# STATE OF NEVADA
# BOARD OF MEDICAL EXAMINERS

AIRPORT CENTER BUILDING
1281 Terminal Way, Suite 211, Reno, Nevada, (702) 329-2559
MAILING ADDRESS: Post Office Box 7238, Reno, Nevada 89510

OCT 3 1977

## APPLICATION FOR LICENSURE

1. Name Gatlin (Last) Robert (First) Allan (Middle)
2. Address 5430 Baltimore Drive # 52 (Street No.) La Mesa (City) Calif. (State) 92041 (Zip)
3. Date of Birth 1947 Place of Birth

I hereby make application for a license to practice medicine in Nevada on the basis of:

- ☐ Endorsement of the written examination given by the State of
- ☐ Endorsement by the Medical Council of Canada
- ☐ Certificate of American Specialty Board, No.
- ☒ Certificate of the National Board of Medical Examiners No. 133754
- ☐ Admission to the written examination of this Board

4. Citizenship Status: U. S. Citizen Yes
   Declaration of Intention
   Alien Registration Card (Form I-151)
   Temporary Work Visa (Form H-1)
   Give date and place where declaration was filed
5. Medical School and Date of Graduation The George Washington University May 27, 1973
   Medical School attended from Sept. 1969 to May 27, 1973
   Location Washington, D.C.
6. List Internship and Residency training, chronologically, and give addresses:
   (1) Cincinnati General Hospital University of Cincinnati Medical Center
   Cincinnati, Ohio July1, 1973 to July 1, 1974
   (2) The George Washington University Medical Center Washington, D.C.
   July 1, 1974 to June 30, 1977
7. Type of Practice Obstetrics and Gynecology
8. Are you Board certified? No If so, by what Board?
   Certificate No. and Date
9. Where have you practiced medicine since graduation, including military service? List month and year.
   At San Diego (City) Calif. (State), from July 5, 1977 to Present
   At (City) (State), from to
   At (City) (State), from to
   At (City) (State), from to

10. List all State and County Medical Societies, and Specialty Societies of which you are or have been a member.

The Medical Society of The District of Columbia

Junior Fellow American College of Obstetricians & Gynecologists

11. List name and address of all hospitals of which you are, or have been a Staff member. (Do not include hospitals where internship or residency served)

Kaiser Foundation Hospital
4647 Zion Avenue
San Diego, Calif. 92120

12. In what states do you hold a license? Give license numbers and date of issue:

| | | |
|---|---|---|
| District of Columbia | 7639 | Dec. 24, 1974 |
| Virginia | 27368 | Sept. 12, 1976 |
| California | G 33381 | Dec. 7, 1976 |

13. Have you ever been charged or convicted of a felony or an offense involving moral turpitude? No

14. Have you ever been addicted to the use of narcotics, controlled substances or alcohol? No

15. Have you ever been charged, convicted or investigated for use or illegal sale or dispensing of controlled substances? No

16. Have you ever been charged or convicted of unprofessional conduct by any medical licensing board or other agency? No

17. Have you ever received psychiatric treatment or received treatment for a mental illness? No

18. Have you ever been expelled from a medical society or other medical professional organization? No

If yes, give details on separate sheet.

I, Robert A. Gatlin, M.D., being duly sworn, depose and say: That the answers to the foregoing questions and the statements made in the above application 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. It is understood by me, that if any part of this application is found to be false or fraudulent, that I forfeit the right to a license.

Signature of Applicant

Subscribed and sworn to before me this 30th day of September, 1977

OFFICIAL SEAL
RAMONA D. COURT
NOTARY PUBLIC - CALIFORNIA
Principal Office: San Diego Co. Calif.
My Commission Exp. Aug. 13, 1981
(Seal)

Notary Public for State of California

My Commission Expires 8-13-81

Residing at La Mesa Ca

ear application is made within the space provided.

Date Sept. 22, 1977 Age 30

Height _____ Weight _____

Color of Eyes _____ Color of Hair _____

Social Security No. _____

I hereby certify that the attached photograph is a true likeness of myself taken within the last year and that the description given above is true and correct.

_____
Signature of Applicant

## INSTRUCTIONS

This application consists of two sections.

Section One, the Application, and Form 4 of Section Two, are to be completed by the applicant, notarized as indicated, and returned to the Nevada State Board of Medical Examiners.

Section Two, Forms 1, 2, 3, 5, 6 and 7, are to be completed by the agencies or individuals indicated. It is the responsibility of the applicant to see that these are promptly returned. Application must be in 60 days before the meeting. The forms may be separated and mailed individually, then returned directly to the Nevada State Board of Medical Examiners by the agencies or individuals concerned.

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

The fee for licensure by endorsement or by written examination is $200.00 and must accompany the application.

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Nevada State Board of Medical Examiners
Airport Center Building
1281 Terminal Way, Suite 211
Reno, Nevada
MAILING ADDRESS:
Post Office Box 7238, Reno, Nevada 89510

# APPLICATION FOR REGISTRATION
## NEVADA STATE BOARD OF MEDICAL EXAMINERS

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

FEB 24 1984

Delinquent after March 1, 1984

Nevada License No. 3436 Date of License Oct 7, 1977

File No. _____ New ☐ Renewal ☒

This shaded section for BOARD USE ONLY

I hereby apply for a 1984 certificate of annual registration AND ENCLOSE the fee for $75.00.

3436
GATLIN, ROBERT A MD
2545 S BRUCE ST #5
LAS VEGAS, NV 89109

TYPE OR PRINT LEGIBLY

NAME Gatlin (Last) Robert (First) Allen (Middle)

Social Security # _____

Business Phone ( 702 ) 737-3200

BUSINESS ADDRESS 2545 S Bruce #5 (City) Las Vegas (State) Nevada 89109 (Zip Code)

MAILING ADDRESS SAME (City) (State) (Zip Code)

NOTE: Business Address will be used as directory address unless requested otherwise IN WRITING!

NEW ADDRESS: If your address will change within the next two months, show new address below.
(If longer than two months, notify this office by letter just prior to changing location.)

ADDRESS WILL CHANGE ON: _____ 19____

BUSINESS ADDRESS _____ (City) (State) (Zip Code)

MAILING ADDRESS _____ (City) (State) (Zip Code)

If you have retired or moved your practice, please indicate the location of former patient's records below:

NAME _____

ADDRESS _____

PHONE # ( ) _____

BOARD CERTIFICATION:

Yes ✓ No _____

AM. Bd. of Obstetrics & Gynecology

Date of Certification or Recertification Feb 7, 1980

Primary Specialty (List only one) OB-Gyn Sub-Specialties: _____

Has any disciplinary action been taken against you in any jurisdiction since your last registration? Yes ☐ No ☒ If "yes" attach a detailed explanation

Has any malpractice action been taken against you in any jurisdiction since your last registration? Yes ☑ No ☐ If "yes" attach a detailed explanation

PRACTICE: (Check One Only)

- Direct Patient Care ☒
- Administration ☐
- Medical Teaching ☐
- Military ☐
- Retired ☐

STAFF PRIVILEGES: List all Nevada Hospitals in which you have any staff privileges: (Name and Location)

1. Humana Hospital Sunrise Las Vegas 2. Women's Hospital Las Vegas
3. Desert Springs Hospital Las Vegas 4. _____

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

I certify that all the above statements are true

Signature _____, M.D.
No rubber stamps please

# APPLICATION FOR REGISTRATION
## NEVADA STATE BOARD OF MEDICAL EXAMINERS

P. O. Box 7238 Reno, Nevada 89510 Phone (702) 329-2559

DEC 03 1984

Delinquent after March 2, 1985

Nevada License No. _____ File No. _____

Date of License _____ New ☐ Renewal ☐

This shaded section for BOARD USE ONLY

I hereby apply for a 1985 certificate of annual registration AND ENCLOSE the fee for $100.00

5091 3436

GATLIN, ROBERT A MD
2545 S BRUCE ST #5
LAS VEGAS, NV 89109

PRACTICE: (Check One Only)
- ☒ Direct Patient Care
- ☐ Administration
- ☐ Medical Teaching
- ☐ Resident
- ☐ Military
- ☐ Retired

TYPE OR PRINT LEGIBLY

NAME Gatlin (Last) Robert (First) A (Middle)

Social Security # _____

Business Phone 702 737-3200

BUSINESS OR MAILING ADDRESS 2545 S. Bruce #5 (Street Address or P. O. Box / Suite No.) Las Vegas (City) Nevada (State) 89109 (Zip Code)

NEW ADDRESS: If your address will change within the next two months, show new address below.
(If longer than two months, notify this office by letter just prior to changing location.)

