MEDICAL DOCTOR

STATE OF NEVADA BOARD OF MEDICAL EXAMINERS APPLICATION FOR LICENSURE

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1. Present Legal Name STANLEY, ELEANOR POWELL
Last First Middle Maiden

List any other name ever used ELEANOR LOUISE POWELL

2. Business and/or Mailing Address 2330 W. MEGAN; CHANDLER, AZ 85224
Street City State Zip

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3. Home Address SAME
Street City State Zip

4. Telephone (480) 236-8245 (480) 726-8401
area code Office CELL area code Home

5. Date of Birth ____ 1957 Place of Birth ____, US
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 Eye ____ 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.

11. Have you failed to in[illegible]e the performance of public service with[illegible]ne 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)
If yes, separate attached explanation required.

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

14. Have you previously applied for medical licensure in Nevada (including a residency program)? _____Yes _____(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.) |
|---|---|---|---|---|
| The George Washington University School of Medicine. | 2300 Eye St. NW; Washington DC 20037. | | 9/1987 | 5/1991 |

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 |
|---|---|---|
| The George Washington University School of Medicine | 2300 Eye Street, NW; Washington, DC 20037. | 5/31/1991 |

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.) |
|---|---|---|---|---|
| UNIVERSITY HOSPITAL UNM - ALBUQUERQUE | 2211 LOMAS BLVD NE ALBUQUERQUE, NM 87106. | OB-GYN | 6/24/1991 | 7/1/1995 |

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.) |
|---|---|---|---|---|
| N/A | | | | |

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 _____(No)
If Yes, separate explanation required.

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

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

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a. NATIONAL BOARDS:

| Location | Part Taken | Date | Results (Scores) |
|---|---|---|---|
| WASHINGTON, DC | I | 6/1989 | 475 |
| WASHINGTON, DC | II | 9/1990 | 590 |
| ALBUQUERQUE, NM | III | 3/4/1992 | 585 |

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b. FLEX (Federation Licensing Examination):

| Location | Part Taken | Date | Result (Scores) |
|---|---|---|---|
| N/A | | | |

c. USMLE (United States Medical Licensing Examination):

| Location | Part Taken | Date | Result (Scores) |
|---|---|---|---|
| N/A | | | |

d. State Written Examination:

| Location | Part Taken | Date | Result (Scores) |
|---|---|---|---|
| N/A | | | |

e. SPEX (Special Purpose Examination):

| Location | Part Taken | Date | Result (Scores) |
|---|---|---|---|
| N/A | | | |

22. State your area of specialty: OBSTETRICS & GYNECOLOGY

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

| Specialty Board | Certification # | Dates of Certification/Recertification |
|---|---|---|
| AMERICAN BOARD OF OBSTETRICS & GYNECOLOGY | #950090 | 11/20/1998. |

Florence Petrucci M.D.

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

| City/State/Country | From (Mo./Yr.) | To (Mo./Yr.) |
|---|---|---|
| SEE ATTACHED | | |

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.) |
|---|---|---|---|
| SEE ATTACHED. | | | |

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.) |
|---|---|---|---|---|
| ARIZONA | 23047 | 3/17/1995 | 8/30/1995 | PRESENT |
| NEW MEXICO | 91 R 91 | 6/24/1991 | 6/24/1991 | 7/31/1995 |

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.

31. Have you ever been investigated for, charged with, or convicted of a 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)
If Yes, separate attached explanation required.

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

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

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

If more space is needed, attach separate sheet.

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## CHILD SUPPORT INFORMATION

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

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

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

### PLACE AN X ON THE APPROPRIATE LINE

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

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

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

ELEANOR POWELL STANLEY
Type or print name

_____ _____
Social Security Number

_____
Signature

10/12/2002.
Date

I, ELEANOR POWELL STANLEY, MD 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

(Notary Seal)

LISA SCORDATO
Notary Public - Arizona
Maricopa County
My Commission Expires
March 18, 2006

Subscribed and sworn to before me this 12th day of October, 2002

Notary Public for State of Arizona

My Commission Expires March 18, 2006

Residing at Bank of America

Signature of Notary

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

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

Proof photos and negatives are not acceptable

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

Signature of Applicant

10/12/2002

Date

## P. 2. # 15: Professional Medical Instruction

Name/ Address: The George Washington University School of Medicine & Health Sciences
2300 Eye Street NW
Washington, DC 20037

Place of Instruction: The George Washington University Medical Center; Washington, DC

