elicensensbme@medboard.nv.gov (Please Note: Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance.) If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov .	N	5/5/2007
10490	ISAACSON, Paul Allen	Is your license currently contingent upon compliance with the Diversion program also known as the Nevada Health Professionals Assistance Foundation? If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov .	N	5/5/2007
10490	ISAACSON, Paul Allen	Was your license issued contingent upon maintaining certification by the American Board of Medical Specialties in the specialty of Family Practice, Emergency Medicine or Preventative medicine? If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov .	N	5/5/2007
10490	ISAACSON, Paul Allen	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	5/5/2007

10490	ISAACSON, Paul Allen	Are you out of compliance with court ordered child support? If this does not apply to you please answer "no". If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov.	N	5/5/2007
10490	ISAACSON, Paul Allen	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 to elicensensbme@medboard.nv.gov	N	5/5/2007
10490	ISAACSON, Paul Allen	Are you currently supervising a Physician Assistant or an Advanced Practitioner of Nursing? If you answer "Yes" please email a list of names of those you are supervising to elicensensbme@medboard.nv.gov	N	5/5/2007
10490	ISAACSON, Paul Allen	I have completed the required amount of AMA Category 1 CME within the current biennial. (Review CME information online at www.medboard.nv.gov) I understand that I may be included in a random audit following July 1st 2007 renewal. I agree to retain CME's taken between July 1, 2005 and June 30, 2007.	Y	5/5/2007
10490	ISAACSON, Paul Allen	I have actively practiced medicine in Nevada within the past 24 months.	Y	5/5/2007
10490	ISAACSON, Paul Allen	I hereby request my license to be placed on inactive status. I will not physically practice in the state of Nevada.	N	5/5/2007
10490	ISAACSON, Paul Allen	I HEREBY SWEAR OR AFFIRM UNDER THE PENALTIES OF PERJURY THAT I AM IN FULL COMPLIANCE WITH ANY AND ALL OBLIGATIONS, TERMS OR CONDITIONS OF MY NEVADA MEDICAL LICENSE SPECIFIED BY THE BOARD.	Y	5/5/2007

10490	ISAACSON, Paul Allen	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	6/3/2009
10490	ISAACSON, Paul Allen	If you have a medical condition which in any way impairs or limits your ability to practice medicine, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? If you do not have a medical condition, select No.	N	6/3/2009
10490	ISAACSON, Paul Allen	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	6/3/2009
10490	ISAACSON, Paul Allen	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	6/3/2009
10490	ISAACSON, Paul Allen	Have you had a professional liability (malpractice) claim paid on your behalf or paid such a claim yourself (including any military tort claims if applicable)? Please include: who, what, where (provide state), when and case number in the textbox directly below this question. Please fax a copy of the complaint, civil or otherwise to 775-688-2551.	N	6/3/2009

10490	ISAACSON, Paul Allen	Have you been arrested, investigated for, charged with, convicted of, or pled guilty or nolo contendere to any criminal offense related to the manufacture, distribution, prescribing, or dispensing of controlled substances? Please note that you MUST disclose ANY investigation or arrest, including those where the final disposition was dismissal, sealing of a record, or expungement.	N	6/3/2009
10490	ISAACSON, Paul Allen	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	6/3/2009
10490	ISAACSON, Paul Allen	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	6/3/2009
10490	ISAACSON, Paul Allen	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	6/3/2009
10490	ISAACSON, Paul Allen	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	6/3/2009
10490	ISAACSON, Paul Allen	Have you been denied membership, been asked to resign or expelled from a medical society or other professional medical organization (including the ABMS)?	N	6/3/2009

10490	ISAACSON, Paul Allen	Regarding any medical licensing board, hospital medical society, or other governmental entity or agency (other than the Nevada State Board of Medical Examiners), have you been: (a) Asked to respond to an investigation; (b) Notified that you were under investigation for; (c) Investigated for; (d) Charged with; or (e) Convicted of any violation of a statute, rule or regulation governing your practice as a physician?	N	6/3/2009
10490	ISAACSON, Paul Allen	Have you surrendered your state or federal controlled substance registration or had it revoked or restricted in any way?	N	6/3/2009
10490	ISAACSON, Paul Allen	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	6/3/2009
10490	ISAACSON, Paul Allen	Are you out of compliance with court ordered child support? If this does not apply to you, please answer "no". If "Yes" during the time period July 1, 2007- June 30, 2009 type an explanation in the textbox directly below this question.	N	6/3/2009