ADDRESS WILL CHANGE ON: _____ 19____

BUSINESS OR MAILING ADDRESS _____
(Street Address or P. O. Box / Suite No. / City / State / Zip Code)

If you have retired or moved your practice, please indicate the location of former patient's records below:

NAME _____

ADDRESS _____

PHONE # ( ) _____

BOARD CERTIFICATION:

Yes ✓ No _____

AM. Bd. of Obstetrics & Gynecology

Date of Certification or Recertification _____

Primary Specialty (List only one) Obstetrics & Gynecology Sub-Specialties: Infertility

SINCE YOUR LAST REGISTRATION:

1. Have you been investigated, charged or convicted of unprofessional conduct, professional incompetence or gross or repeated malpractice by any medical licensing board or other agency, hospital or medical society?
   Yes ☐ No ☒ If "yes" attach a detailed explanation
2. Have you been investigated, charged or convicted for the possession, use of, or illegal sale or dispensing of controlled substances?
   Yes ☐ No ☒ If "yes" attach a detailed explanation
3. Have you surrendered your license to practice medicine in another jurisdiction?
   Yes ☐ No ☒ If "yes" attach a detailed explanation
4. Have any malpractice settlements, awards or judgment been made against you in any jurisdiction?
   Yes ☐ No ☒ If "yes" attach a detailed explanation

STAFF PRIVILEGES: List all Nevada Hospitals in which you have any staff privileges: (Name and Location)

1. Humana Hospital Sunrise
2. Desert Springs Hospital
3. Women's Hospital
4. _____

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

I certify that all the above statements are true

Signature _____ M.D.
No rubber stamps please

JUL 12 1985

# APPLICATION FOR REGISTRATION
## NEVADA STATE BOARD OF MEDICAL EXAMINERS

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

Date Received by State Board

Nevada License No. _____

File No. _____

New ☐ Renewal ☐

This shaded section for BOARD USE ONLY

I hereby apply for a 1985-87 certificate of biennial registration and enclose the appropriate prorated fee as indicated below.

☑ ACTIVE STATUS $250.00
☐ INACTIVE STATUS $100.00
☐ RETIRED (NO FEE REQUIRED FOR 1985-87)

Delinquent after September 15, 1985.

Robert A. GATLIN
2545 S Bruce #5
Las Vegas NV
89109

PRACTICE: (Check One Only)
☒ Direct Patient Care ☐ Resident
☐ Administration ☐ Military
☐ Medical Teaching ☐ Retired

**TYPE OR PRINT LEGIBLY**

NAME Gatlin (Last) Robert (First) Allan (Middle)

Social Security #

Business Phone (702) 737-3200

BUSINESS OR MAILING ADDRESS 2545 So. Bruce St. #5. Las Vegas, Nev. 89109
Street Address or P. O. Box / Suite No. / City / State / Zip Code

**NEW ADDRESS:** If your address will change within the next two months, show new address below.
(If longer than two months, notify this office by letter just prior to changing location.)

**ADDRESS WILL CHANGE ON:** _____ 19____

BUSINESS OR MAILING ADDRESS _____
Street Address or P. O. Box / Suite No. / City / State / Zip Code

If you have retired or moved your practice, please indicate the location of former patient's records below:

NAME _____

ADDRESS _____

PHONE # ( ) _____

BOARD CERTIFICATION:

Yes ✓ No _____

AM. Bd. of OB-Gyn

Date of Certification or Recertification Dec. 31, 1980

Primary Specialty (List only one) OB-Gyn Sub-Specialties: _____

SINCE YOUR LAST REGISTRATION:

1. Have you been investigated, charged or convicted of unprofessional conduct, professional incompetence or gross or repeated malpractice by any medical licensing board or other agency, hospital or medical society?
   Yes ☐ No ☑ If "yes" attach a detailed explanation
2. Have you been investigated, charged or convicted for the possession, use of, or illegal sale or dispensing of controlled substances?
   Yes ☐ No ☑ If "yes" attach a detailed explanation
3. Have you surrendered your license to practice medicine in another jurisdiction?
   Yes ☐ No ☑ If "yes" attach a detailed explanation
4. Have any malpractice settlements, awards or judgment been made against you in any jurisdiction?
   Yes ☐ No ☑ If "yes" attach a detailed explanation

**STAFF PRIVILEGES:** List all Nevada Hospitals in which you have any staff privileges: (Name and Location)

1. Humana Sunrise, Las Vegas
2. Desert Springs, Las Vegas
3. Women's Hosp. - Las Vegas
4. _____

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

I certify that all the above statements are true

Signature _____ M.D.
No rubber stamps please

# APPLICATION FOR REGISTRATION

**NEVADA STATE BOARD OF MEDICAL EXAMINERS**

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

RECEIVED
Date Received by State Board
JUN 03 1987
NEVADA STATE BOARD OF MEDICAL EXAMINERS

License No. _____
File No. _____
New ☐ Renewal ☐
For BOARD USE ONLY

I hereby apply for a 1987-89 certificate of biennial registration and enclose the appropriate fee as indicated below:

| | |
|---|---|
| X ACTIVE STATUS | $300.00 |
| ☐ INACTIVE STATUS | $150.00 |
| ☐ RETIRED STATUS | $ 50.00 |

NRS630 explanation of status on reverse side

NOTICE: FEES ARE DUE JULY 1, 1987
THERE IS NO GRACE PERIOD

Robert A. GATLIN MD
2545 S Bruce #5
Las Vegas NV
89109

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

TYPE OR PRINT LEGIBLE

NAME Gatlin (Last) Robert (First) A Han (Middle)

Social Security # _____

Business Phone (702) 737-3200

BUSINESS OR MAILING ADDRESS 3901 So. Maryland Pkwy #406 (Street Address or P.O. Box) (Suite No.) Las Vegas (City) NV (State) 89109 (Zip Code)

If you have retired or moved your practice, please indicate the location of former patient's records below:

NAME _____
ADDRESS _____
PHONE # (___) _____

BOARD OF CERTIFICATION

Yes ✓ No N/A

AM. Bd. of Obstetrics and Gynecology

Date of Certification or Recertification February 7, 1980

Primary Specialty (List only one) Ob / Gyn Sub-Specialties: _____

I certify that since July 1, 1985, I have completed a minimum of 40 hours of Continuing Medical Education, AMA-Category 1 and that I have in my files documentation of such. I understand that the CME requirement is mandated by NRS 630.253 and NAC 630.153.