Dates of Attendence: 9/1987 to 5/1991

## P. 4. #24: Account for Time Since Graduation from Medical School

| | |
|---|---|
| 6/1991 to 7/1995 | Internship & Residency, UNM Department of Ob-Gyn<br>New Mexico Medical Center:Albuquerque, NM |
| 8/1995 to 8/1997 | Physician, Women's Health Care Associates;<br>Chandler, AZ |
| 9/1997 to present | Physician, East Valley Obstetrics & Gynecology;<br>Mesa, AZ |
| 1/2000 to present | Physician, Family Planning Associates; Phoenix, AZ |

## P. 4, #25: Hospital Staff Affiliation

| | | FROM: | TO: |
|---|---|---|---|
| (1) | Chandler Regional Hospital<br>475 S. Dobson Rd.<br>Chandler AZ 85224 | 9/1995 | Present |
| (2) | Desert Samaritan Medical Center<br>1400 S. Dobson Rd.<br>Mesa AZ 85202 | 10/1995 | Present |
| (3) | Good Samaritan Regional Medical Center<br>1111 E. McDowell Rd.<br>Phoenix AZ 85006 | 2/2002 | Present |
| (4) | Mesa General Hospital<br>515 N. Mesa Dr.<br>Mesa AZ 85201 | 12/1995 | 9/1997 |
| (5) | Mesa Lutheran Hospital<br>525 W. Brown Rd.<br>Mesa AZ 85201 | 11/1995 | 12/1997 |
| (6) | Tempe St. Luke's Hospital<br>1500 S. Mill Ave.<br>Tempe AZ 85281 | 10/1995 | 6/1998 |
| (7) | Valley Lutheran Hospital<br>6644 E. Baywood Ave.<br>Mesa AZ 85206 | 12/1995 | 9/1997 |

**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 (Board Use Only)

License No. 10459

File No.

Eleanor Powell Stanley, M.D.
2330 W. Megan
Chandler, AZ 85224

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**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 N/A

Street _____

City _____ County _____ State _____ Zip Code _____

2. Are you currently active in medicine?

a. [ ] YES, in training.
b. [X] YES, working full-time
c. [ ] YES, working part-time
d. [ ] NO, retired.
e. [ ] NO, other (specify _____)

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 | OTOLOGY | 79 | SLEEP DISORDERS |
| 17 | GASTROENTEROLOGY | 49 | PAIN MANAGEMENT | 100 | SPORTS MEDICINE |
| 18 | GENERAL PRACTICE | 50 | PATHOLOGY | 80 | SURGERY, ABDOMINAL |
| 19 | GERIATRICS | 51 | PATHOLOGY, ANATOMIC | 103 | SURGERY, CARDIOTHORACIC |
| 20 | GYNECOLOGY | 52 | PATHOLOGY, CLINICAL | 81 | SURGERY, CARDIOVASCULAR |
| 21 | HEMATOLOGY | 53 | PATHOLOGY, FORENSIC | 91 | SURGERY, COLON/RECTAL |
| 105 | HOMEOPATHY | 54 | PEDIATRIC, ALLERGY | 82 | SURGERY, GENERAL |
| 22 | HYPNOSIS | 55 | PEDIATRIC, CARDIOLOGY | 83 | SURGERY, HAND |
| 23 | IMMUNOLOGY | 99 | PEDIATRIC, CRITICAL CARE | 84 | SURGERY, HEAD/NECK |
| 24 | INFECTIOUS DISEASES | 97 | PEDIATRIC, EMERGENCY MEDICINE | 92 | SURGERY, MAXILLOFACIAL |
| 25 | INFERTILITY | 56 | PEDIATRIC, ENDOCRINOLOGY | 93 | SURGERY, NEUROLOGICAL |
| 26 | INTERNAL MEDICINE | 57 | PEDIATRIC, HEMATOLOGY/ONCOLOGY | 85 | SURGERY, ORTHOPEDIC |
| 27 | LARYNGOLOGY | 58 | PEDIATRIC, INFECTIOUS DISEASES | 86 | SURGERY, PLASTIC |
| 28 | LEGAL MEDICINE | 59 | PEDIATRIC, INTENSIVIST | 87 | SURGERY, THORACIC |
| 29 | MATERNAL/FETAL MEDICINE | 60 | PEDIATRIC, NEPHROLOGY | 88 | SURGERY, TRAUMATIC |
| 106 | MEDICAL ACUPUNCTURE | 98 | PEDIATRIC, NEUROLOGY | 89 | SURGERY, UROLOGIC |
| 107 | MEDICAL ETHICS | 101 | PEDIATRIC, OPHTHALMOLOGY | 90 | SURGERY, VASCULAR |
| 30 | NEO/PERINATAL MEDICINE | 61 | PEDIATRIC, PHYSIATRY | 94 | UROLOGY |
| | | 95 | PEDIATRIC, PULMONARY | | |

| | Code | Percent of Time | Board Certified (Indicate Yes/No) |
|---|---|---|---|
| Primary | 38 | 100% | YES |
| Secondary | N/A | | |
| Tertiary | N/A | | |