10490	ISAACSON, Paul Allen	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	6/3/2009
10490	ISAACSON, Paul Allen	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	6/3/2009
10490	ISAACSON, Paul Allen	I have completed the required amount of AMA Category 1 CME within the current biennial. (Review CME information online at www.medboard.nv.gov) I understand that I may be included in a random audit following the July 1st, 2009 renewal. I agree to retain CME's taken between July 1, 2007 and June 30, 2009. If renewing to an Inactive status, CME is not required and "No" can be selected.	Y	6/3/2009
10490	ISAACSON, Paul Allen	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	6/3/2009

[Reports Home Page](#)

Renewal Questions for License Number 10490



Licensee	Question	Answer	Date
ISAACSON, Paul Allen	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	6/8/2011
ISAACSON, Paul Allen	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.		
ISAACSON, Paul Allen	If you have a medical condition which in any way impairs or limits your ability to practice medicine, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? If you do not have a medical condition, select No.	N	6/8/2011
ISAACSON, Paul Allen	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.		
ISAACSON, Paul Allen	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	6/8/2011
ISAACSON, Paul Allen	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.		
ISAACSON, Paul Allen	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?	N	6/8/2011
ISAACSON, Paul Allen	Please include: who, what, where (provide state), and when in the textbox directly below this question.		
ISAACSON,	Explanation 4: For the above question if your answer is "Yes" for the time period July 1, 2009 - June 30, 2011,		

Paul Allen **or since your last renewal, please type your explanation in this text box.**

Have you had a professional liability, malpractice, claim paid on your behalf or paid such a claim yourself including any military tort claims if applicable?

ISAACSON,
Paul Allen

N

6/8/2011

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

ISAACSON,
Paul Allen

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.

ISAACSON,
Paul Allen

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

6/8/2011

ISAACSON,
Paul Allen

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.

ISAACSON,
Paul Allen

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

6/8/2011

ISAACSON,
Paul Allen

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.

ISAACSON,
Paul Allen

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

6/8/2011

Explanation 8: For the above question if your answer is

ISAACSON, Paul Allen **"Yes" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box.**

ISAACSON, Paul Allen 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 6/8/2011

ISAACSON, Paul Allen **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.**

ISAACSON, Paul Allen Have you been denied membership, been asked to resign or expelled from a medical society or other professional medical organization (including the ABMS)? N 6/8/2011

ISAACSON, Paul Allen **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.**

ISAACSON, Paul Allen 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 6/8/2011

ISAACSON, Paul Allen **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.**

ISAACSON, Paul Allen Have you surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? N 6/8/2011

ISAACSON, Paul Allen **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.**

ISAACSON, Paul Allen 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 6/8/2011

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.

ISAACSON,
Paul Allen

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

ISAACSON,
Paul Allen

If "Yes" during the time period July 1, 2009 - June 30, 2011 type an explanation in the textbox directly below this question. N 6/8/2011

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

ISAACSON,
Paul Allen

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

ISAACSON,
Paul Allen

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 6/8/2011

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.

ISAACSON,
Paul Allen

ISAACSON,
Paul Allen

Is your license contingent upon maintaining certification with the American Board of Medical Specialties (ABMS) in the specialty of Family Practice, Emergency Medicine, or Preventative Medicine? N 6/8/2011

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

ISAACSON,
Paul Allen

Do you want to change your scope of practice or specialty?

ISAACSON,
Paul Allen

If you answer "Yes" type your current scope of practice or specialty in the textbox directly below this question. N 6/8/2011

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.

ISAACSON,
Paul Allen

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

ISAACSON, Paul Allen I understand that I may be included in a random audit following the July 1st, 2011 renewal. I agree to retain CME's taken between July 1, 2009 and June 30, 2011. Y 6/8/2011

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

ISAACSON, Paul Allen 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 6/8/2011

Nevada State Board of Medical Examiners

Renewal Responses Report
Thursday, August 20, 2015



License Number Licensee
10490 Paul Allen ISAACSON

License Type
Medical Doctor

Question

Answer

Date

NSBME Renewal Responses Report

8/20/2015

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

06/13/2013

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

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

06/13/2013

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

NSBME Renewal Responses Report

8/20/2015

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 do not use chemical substances, select No.