Signed: Robert A. Gatlin, M.D. Date May 25, 1987
(No rubber stamps please)

**SINCE YOUR LAST REGISTRATION:** (If any question is answered "yes," attach a detailed explanation.)

1. Have you been investigated, charged or convicted of unprofessional conduct, professional incompetence or gross or repeated malpractice by any medical licensing board or other agency, hospital or medical society? Yes ☐ No X

2. Have you been arrested, fined (over $100), charged with or convicted of a crime, indicted, imprisoned or placed on probation? Yes ☐ No X

3. Have you been investigated, arrested, charged or convicted for the possession, use of, or illegal sale or dispensing of controlled substances? Yes ☐ No X

4. Have you been denied a medical license or surrendered your licens to practice in another jurisdiction or had your medical license revoke suspended or limited in another jurisdiction. Yes ☐ No X

5. Have you had staff privileges in a hospital denied, suspended, limite revoked or not renewed, or have you resigned from a medical staff in lie of disciplinary or administrative action? Yes ☐ No X

6. Have any malpractice settlements, awards or judgments been mad against you in any jurisdiction? Yes ☐ No X

STAFF PRIVILEGES: List all Nevada Hospitals in which you have any staff privileges: (Name and Location)

1. Humana Hospital Sunrise — LV, NV.
2. Womens Hospital — LV, NV.
3. Desert Springs Hospital — LV, NV.
4. _____
5. _____
6. _____

I certify that all the above statements are true and that I have actively practiced in Nevada within the past 12 months.

Signature _____ Date May 25, 1987
(No rubber stamps please)

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

1. Any licensee who changes the location of his practice of medicine from this state to another state or country, has never engaged in the practice of medicine in this state after licensure or has ceased to engage in the practice of medicine in this state for a period of 12 consecutive months must be placed on inactive status upon notification of the board.

2. Before resuming the practice of medicine in this state, the inactive registrant shall:

(a) Notify the board of his intent to resume the practice of medicine in this state;

(b) File an affidavit with the board describing his activities during the period of his inactive status;

(c) Complete the form for registration for active status; and

(d) Pay the applicable fee for biennial registration.

3. If the board determines that the conduct of the registrant during the period of inactive status would have warranted denial of an application for a license to practice medicine in this state, the board may refuse to place the registrant on active status.

(Added to NRS by 1985, 2222)

**630.256 Retired licensees: Duties; reinstatement.** If a licensee retires from the practice of medicine, he shall notify the board in writing of his intention to retire, and the board shall record the fact of retirement. A licensee who is retired may not engage in the practice of medicine. If a licensee who is retired desires to return to the practice of medicine, he shall apply to the board for registration and pay the applicable fee for biennial registration.

(Added to NRS by 1985, 2222)

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

(Added to NRS by 1985, 2222)

# APPLICATION FOR REGISTRATION

**NEVADA STATE BOARD OF MEDICAL EXAMINERS**

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

RECEIVED by State Board JUN 22 1989 NEVADA STATE BOARD OF MEDICAL EXAMINERS

License No. _____ File No. _____ New ☐ Renewal ☐

FOR BOARD USE ONLY

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

| | |
|---|---|
| ☑ ACTIVE STATUS | $300.00 |
| ☐ INACTIVE STATUS | $150.00 |
| ☐ RETIRED STATUS | $ 50.00 |

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

FINAL NOTICE NRS630 explanation of status on reverse side

Robert A. GATLIN MD

3201 S Maryland Pky #406

Las Vegas NV 89109

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

TYPE OR PRINT LEGIBLY

NAME GATLIN (Last) ROBERT (First) Allan (Middle)

Social Security _____

Business Phone 702-737-3200

BUSINESS OR MAILING ADDRESS 3201 So. Maryland Pkwy #406 (Street Address or P.O. Box / Suite No.) Las Vegas (City) NV (State) _____ (Zip Code)

If you have retired or moved your practice, please indicate the location of former patient's records below:

NAME _____

ADDRESS _____

PHONE # (___) _____

BOARD OF CERTIFICATION

Yes yes No _____

AM. Bd. of Obstetrics & Gynecology

Date of Certification or Recertification Feb 7, 1980

Primary Specialty (List only one) OB/GYN Sub-Specialties: _____

I certify that within the past 24 months, I have completed a minimum of 40 hours of Continuing Medical Education, AMA-Category 1 and that I have in my files documentation of such. I understand that the CME requirement is mandated by NRS 630.253 and NAC 630.153.

Signed: Robert A. Gatlin, M.D. (No rubber stamps) Date June 15, 1989

**SINCE YOUR LAST REGISTRATION:** (If any question is answered "yes," attach a detailed explanation.)

1. Have you been investigated, charged or convicted of unprofessional conduct, professional incompetence or gross or repeated malpractice by any medical licensing board or other agency, hospital or medical society? Yes ☐ No ☑
2. Have you been arrested, fined (over $100), charged with or convicted of a crime, indicted, imprisoned or placed on probation? Yes ☐ No ☑
3. Have you been investigated, arrested, charged or convicted for the possession, use of, or illegal sale or dispensing of controlled substances? Yes ☐ No ☑
4. Have you been denied a medical license or surrendered your license to practice in another jurisdiction or had your medical license revoked suspended or limited in another jurisdiction. Yes ☐ No ☐
5. Have you had staff privileges in a hospital denied, suspended, limited revoked or not renewed, or have you resigned from a medical staff in lieu of disciplinary or administrative action, excluding failure to complete medical records? Yes ☐ No ☐
6. Have any malpractice settlements, awards or judgments been made against you in any jurisdiction? Yes ☐ No ☐

STAFF PRIVILEGES: List all Nevada Hospitals in which you have any staff privileges: (Name and Location)

1. Humana Hospital Sunrise
2. Desert Springs Hosp.
3. Womens Hosp
4. Valley Hosp.
5. _____
6. _____

I certify that all the above statements are true and that I have actively practiced in Nevada within the past 12 months.

Signature _____ (No rubber stamps) Date June 15, 1989

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

1. Any licensee who changes the location of his practice of medicine from this state to another state or country, has never engaged in the practice of medicine in this state after licensure or has ceased to engage in the practice of medicine in this state for a period of 12 consecutive months must be placed on inactive status upon notification of the board.

2. Before resuming the practice of medicine in this state, the inactive registrant shall:

(a) Notify the board of his intent to resume the practice of medicine in this state;

(b) File an affidavit with the board describing his activities during the period of his inactive status;

(c) Complete the form for registration for active status; and

(d) Pay the applicable fee for biennial registration.

3. If the board determines that the conduct of the registrant during the period of inactive status would have warranted denial of an application for a license to practice medicine in this state, the board may refuse to place the registrant on active status.

(Added to NRS by 1985, 2222)

**630.256 Retired licensees: Duties; reinstatement.** If a licensee retires from the practice of medicine, he shall notify the board in writing of his intention to retire, and the board shall record the fact of retirement. A licensee who is retired may not engage in the practice of medicine. If a licensee who is retired desires to return to the practice of medicine, he shall apply to the board for registration and pay the applicable fee for biennial registration.

(Added to NRS by 1985, 2222)

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

(Added to NRS by 1985, 2222)

**REMINDER: NEVADA LAW REQUIRES NOTICE TO THE BOARD PRIOR TO CHANGING YOUR PRACTICE LOCATION OR CLOSURE OF OFFICE.**
(NRS 630.254)

JUL 8 1991

# APPLICATION FOR REGISTRATION
## NEVADA STATE BOARD OF MEDICAL EXAMINERS

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

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

| | |
|---|---|
| ☒ ACTIVE STATUS | $400.00 |
| ☐ INACTIVE STATUS | $150.00 |
| ☐ RETIRED STATUS | $ 50.00 |

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

NRS630 explanation of status on reverse side

Robert A. GATLIN, MD
3201 S Maryland Pky #406
Las Vegas NV 89109-0000

NAME GATLIN (Last) Robert (First) Allan (Middle)

Social Security # [redacted]

Business Phone ( 702 ) 737-3200

BUSINESS OR MAILING ADDRESS 3201 S. Maryland Parkway (Street Address or P.O. Box) #406 (Suite No.) LAS VEGAS (City), NV (State) 89109 (Zip Code)

If you have retired or moved your practice, please indicate the location of former patient's records for the last 5 years below:

NAME _____

ADDRESS _____

PHONE # (____) _____

BOARD OF CERTIFICATION

Yes ✓ No _____

AM. Bd. of Obstetrics & Gynecology

Date of Certification or Recertification Feb 7, 1980

Primary Specialty (List only one) Obstetrics & Gynecology Sub-Specialties: _____

I certify that within the past 24 months, I have completed a minimum of 40 hours of Continuing Medical Education, AMA-Category 1 and that I ha in my files documentation of such. I understand that the CME requirement is mandated by NRS 630.253 and NAC 630.153.