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

| | Date of Initial Certification (Mo./Yr.) | Date of Last Certification (Mo./Yr.) |
|---|---|---|
| Board AMERICAN BOARD OF OBSTETRICS & GYNECOLOGY | 11/20/1998 | |
| Subboard N/A | | |
| Board N/A | | |
| Subboard N/A | | |

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

**SELF-EMPLOYED:**
1001 Solo Practice
1002 Partnership or Group Practitioners

**SALARIED, EMPLOYED BY:**
1003 Individual Practitioner ✓
1004 Partnership or Group of Practitioners
1005 Group Health Plan Facility (such as H.M.O.)

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

1012 Other (specify)_____

## 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 ____(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 _____(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 _____(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 _____(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? _____(Yes)_____No

f. 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)

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)

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h. Have you ever had a medical license or license to practice [illegible] 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.) |
|---|---|---|---|
| N/A | | | |
| | | | |
| | | | |
| | | | |
| | | | |

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

**PLEASE CHECK ONE OF THE FOLLOWING:**

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

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

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

Signature_____

SIGNATURE STAMP UNACCEPTABLE

**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.**

480-726-8401 — Business Telephone #

2/20/03 — Date

_____ Signature (SIGNATURE STAMP UNACCEPTABLE)

PHYSICIAN

**APPLICATION FOR REGISTRATION RENEWAL**
**FOR THE BIENNIAL REGISTRATION PERIOD 2003- 2005**
**NEVADA STATE BOARD OF MEDICAL EXAMINERS**

Post Office Box 7238 Reno, Nevada 89510 Phone (775) 688-2559
Physical Address: 1105 Terminal Way, Suite 301 Reno, Nevada 89502

Date Received by Board
JUN 23 2003
(For Board Use Only)

License No. 10429
File No.

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

| | | |
|---|---|---|
| X | 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) | |

[redacted]
Eleanor Powell STANLEY M.D.
2330 W. Megan
Chandler AZ 85224-

Make checks payable to:
VADA 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. NEW ADDRESS ONLY
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 ELEANOR POWELL STANLEY MD
Street 1331 N. 7th STREET #225
City PHOENIX County MARICOPA State AZ Zip 85006
Phone Number 602·553·0440 Fax Number 602·462·5588

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

Name N/A
Street
City County State Zip
Phone Number

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** | N/A. |

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

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

(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).**

6/21/2003
Date

Signature **(SIGNATURE STAMP UNACCEPTABLE)**

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

Date Received by Board
APR 26 2005
(For Board Use Only)

License No. 10429
File No. 3/8/03

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

X 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)

[redacted]

Eleanor Powell STANLEY M.D.
2900 E. Desert Inn Road, Suite 209
Summit Family Planning Las Vegas, NV. 89121

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

N/A

## *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.]

No changes to address.

Name _____
Street _____
City _____ County _____ State _____ Zip _____
Phone Number 702-853-2281 Fax Number 702-853-2287.

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

Name N/A

Street _____

City _____ County _____ State _____ Zip _____

Phone Number _____

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 |
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| 20 | FAMILY PRACTICE | 62 | OTOLOGY | 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** 26 **Secondary Scope of Practice** N/A

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

**Board** AMERICAN BOARD OF OBSTETRICS & GYNECOLOGY — **Date of Initial Certification** W/1998 (Mo./Yr.) — **Date of Last Recertification** N/A. (Mo./Yr.)

**Subboard** N/A (Mo./Yr.) (Mo./Yr.)

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

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

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

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

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

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

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

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

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

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

2. If you have a medical condition which in any way impairs or limits your ability to practice medicine, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? _____Yes _____No _____(N/A)

3. If you use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety? _____Yes _____No _____(N/A)

4. Have you failed to initiate the performance of public service within one year after the date the public service is required to begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local government for your medical education? _____Yes _____No _____(N/A)

5. Have you been a defendant in a legal action involving professional liability (malpractice) or had a professional liability claim paid in your behalf or paid such a claim yourself? _____(Yes) _____No

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

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

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

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

10. Have you ever been denied membership or expelled from a medical society or other professional medical organization? _____Yes _____(No)