06/13/2013

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

N

06/13/2013

NSBME Renewal Responses Report

8/20/2015

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.

06/13/2013

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

06/13/2013

NSBME Renewal Responses Report

8/20/2015

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

06/13/2013

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

06/13/2013

NSBME Renewal Responses Report

8/20/2015

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

06/13/2013

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

06/13/2013

NSBME Renewal Responses Report

8/20/2015

Have you been: a) asked to respond to an investigation; b) notified that you were under investigation for; c) investigated for; d) charged with; or e) convicted of any violation of a statute, rule or regulation governing your practice as a physician by any medical licensing board, hospital, medical society, governmental entity or agency other than the Nevada State Board of Medical Examiners?

N

06/13/2013

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

N

06/13/2013

NSBME Renewal Responses Report

8/20/2015

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.)

06/13/2013

N

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

Y

06/13/2013

NSBME Renewal Responses Report

8/20/2015

06/13/2013

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.

Y

06/13/2013

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

If you have submitted your In-Office Surgery/Procedure Reporting Forms (A/B forms) to the Board and are in compliance with NRS 630.30665, your answer should be "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.

NSBME Renewal Responses Report

8/20/2015

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

N

06/13/2013

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

06/13/2013

(Review CME information online at www.medboard.nv.gov)

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

NSBME Renewal Responses Report

8/20/2015

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

06/13/2013

Renewal Questions for License Number 10490



Licensee	Question	Answer	Date
ISAACSON, Paul Allen	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	6/1/2015
ISAACSON, Paul Allen	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	6/1/2015
ISAACSON, Paul Allen	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	6/1/2015
ISAACSON, Paul Allen	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	6/1/2015
ISAACSON, Paul Allen	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	6/1/2015
ISAACSON, Paul Allen	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	6/1/2015
ISAACSON, Paul Allen	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	6/1/2015
ISAACSON, Paul Allen	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	6/1/2015
ISAACSON, Paul Allen	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	6/1/2015
ISAACSON, Paul Allen	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	N	6/1/2015

	of your receiving a loan or scholarship from the federal government or a state or local government for your medical education?		
ISAACSON, Paul Allen	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	6/1/2015
ISAACSON, Paul Allen	Have you surrendered your state or federal controlled substance registration or had it revoked or restricted in any way?	N	6/1/2015
ISAACSON, Paul Allen	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	6/1/2015
ISAACSON, Paul Allen	Have you actively practiced medicine in Nevada within the past 12 months?	Y	6/1/2015
ISAACSON, Paul Allen	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 <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 AND choose the Inactive status in the dropdown box located at the end of the questions.	N	6/1/2015
ISAACSON, Paul Allen	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	6/1/2015
ISAACSON, Paul Allen	http://www.cdc.gov/injectionsafety/IP07_standardPrecaution.html 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.	Y	6/1/2015

	<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: www.medboard.nv.gov.</p> <p>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."</p>		
ISAACSON, Paul Allen	<p>Are you out of compliance with court ordered child support? If this does not apply to you, please answer "no".</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	6/1/2015
ISAACSON, Paul Allen	<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>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.</p> <p>www.leg.state.nv.us/NRS/NRS-432B.html#NRS432BSec220</p>	Y	6/1/2015
ISAACSON, Paul Allen	Have you ever served in the United States Military (to include National Guard or Reserves)?	N	6/1/2015
ISAACSON, Paul Allen	Do you hold a Nevada state business license issued <u>in your individual name</u> ?	Y	6/1/2015
ISAACSON, Paul Allen	Explanation 18: If yes, provide the business license number:		6/1/2015
ISAACSON, Paul Allen	<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 www.medboard.nv.gov)</p> <p>If renewing to an <u>Inactive</u> status, CME is not required and "No" can be selected.</p>	Y	6/1/2015
ISAACSON, Paul Allen	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	6/1/2015