Signature: Robert A. Gatlin, M.D. (No rubber stamps) Date May 17, 1991

**SINCE YOUR LAST REGISTRATION:** (If any question is answered "yes," attach a detailed explanation.)

1. Have you been investigated by, or charged or convicted of unprofessional conduct, professional incompetence or gross or repeated malpractice by any medical licensing board or other agency, hospital or medical society? Yes ☐ No ☒

2. Have you been arrested, fined (over $100), charged with or convicted of a crime, indicted, imprisoned or placed on probation? Yes ☐ No ☒

3. Have you been investigated, arrested, charged or convicted for the possession, use of, or illegal sale or dispensing of controlled substances? Yes ☐ No ☒

4. Have you been denied a medical license or surrendered your licens to practice in another jurisdiction or had your medical license or right t practice medicine revoked, suspended or limited in another jurisdiction Yes ☐ No ☒

5. Have you had staff privileges in a hospital denied, suspended, limite revoked or not renewed, or have you resigned from a medical staff in lie of disciplinary or administrative action, excluding failure to complet medical records? Yes ☐ No ☒

6. Have any malpractice settlements, awards or judgments been mad against you in any jurisdiction? Yes ☒ No ☐

STAFF PRIVILEGES: List all Nevada Hospitals in which you have any staff privileges: (Name and Location)

1. Humana Hospital Sunrise
2. Desert Springs Hospital
3. Women's Hospital
4. Valley Hospital Medical center
5. _____
6. _____

I certify that all my statements in this application are true. I have ☒ have not ☐ actively practiced in Nevada within the past 12 months. (Check one)

Signature: _____ (No rubber stamps) Date May 17, 1991

NOTE: Have you signed both "signature" lines.

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

1. Any licensee who changes the location of his practice of medicine from this state to another state or country, has never engaged in the practice of medicine in this state after licensure or has ceased to engage in the practice of medicine in this state for a period of 12 consecutive months must be placed on inactive status upon notification of the board.

2. Before resuming the practice of medicine in this state, the inactive registrant shall:

(a) Notify the board of his intent to resume the practice of medicine in this state;

(b) File an affidavit with the board describing his activities during the period of his inactive status;

(c) Complete the form for registration for active status; and

(d) Pay the applicable fee for biennial registration.

3. If the board determines that the conduct of the registrant during the period of inactive status would have warranted denial of an application for a license to practice medicine in this state, the board may refuse to place the registrant on active status.

(Added to NRS by 1985, 2222)

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(Added to NRS by 1985, 2222)

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

(Added to NRS by 1985, 2222)

**REMINDER: NEVADA LAW REQUIRES NOTICE TO THE BOARD PRIOR TO CHANGING YOUR PRACTICE LOCATION OR CLOSURE OF OFFICE.**
(NRS 630.254)

# APPLICATION FOR REGISTRATION

**NEVADA STATE BOARD OF MEDICAL EXAMINERS**

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

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

| | |
|---|---|
| ☒ ACTIVE STATUS | $320.00 ✓ |
| ☐ INACTIVE STATUS | $150.00 |
| ☐ RETIRED STATUS | $ 50.00 |

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

Robert A. Gatlin, MD
2080 E Flamingo Rd #108
Las Vegas NV 89119-0000

## INSTRUCTIONS – TYPE OR PRINT LEGIBLY

1. YOUR CURRENT LICENSE EXPIRES ON **JUNE 30, 1993.** This is the notice to renew your M.D. license. You may apply for your license renewal upon receipt of this notice.

2. IN ORDER TO PROVIDE SUFFICIENT TIME FOR PROCESSING, PLEASE RETURN THIS RENEWAL APPLICATION WITH THE CORRECT RENEWAL FEE PRIOR TO **JULY 1, 1993.**

3. Use the enclosed self-addressed envelope to return this renewal notice and registration fee. ACTIVE registration requires submission of proof of 40 hours AMA Category I CME. If you register your license INACTIVE or RETIRED, you may not practice medicine in Nevada, including the writing of prescriptions.

4. All fees are non-refundable. Do not send cash through the mail.

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

Name_____

Street _____

City _____ County _____ State _____ Zip Code _____

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

**ACTIVE REGISTRANTS MUST SUBMIT PROOF OF 40 HOURS AMA CATEGORY I CONTINUING MEDICAL EDUCATION (CME).**

7-1-91 — 6-30-93

**PLEASE ALLOW 60 DAYS FOR THE PROCESSING OF YOUR LICENSE RENEWAL. ALL PAGES MUST BE COMPLETED AND RETURNED.**

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

1. 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 _____)

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

**SPECIALTY CODE:**

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

| | Code | Percent of Time | Board Certified (Indicate Yes/No) |
|---|---|---|---|
| Primary | 38 | 95 | _____ |
| Secondary | 26 | 5 | _____ |
| Tertiary | _____ | _____ | _____ |

PLEASE INDICATE AMERICAN BOARD OF MEDICAL SPECIALTIES BOARD CERTIFICATION:

Board Obstetrics & Gynecology

Subboard _____

3. How many hours per week do you spend in each of the following activities?
   60 hours Patient care or services
   _____ hours Administration (schools, agencies, association, etc.)
   _____ hours Teaching medical courses
   _____ hours Research
   _____ hours Other (specify _____)

4. Form of employment is 1002 . (Use the following codes.)

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

All of the following questions refer to the time period of **July 1, 1991, through the present date** only. FOR ALL **YES** RESPONSES, PLEASE EXPLAIN ON A SEPARATE SHEET AND RETURN WITH THE RENEWAL APPLICATION.

5. Have you been rejected for membership by any medical society? Yes ☐ No ☒
6. Have you been denied a license to practice medicine? Yes ☐ No ☒
7. Have you been denied staff membership with any licensed hospital, nursing home or other hospital care facility with an organized medical staff? Yes ☐ No ☒
8. Have you been censured, reprimanded, disciplined, had privileges limited, had privileges suspended, been put on probation, or been requested to withdraw from any licensed hospital, nursing home, clinic, or other hospital care facility with an organized medical staff, in which you trained, have been a staff member, have been a partner, or have held hospital privileges? Yes ☐ No ☒
9. Have you lost American Board certification because of disciplinary action? Yes ☐ No ☒
10. Have any U.S. state and/or Canadian provincial licensing or disciplinary agencies limited, restricted, suspended or revoked a license you have held or taken any other disciplinary action against you? Yes ☐ No ☒
11. Have you voluntarily surrendered a license issued to you by any state and/or Canadian provincial licensing agency while an investigation or other disciplinary action was pending? Yes ☐ No ☒
12. Have you been notified of any current/pending charges or complaints filed against you with any state and/or Canadian provincial licensing or disciplinary agency? Yes ☒ No ☐
13. Have you been diagnosed or treated for any physical illness that would serve to hinder your ability to practice medicine? Yes ☐ No ☒
14. Have you been diagnosed or treated for mental illness? Yes ☐ No ☒
15. Have you been chemically dependent? Yes ☐ No ☒
16. Have you interrupted your training because of illness or impairment? Yes ☐ No ☒
17. Have you been unable to practice medicine because of illness or impairment? Yes ☐ No ☒
18. Have you been denied a controlled substances registration certificate by the Drug Enforcement Administration (DEA) or State Board of Pharmacy or other lawful authority concerned with controlled substances or been censured, reprimanded, restricted, voluntarily surrendered, placed on probation or had such authority revoked? Yes ☐ No ☒
19. Have you been indicted, arrested, charged with, convicted, pled guilty or nolo contendere in any criminal prosecution under the laws of any state or of the United States, for any offense reasonably related to the qualifications, functions or duties of a physician, for any offense an essential element of which is fraud, dishonesty or an act of violence, or for any offense involving moral turpitude? Yes ☐ No ☒
20. 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 ☒
21. Have you been denied provider participation in any State Medicaid or Federal Medicare Program? Yes ☐ No ☒
22. Have you been terminated from, sanctioned or penalized by, or had to repay monies to any State Medicaid or Federal Medicare Program as a result of administrative or criminal action? Yes ☐ No ☒