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

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

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

| Hospital | Mailing Address | Type of Action | Dates of Action From (Mo./Yr.) To (Mo./Yr.) |
|---|---|---|---|
| N/A. | | | |
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**CHILD SUPPORT STATEMENT**

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

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

_____ (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).**

4/22/2005

**Date** **Signature (SIGNATURE STAMP UNACCEPTABLE)**

| License Number | Licensee Name | Question Text | Answer | Date Answered |
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| 10429 | STANLEY, Eleanor Powell | 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 elicensensbme@medboard.nv.gov | N | 5/1/2007 |
| 10429 | STANLEY, Eleanor Powell | 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 elicensensbme@medboard.nv.gov | N | 5/1/2007 |
| 10429 | STANLEY, Eleanor Powell | 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 elicensensbme@medboard.nv.gov | N | 5/1/2007 |
| 10429 | STANLEY, Eleanor Powell | 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 | 5/1/2007 |

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| 10429 | STANLEY, Eleanor Powell | Have you been named as a defendant, or been requested to respond as a defendant, to a legal action involving professional liability (malpractice), or had a professional liability claim paid on your behalf, or paid such a claim yourself? | N | 5/1/2007 |
| 10429 | STANLEY, Eleanor Powell | Have you been investigated for, arrested for, charged with, convicted of, or plead guilty or nolo contendere to any offense or violation of any federal (including the U.S. Military), state or local law, including any foreign country, which is in a foreign jurisdiction equivalent to, a misdemeanor, gross misdemeanor, court martial, or felony, excluding any minor traffic offense (driving or being in control of a motor vehicle while under the influence of any chemical substance and/or including alcohol, is not considered a minor traffic offense), or for any offense which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? Please note that you MUST disclose ANY investigation or arrest, even if the ultimate disposition was dismissal or expungement. If you answer "Yes" during the time period July 1, 2005 - June 30, 2007 email to elicensensbme@medboard.nv.gov | N | 5/1/2007 |

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| 10429 | STANLEY, Eleanor Powell | Have you been denied a license, permission to practice medicine or any other healing art, or permission to take an examination to practice medicine or any other healing art in any state, country or U.S. territory? If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov. | N | 5/1/2007 |
| 10429 | STANLEY, Eleanor Powell | 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 elicensensbme@medboard.nv.gov. | N | 5/1/2007 |
| 10429 | STANLEY, Eleanor Powell | 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 | 5/1/2007 |
| 10429 | STANLEY, Eleanor Powell | 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 | 5/1/2007 |

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| 10429 | STANLEY, Eleanor Powell | 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 | 5/1/2007 |
| 10429 | STANLEY, Eleanor Powell | 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 | 5/1/2007 |
| 10429 | STANLEY, Eleanor Powell | 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 | 5/1/2007 |

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| 10429 | STANLEY, Eleanor Powell | 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 | 5/1/2007 |
| 10429 | STANLEY, Eleanor Powell | 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 | 5/1/2007 |
| 10429 | STANLEY, Eleanor Powell | 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 | 5/1/2007 |
| 10429 | STANLEY, Eleanor Powell | 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 | 5/1/2007 |
| 10429 | STANLEY, Eleanor Powell | 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 | 5/1/2007 |

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| 10429 | STANLEY, Eleanor Powell | 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 | 5/1/2007 |
| 10429 | STANLEY, Eleanor Powell | 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 | 5/1/2007 |
| 10429 | STANLEY, Eleanor Powell | I have actively practiced medicine in Nevada within the past 24 months. | Y | 5/1/2007 |
| 10429 | STANLEY, Eleanor Powell | I hereby request my license to be placed on Inactive status. I will not physically practice in the state of Nevada. | N | 5/1/2007 |
| 10429 | STANLEY, Eleanor Powell | 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 | 5/1/2007 |
| 10429 | STANLEY, Eleanor Powell | Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? | N | 5/16/2009 |
| 10429 | STANLEY, Eleanor Powell | 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 | 5/16/2009 |
| 10429 | STANLEY, Eleanor Powell | 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 | 5/16/2009 |

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| 10429 | STANLEY, Eleanor Powell | 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 | 5/16/2009 |
| 10429 | STANLEY, Eleanor Powell | 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 | 5/16/2009 |
| 10429 | STANLEY, Eleanor Powell | 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 | 5/16/2009 |
| 10429 | STANLEY, Eleanor Powell | 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 | 5/16/2009 |