PLEASE LIST CURRENT HOSPITAL AFFILIATION(S):

HUMANA HOSPITAL SUNRISE
Name Address

Desert Springs Hospital
Name Address

Women's Hospital
Name Address

St. Rose Dominican
Name Address

## CONTINUING MEDICAL EDUCATION

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

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

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

(b) Be approved by the board; and

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

2. Any holder of a license who has completed a full year of residency or fellowship any time during the period for biennial registration immediately preceding the submission of the application for biennial registration is exempt from the requirements set forth in subsection 1.

3. If the holder of a license fails to submit evidence of his completion of continuing medical education within the time and in the manner prescribed by subsection 1, his license will not be renewed. Such a person may not resume the practice of medicine unless, within 2 years after the end of the biennial period of registration, he:

(a) Pays a fee to the board which is twice the fee for biennial registration otherwise prescribed by subsection 1 of NRS 630.290;

(b) Submits to the board, in such form as it requires, evidence that he has completed 40 full hours of continuing medical education in addition to that otherwise required by subsection 1 or NAC 630.157; and

(c) Is found by the board to be otherwise qualified for active status pursuant to the provisions of this chapter and chapter 630 of NRS.

(Added to NAC by Bd. of Medical Exam'rs, 7-31-85, eff. 8-1-85; A 6-23-86; 11-21-88; 9-12-91)

PLEASE CHECK ONE OF THE FOLLOWING:

✓ 1. I have earned a minimum of 40 hours approved AMA Category I continuing medical education (CME) for the period July 1, 1991, through June 30, 1993.

____ 2. I am exempt because I have completed a full year of residency or fellowship training during the period for biennial registration immediately preceding the submission of this application.

____ 3. I am exempt as I am applying for INACTIVE or RETIRED status.

Signature _____
(SIGNATURE STAMP UNACCEPTABLE)

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

Date of Birth: _____ 1947
month/day/year

Social Security Number: _____

DEA Number: AG 7787635

Medical School: The George Washington University — City: Washington — State: D.C.

Internship: Cincinnati University Medical Center — City: Cincinnati — State: Ohio

Residency: The George Washington University — City: Washington — State: D.C.

_____ — City: _____ — State: _____

_____ — City: _____ — State: _____

Fellowship: _____ — City: _____ — State: _____

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

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

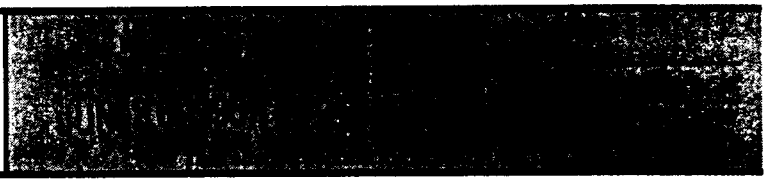
(702) 737-3200 — Business Telephone #

April 30, 1993 — Date

_____ — Signature (SIGNATURE STAMP UNACCEPTABLE)

**ALL PAGES MUST BE RETURNED OR YOUR LICENSE WILL NOT BE RENEWED.**

**APPLICATION FOR REGISTRATION RENEWAL**
**NEVADA STATE BOARD OF MEDICAL EXAMINERS**
Post Office Box 7238 Reno, Nevada 89510 Phone (702) 688-2559

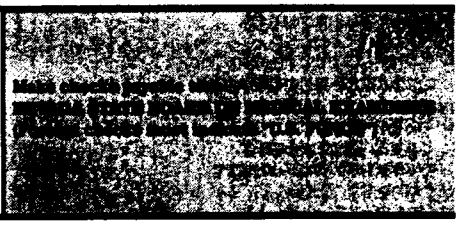


I hereby apply for renewal of biennial registration and enclose the appropriate fees as indicated below:

_____ ACTIVE STATUS $420
_____ INACTIVE STATUS $150 (see attached NRS 630.255 & 630.257)
_____ RETIRED STATUS $ 50 (see attached NRS 630.256 & 630.257) (MUST NOT BE PRACTICING MEDICINE IN ANY STATE)
_____ P.A. SUPERVISING PHYSICIAN $200

**PLEASE NOTE:** NEVADA HAS NO GRACE PERIOD. LICENSES NOT RENEWED BY JULY 1, 1995 ARE AUTOMATICALLY SUSPENDED FOR NON-PAYMENT.

Robert A. Gatlin, MD
2080 E Flamingo Rd #100
Las Vegas NV 89119-0000



## INSTRUCTIONS - TYPE OR PRINT LEGIBLY

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

Name _____

Street _____

City _____ County _____ State _____ Zip Code _____

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

Name _____

Street _____

City _____ County _____ State _____ Zip Code _____

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

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

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

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

**PLEASE PROVIDE ALL INFORMATION AS REQUESTED.**

1. Are you currently active in medicine?
   a. ( ) YES, in training.
   b. (X) YES, working full-time.
   c. ( ) YES, working part-time.
   d. ( ) NO, retired.
   e. ( ) NO, other (specify _____)

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

**SPECIALTY CODE:**

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

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

**PLEASE INDICATE AMERICAN BOARD OF MEDICAL SPECIALTIES BOARD CERTIFICATION:**

| | Date of Initial Certification (Mo./Yr.) | Date of Last Recertification (Mo./Yr.) |
|---|---|---|
| Board: American Board of Obstetrics & Gynecology | Feb 7, 1980 | N/A |
| Subboard: _____ | | |

3. How many hours per week do you spend in each of the following activities?
   65 hours Patient care or services
   _____ hours Administration (schools, agencies, associations, etc.)
   _____ hours Teaching medical courses
   _____ hours Research
   _____ hours Other (specify _____)

4. Form of employment is 1001 . (Use the following codes.)

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

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

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

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

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

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

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

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

1. Have you failed to repay, in accordance with the terms of the loan, any direct loan or loan which is insured or guaranteed by the Federal Government or a state or local government which you received to finance all or any part of your medical education? ☐ Yes ☒ No
2. 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
3. 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
4. Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? ☐ Yes ☒ No
5. Have you been diagnosed as having, or have you been treated for pedophilia, exhibitionism, or voyeurism? ☐ Yes ☒ No
6. Are you currently engaged in the illegal use of controlled dangerous substances? ☐ Yes ☒ No
7. 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
8. Have you been investigated for, charged with or convicted of, or pled nolo contendere to a violation of any federal, state or local law relating to the manufacture, distribution, prescribing, or dispensing of controlled substances? ☐ Yes ☒ No
9. Have you been arrested, investigated for, charged with or convicted of, or pled nolo contendere to any offense, misdemeanor or felony in any state, the United States, or a foreign country? ☐ Yes ☒ No
10. Have you previously applied for medical licensure in Nevada (including a residency program)? ☒ Yes ☐ No
11. Have you failed to initiate the performance of public service within one year after the date the public service is required to begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local government for your medical education? ☐ Yes ☒ No
12. Have you 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
13. Have you had a medical license revoked, suspended, limited, or restricted in any state, country or U.S. territory? ☐ Yes ☒ No
14. Have you voluntarily surrendered a license to practice in the healing arts in any state, country or U.S. territory? ☐ Yes ☒ No
15. Have you been denied membership or expelled from a medical society or other professional medical organization? ☐ Yes ☒ No
16. 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.) |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

17. Have you 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
18. Have you surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? ☐ Yes ☒ No

## CONTINUING MEDICAL EDUCATION

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

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

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

(b) Be approved by the board; and

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

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

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

3. If the holder of a license fails to submit evidence of his completion of continuing medical education within the time and in the manner prescribed by subsection 1, his license will not be renewed. Such a person may not resume the practice of medicine unless, within 2 years after the end of the biennial period of registration, he:

(a) Pays a fee to the board which is twice the fee for biennial registration otherwise prescribed by subsection 1 of NRS 630.290;

(b) Submits to the board, in such form as it requires, evidence that he has completed 40 full hours of continuing medical education in addition to that otherwise required by subsection 1 or NAC 630.157; and

(c) Is found by the board to be otherwise qualified for active status pursuant to the provisions of this chapter and chapter 630 of NRS.

(Added to NAC by Bd. of Medical Exam'rs, 7-31-85, eff. 8-1-85; A 6-23-86; 11-21-88; 9-12-91)

PLEASE CHECK ONE OF THE FOLLOWING:

X 1. I have earned a minimum of 40 hours approved AMA Category I continuing medical education (CME) for the biennial period July 1, 1993 through June 30, 1995.

____ 2. I was initially licensed in Nevada during the second six months of the biennial period July 1, 1993, through June 30, 1995 and have earned a minimum of 30 hours approved AMA Category I continuing medical education (CME).

____ 3. I was initially licensed in Nevada during the third six months of the biennial period July 1, 1993, through June 30, 1995 and have earned a minimum of 20 hours approved AMA Category I continuing medical education (CME).

____ 4. I was initially licensed in Nevada during the fourth six months of the biennial period July 1, 1993, through June 30, 1995 and have earned a minimum of 10 hours approved AMA Category I continuing medical education (CME).

____ 5. I am exempt from submitting proof of continuing medical education (CME) because I have completed a full year of residency or fellowship training during the biennial period July 1, 1993 through June 30, 1995.

Signature _____ (SIGNATURE STAMP UNACCEPTABLE)

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

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

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

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

(702)737-3200 — Business Telephone #

6-14-95 — Date

X _____ Signature (SIGNATURE STAMP UNACCEPTABLE)

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

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

2. When a holder of a license fails to pay the fee for biennial registration after it becomes due, his license to practice medicine in this state is automatically suspended. The holder may, within 2 years after the date his license is suspended, upon payment of twice the amount of the current fee for biennial registration to the secretary-treasurer, and after he is found to be in good standing and qualified under the provisions of this chapter, be reinstated to practice.

3. The board shall notify a licensee:

(a) At least once that his fee for biennial registration is due; and

(b) That his license is suspended for nonpayment of the fee. A copy of this notice must be sent to the Drug Enforcement Administration o. : United States Department of Justice or its successor agency.

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

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

1. Any licensee who changes the location of his practice of medicine from this state to another state or country, has never engaged in the practice of medicine in this state after licensure or has ceased to engage in the practice of medicine in this state for 12 consecutive months must be placed on inactive status.

2. Before resuming the practice of medicine in this state, the inactive registrant shall:

(a) Notify the board of his intent to resume the practice of medicine in this state;

(b) File an affidavit with the board describing his activities during the period of his inactive status;

(c) Complete the form for registration for active status;

(d) Pay the applicable fee for biennial registration; and

(e) Satisfy the board of his competence to practice medicine.

3. If the board determines that the conduct or competence of the registrant during the period of inactive status would have warranted denial of an application for a license to practice medicine in this state, the board may refuse to place the registrant on active status.

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

**630.286 Retired licensees: Duties; requirements for reinstatement.**

1. If a licensee retires from the practice of medicine, he shall notify the board in writing of his intention to retire, and the board shall record the fact of retirement. A licensee who is retired may not engage in the practice of medicine. Any licensee who is retired and desires to return to the practice of medicine, must, before resuming the practice of medicine in this state:

(a) Notify the board of his intent to resume the practice of medicine in this state;

(b) File an affidavit with the board describing his activities during the period of his retired status;

(c) Complete the form for registration for active status;

(d) Pay the applicable fee for biennial registration; and

(e) Satisfy the board of his competence to practice medicine.

2. If the board determines that the conduct or competence of the registrant during the period of retirement would have warranted denial of an application for a license to practice medicine in this state, the board may refuse to place the registrant on active status.

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

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

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

Date received by Board

JUN 16 1997

License No._____

File No._____

(Board Use Only)

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

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

I hereby apply for renewal of biennial registration and enclose the appropriate fees as indicated below:

| | | |
|---|---|---|
| ___✓___ ACTIVE STATUS | $600.00 | **PLEASE NOTE:** **NEVADA HAS NO GRACE PERIOD.** |
| _____ INACTIVE STATUS | $150.00 | **LICENSES NOT RENEWED BY** |
| _____ RETIRED STATUS | $ 50.00 | **JULY 1, 1997 ARE AUTOMATICALLY** |
| _____ P.A. SUPERVISING PHYSICIAN | $200.00 | **SUSPENDED FOR NON-PAYMENT** |

**FINAL NOTICE**

Robert A. Gatlin, MD
2110 E Flamingo Rd #202
Las Vegas NV 89119

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

## INSTRUCTIONS - TYPE OR PRINT LEGIBLY

**1. YOUR CURRENT M.D. LICENSE EXPIRES ON JUNE 30, 1997. THIS IS THE NOTICE TO RENEW YOUR M.D. LICENSE.**

2. To be eligible to act as a supervising physician for a physician assistant, complete the enclosed Application for Approval as Supervising Physician form.

**3. ACTIVE STATUS REGISTRATION RENEWAL REQUIRES THE SUBMISSION OF PROOF OF 40 HOURS OF AMA CATEGORY I, CONTINUING MEDICAL EDUCATION** completed during the period July 1, 1995 through June 30, 1997. Submit your proof of CME with your completed Application for Registration Renewal form.

4. In order to provide sufficient time for processing, please complete and return your Application for Registration Renewal form and Application for Approval as Supervising Physician form (if applicable) with your proof of 40 hours AMA Category I CME and the correct fee(s) **PRIOR TO JULY 1, 1997.** Use the enclosed self-addressed envelope to return your completed form(s) and fee(s).

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

Name Robert A. Gatlin, M.D.