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| 10429 | STANLEY, Eleanor Powell | 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 | 5/16/2009 |
| 10429 | STANLEY, Eleanor Powell | 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 | 5/16/2009 |
| 10429 | STANLEY, Eleanor Powell | 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 | 5/16/2009 |
| 10429 | STANLEY, Eleanor Powell | Have you been denied membership, been asked to resign or expelled from a medical society or other professional medical organization (including the ABMS)? | N | 5/16/2009 |
| 10429 | STANLEY, Eleanor Powell | 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 | 5/16/2009 |
| 10429 | STANLEY, Eleanor Powell | Have you surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? | N | 5/16/2009 |

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| 10429 | STANLEY, Eleanor Powell | 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 | 5/16/2009 |
| 10429 | STANLEY, Eleanor Powell | 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 | 5/16/2009 |
| 10429 | STANLEY, Eleanor Powell | I hereby request my license to be placed on Inactive status, which means I will not physically practice in the state of Nevada. | N | 5/16/2009 |
| 10429 | STANLEY, Eleanor Powell | 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 | 5/16/2009 |
| 10429 | STANLEY, Eleanor Powell | 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. | Y | 5/16/2009 |

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| 10429 | STANLEY, Eleanor Powell | 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 | 5/16/2009 |
| 10429 | STANLEY, Eleanor Powell | Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? If you do not have a medical condition, select No. | N | 4/27/2011 |
| 10429 | STANLEY, Eleanor Powell | 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 | 4/27/2011 |
| 10429 | STANLEY, Eleanor Powell | If you use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety? If you do not use chemical substances, select No. | N | 4/27/2011 |
| 10429 | STANLEY, Eleanor Powell | 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 | 4/27/2011 |
| 10429 | STANLEY, Eleanor Powell | Have you had a professional liability, malpractice, claim paid on your behalf or paid such a claim yourself including any military tort claims if applicable? If "Yes" during the time period July 1, 2009 - June 30, 2011 type an explanation in the textbox directly below this question. | N | 4/27/2011 |

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| 10429 | STANLEY, Eleanor Powell | 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 | 4/27/2011 |
| 10429 | STANLEY, Eleanor Powell | 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 | 4/27/2011 |
| 10429 | STANLEY, Eleanor Powell | 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 | 4/27/2011 |
| 10429 | STANLEY, Eleanor Powell | Have you voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory in lieu of any disciplinary action? | N | 4/27/2011 |

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| 10429 | STANLEY, Eleanor Powell | Have you been denied membership, been asked to resign or expelled from a medical society or other professional medical organization (including the ABMS)? | N | 4/27/2011 |
| 10429 | STANLEY, Eleanor Powell | Have you been: a) asked to respond to an investigation; b) notified that you were under investigation for; c) investigated for; d) charged with; or e) convicted of any violation of a statute, rule or regulation governing your practice as a physician by any medical licensing board, hospital, medical society, governmental entity or agency other than the Nevada State Board of Medical Examiners? | N | 4/27/2011 |
| 10429 | STANLEY, Eleanor Powell | Have you surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? | N | 4/27/2011 |
| 10429 | STANLEY, Eleanor Powell | 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 | 4/27/2011 |

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| 10429 | STANLEY, Eleanor Powell | Are you out of compliance with court ordered child support? If this does not apply to you, please answer "no". If "Yes" during the time period July 1, 2009 - June 30, 2011 type an explanation in the textbox directly below this question. | N | 4/27/2011 |
| 10429 | STANLEY, Eleanor Powell | 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 | 4/27/2011 |
| 10429 | STANLEY, Eleanor Powell | Is your license contingent upon maintaining certification with the American Board of Medical Specialties (ABMS) in the specialty of Family Practice, Emergency Medicine, or Preventative Medicine? | N | 4/27/2011 |
| 10429 | STANLEY, Eleanor Powell | 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 | 4/27/2011 |
| 10429 | STANLEY, Eleanor Powell | I have completed the required amount of AMA Category 1 CME within the current biennial. (Review CME information online at www.medboard.nv.gov) I understand that I may be included in a random audit following the July 1st, 2011 renewal. I agree to retain CME's taken between July 1, 2009 and June 30, 2011. If renewing to an inactive status, CME is not required and "No" can be selected. | Y | 4/27/2011 |

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| 10429 | STANLEY, Eleanor Powell | I SWEAR OR AFFIRM UNDER THE PENALTY OF PERJURY THAT I PERSONALLY ANSWERED ALL OF THE QUESTIONS IN THIS APPLICATION AND THAT THE ANSWERS I HAVE PROVIDED ARE TRUE AND CORRECT. | Y | 4/27/2011 |