Street 2110 E. Flamingo Road Suite 202

City LAS VEGAS County Clark State Nv. Zip 89119

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

Name_____

Street_____

City_____ County_____ State_____ Zip_____

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

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

**ALL FEES ARE NON-REFUNDABLE**

**DO NOT SEND CASH THROUGH THE MAIL**

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

1. Are you currently active in medicine?
   a. [ ] YES, in training.
   b. [ ✓ ] YES, working full-time
   c. [ ] YES, working part-time
   d. [ ] NO, retired.
   e. [ ] NO, other (specify_____)

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

**SPECIALTY CODE:**

| | |
|---|---|
| 1 ADOLESCENT MEDICINE | 35 NEURORADIOLOGY |
| 2 AEROSPACE MEDICINE | 36 NUCLEAR MEDICINE |
| 3 ALLERGY/IMMUNOLOGY | 37 NUTRITION |
| 4 ANESTHESIOLOGY | 38 OBSTETRIC/GYNECOLOGY |
| 5 BLOODBANKING | 39 OBSTETRICS |
| 6 BRONCO-ESOPHAGOLOGY | 40 OCCUPATIONAL MED |
| 7 CARDIOVASC DISEASES | 41 ONCOLOGY |
| 8 CATSCAN/ULTRASOUND | 45 ONCOLOGY, GYNECOLOGIC |
| 9 CHILD NEUROLOGY | 42 ONCOLOGY, HEMATOLOGY |
| 10 CHILD PSYCHIATRY | 43 ONCOLOGY, RADIATION |
| 11 CLINICAL PHARMACOL | 44 ONCOLOGY, SURGICAL |
| 12 CRITICAL CARE | 46 OPHTHALMOLOGY |
| 13 DERMATOLOGY | 47 OTOLARYNGOLOGY |
| 14 EMERGENCY MEDICINE | 48 OTOLOGY |
| 15 ENDOCRINOLOGY | 49 PAIN MANAGEMENT |
| 16 FAMILY PRACTICE | 50 PATHOLOGY |
| 17 GASTROENTEROLOGY | 51 PATHOLOGY, ANATOMIC |
| 18 GENERAL PRACTICE | 52 PATHOLOGY, CLINICAL |
| 19 GERIATRICS | 53 PATHOLOGY, FORENSIC |
| 20 GYNECOLOGY | 54 PED. ALLERGY |
| 21 HEMATOLOGY | 55 PED. CARDIOLOGY |
| 22 HYPNOSIS | 99 PED. CRITICAL CARE |
| 23 IMMUNOLOGY | 97 PED. EMERGENCY MED |
| 24 INFECTIOUS DISEASES | 56 PED. ENDOCRINOLOGY |
| 25 INFERTILITY | 57 PED. HEMAT/ONCOLOGY |
| 26 INTERNAL MEDICINE | 58 PED. INFECTIOUS DIS |
| 27 LARYNGOLOGY | 59 PED. INTENSIVIST |
| 28 LEGAL MEDICINE | 60 PED. NEPHROLOGY |
| 29 MATERNAL/FETAL MED | 98 PED. NEUROLOGY |
| 30 NEO/PERINATAL MED | 101 PED. OPHTHALMOLOGY |
| 31 NEOPLASTIC DISEASES | 61 PED. PHYSIATRY |
| 32 NEPHROLOGY | 95 PED. PULMONARY |
| 33 NEUROLOGY | 62 PED. RADIOLOGY |
| 34 NEUROPATHOLOGY | 63 PED. SURGERY |

| | 64 PED. UROLOGY |
|---|---|
| | 65 PEDIATRICS |
| | 66 PHYSICAL MED/REHAB |
| | 96 PHYSICIAN ASSISTANT |
| | 67 PREVENTIVE MED |
| | 68 PSYCHIATRY |
| | 69 PSYCHOANALYSIS |
| | 70 PSYCHOMATIC MEDICINE |
| | 71 PUBLIC HEALTH |
| | 72 PULMONARY DISEASES |
| | 73 RADIOLOGY |
| | 74 RADIOLOGY, DIAGNOSTIC |
| | 75 RADIOLOGY, NUCLEAR |
| | 76 RADIOLOGY, THERAPEUT |
| | 77 RHEUMATOLOGY |
| | 78 RHINOLOGY |
| | 79 SLEEP DISORDERS |
| | 100 SPORTS MEDICINE |
| | 80 SURGERY, ABDOMINAL |
| | 81 SURGERY, CARDIOVASC |
| | 91 SURGERY, COLON/RECTAL |
| | 82 SURGERY, GENERAL |
| | 83 SURGERY, HAND |
| | 84 SURGERY, HEAD/NECK |
| | 92 SURGERY, MAXILLOFAC |
| | 93 SURGERY, NEUROLOGICAL |
| | 85 SURGERY, ORTHOPEDIC |
| | 86 SURGERY, PLASTIC |
| | 87 SURGERY, THORACIC |
| | 88 SURGERY, TRAUMATIC |
| | 89 SURGERY, UROLOGIC |
| | 90 SURGERY, VASCULAR |
| | 94 UROLOGY |

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

**PLEASE INDICATE AMERICAN BOARD OF MEDICAL SPECIALTIES BOARD CERTIFICATION:**

| | Date of Initial Certification | Date of Last Certification |
|---|---|---|
| Board American Board of Obstetrics & Gynecology | Feb 1980 (Mo./Yr.) | Feb 1980 (Mo./Yr.) |
| Subboard | (Mo./Yr.) | (Mo./Yr.) |

3. Form of employment is 1001 (Use the following codes)

SELF-EMPLOYED
1001 Solo Practice
1002 Partnership or Group Practitioners

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

SALARIED, EMPLOYED BY (continued)
1006 Other Non-Government Employer (hospital, school, etc.)
1007 Federal Government (armed services personnel only)
1008 Federal Government (civilian, P.H.S., etc.)
1009 State Government
1010 County Government
1011 Local Government
1012 Other (specify)_____

**All of the following questions refer to the time period July 1, 1995, through the present date only.**
**FOR ALL YES RESPONSES, PLEASE EXPLAIN ON A SEPARATE SHEET AND RETURN WITH THIS REGISTRATION APPLICATION**

For the purposes of the following questions, these phrases or words have these meanings:
**"Ability to practice medicine"** is to be construed to include all of the following:

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

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

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

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

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

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

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

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

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

3. If you use chemical substances, does your use of chemical substance(s) in any way impair or limit your ability to practice medicine with reasonable skill and safety? ____Yes ✓ No ____N/A

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

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

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

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

8. Have you ever had a medical license revoked, suspended, limited, or restricted in any state, country or U.S. territory? ____Yes ✓ No

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

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

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

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

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

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

If more space is needed, attach separate sheet.

PLEASE CHECK ONE OF THE FOLLOWING:

✓ 1. I have earned a minimum of 40 hours approved AMA Category I continuing medical education (CME) for the biennial period July 1, 1995, through June 30, 1997.

____ 2. I was initially licensed in Nevada during the second six months of the biennial period July 1, 1995, through June 30, 1997 and have earned a minimum of 30 hours approved AMA Category I continuing medical education (CME).

____ 3. I was initially licensed in Nevada during the third six months of the biennial period July 1, 1995, through June 30, 1997 and have earned a minimum of 20 hours approved AMA Category I continuing medical education (CME).

____ 4. I was initially licensed in Nevada during the fourth six months of the biennial period July 1, 1995, through June 3, 1997 and have earned a minimum of 10 hours approved AMA Category I continuing medical education (CME).

____ 5. I am exempt from submitting proof of continuing medical education (CME) because I have completed a full year of residency or fellowship training during the biennial period July 1, 1995, through June 30, 1997.

Signature _____ _____
Signature stamp unacceptable

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

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

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

(702) 737-3200 June 12, 1997 _____ _____
Business Telephone # Date Signature (SIGNATURE STAMP UNACCEPTABLE)

**PHYSICIAN**
**APPLICATION FOR RENEWAL REGISTRATION**
**NEVADA STATE BOARD OF**
**MEDICAL EXAMINERS**
Post Office Box 7238 Reno, Nevada 89510 Phone (775) 688-2559

Date Received by Board
JUN 2 3 1999
(Board Use Only)

License No._____

File No._____

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

| | | |
|---|---|---|
| ✓ | ACTIVE STATUS | $600.00 |
| | INACTIVE STATUS | $200.00 |
| | RETIRED STATUS | $ 50.00 |
| | SUPERVISING/COLLABORATING PHYSICIAN | $200.00 |

Robert A. Gatlin, MD
2110 E Flamingo Rd #202
Las Vegas NV 89119

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

**NEVADA HAS NO GRACE PERIOD - - - - - LICENSES NOT RENEWED BY JULY 1, 1999 ARE AUTOMATICALLY SUSPENDED FOR NON-PAYMENT.**
**EXTENSIONS OF TIME ARE NOT ALLOWED FOR ANY REASON.**
**YOUR LICENSE WILL NOT BE RENEWED WITHOUT ANSWERING ALL QUESTIONS.**
**ALL YES ANSWERS MUST BE EXPLAINED.**
**YOU MUST INCLUDE PROOF OF 40 HOURS OF AMA CATEGORY 1 CME WHICH INCLUDES 2 HOURS IN MEDICAL ETHICS AND 20 HOURS IN YOUR SCOPE OF PRACTICE OR SPECIALTY.**
**ALL FEES MUST BE PAID AND ARE NON-REFUNDABLE.**
**DO NOT SEND CASH THROUGH THE MAIL.**
**PLEASE ALLOW SIXTY (60) DAYS FOR PROCESSING OF YOUR APPLICATION.**

## PLEASE TYPE OR PRINT LEGIBLY

1. **YOUR CURRENT M.D. LICENSE EXPIRES ON JUNE 30, 1999. THIS IS THE NOTICE TO RENEW YOUR M.D. LICENSE.**

2. To be eligible to act as a supervising physician for a physician's assistant, or as a collaborating physician for an advanced practitioner of nursing, complete the enclosed Application for Approval as Supervising/Collaborating Physician.

3. **ACTIVE STATUS REGISTRATION RENEWAL REQUIRES THE SUBMISSION OF PROOF OF 40 HOURS OF AMA CATEGORY 1 CONTINUING MEDICAL EDUCATION** which includes 2 hours of medical ethics and 20 hours in your scope of practice or specialty completed during the period July 1, 1997 through June 30, 1999. Submit your proof of CME with your completed Application for Registration Renewal form.

4. In order to provide sufficient time for processing, please complete and return your Application for Registration Renewal form and Application for Approval as Supervising/Collaborating Physician form (if applicable) with your proof of 40 hours AMA Category I CME and the correct fee(s) **BY JUNE 30, 1999.** Use the enclosed self-addressed envelope to return your completed form(s) and fee(s).

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

Name Robert A. Gatlin, M.D.
Street 1701 Green Valley Parkway; Bldg #3, Suite B
City Henderson County Clark State NV Zip 89014

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

Name Robert A. Gatlin, M.D.
Street 1701 Green Valley Parkway; Bldg #3, Suite B
City Henderson County Clark State NV Zip 89014

7. 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_____)

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

**SCOPE OF PRACTICE SPECIALTY CODES**

| | | | | | |
|---|---|---|---|---|---|
| 102 | ADDICTION MEDICINE | 31 | NEOPLASTIC DISEASES | 62 | PEDIATRIC, RADIOLOGY |
| 1 | ADOLESCENT MEDICINE | 32 | NEPHROLOGY | 63 | PEDIATRIC, SURGERY |
| 2 | AEROSPACE MEDICINE | 33 | NEUROLOGY | 64 | PEDIATRIC, UROLOGY |
| 3 | ALLERGY/IMMUNOLOGY | 34 | NEUROPATHOLOGY | 65 | PEDIATRICS |
| 104 | ALTERNATIVE MEDICINE | 35 | NEURORADIOLOGY | 66 | PHYSICAL MEDICINE/REHABILITATION |
| 4 | ANESTHESIOLOGY | 36 | NUCLEAR MEDICINE | 67 | PREVENTIVE MEDICINE |
| 5 | BLOODBANKING | 37 | NUTRITION | 68 | PSYCHIATRY |
| 6 | BRONCO-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 | | | |
| Tertiary | | | |

**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 | 02/1980 | |
| Subboard | | |
| Board | | |
| Subboard | | |

9. Form of employment is 1001. (Use one of the following codes.)

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

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

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

1012 Other (specify)_____

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

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

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

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

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

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

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

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

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

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

3. If you use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety?
_____Yes_____No ___✓___N/A

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

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

6. Have you ever been investigated for, charged with, convicted of, or plead guilty or nolo contendere to any offense or violation of any federal, state or local law, including any foreign country, which is a misdemeanor, gross misdemeanor, or felony, excluding any minor traffic offense (driving or in control of a motor vehicle while under the influence of any chemical substance is not considered a minor traffic offense) or which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances?
_____Yes ___✓___No

7. Have you ever been denied a license, permission to practice medicine or any other healing art(s), or permission to take an examination to practice medicine or any other healing art(s) in any state, country or U.S. territory? _____Yes ___✓___No

8. Have you ever had a medical license or license to practice any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory?
_____Yes ___✓___No

9. Have you ever voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory?
_____Yes_____✓___No

10. Have you ever been denied membership or expelled from a medical society or other professional medical organization?
_____Yes _____✓___No

11. Have you ever been investigated for, charged with, or convicted of any violation of a statute, rule or regulation governing the practice of medicine by any medical licensing board, hospital, medical society, governmental entity or other agency?

_____Yes ✓ No

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

_____Yes ✓ No

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

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

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

**PLEASE CHECK ONE OF THE FOLLOWING:**

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

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

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

Signature_____

**(SIGNATURE STAMP UNACCEPTABLE)**

**PLEASE CHECK ONE OF THE FOLLOWING:**

✓ 1. I have earned a minimum of 40 hours approved AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics, and 20 hours of which were in my scope of practice or specialty during the biennial period July 1, 1997, through June 30, 1999.

_____ 2. I was initially licensed in Nevada during the second six months of the biennial period July 1, 1997, through June 30, 1999, and have earned a minimum of 30 hours approved AMA Category I continuing medical education (CME).

_____ 3. I was initially licensed in Nevada during the third six months of the biennial period July 1, 1997, through June 30, 1999, and have earned a minimum of 20 hours approved AMA Category I continuing medical education (CME).

_____ 4. I was initially licensed in Nevada during the fourth six months of the biennial period July 1, 1997, through June 30, 1999, and have earned a minimum of 10 hours approved AMA Category I continuing medical education (CME).

_____ 5. I am exempt from submitting proof of continuing medical education (CME) because I have completed a full year of residency or fellowship training during the biennial period July 1, 1997, through June 30, 1999.

## IMPORTANT

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

Signature_____

**(SIGNATURE STAMP UNACCEPTABLE)**

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

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

(702) 737-3200 June 19, 1999 _____

Business Telephone # Date Signature **(SIGNATURE STAMP UNACCEPTABLE)**

**PHYSICIAN**
**APPLICATION FOR REGISTRATION RENEWAL**
**FOR THE BIENNIAL REGISTRATION PERIOD 2001- 2003**
**NEVADA STATE BOARD OF MEDICAL EXAMINERS**
Post Office Box 7238 Reno, Nevada 89510 Phone (775) 688-2559

Date Received by Board
JUN 2 6 2001
(For Board Use Only)

License No. 3436

File No. ____

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

| | | |
|---|---|---|
| [redacted] | $800.00 | |
| ____INACTIVE STATUS | $200.00 | *(RETIRED STATUS REQUIRES THAT THE* |
| ____RETIRED STATUS | $ 50.00 | *APPLICANT NOT PRACTICE MEDICINE* |
| ____SUPERVISING/COLLABORATING PHYSICIAN | $200.00 | *ANYWHERE)* |

[redacted]
Robert A GATLIN M.D.
1701 Green Valley Pkwy Bldg 3 #B
Henderson, NV 89014

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

## *PLEASE NOTE:*

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

## PLEASE TYPE OR PRINT LEGIBLY

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

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

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

Name_____

Street_____

City_____ County_____ State_____ Zip_____

Phone Number_____ Fax Number_____

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

Name_____

Street_____

City_____ County_____ State_____ Zip_____

Phone Number_____

5. Indicate below the **EXACT NAME AND LOCATION** of the Medical School from which you graduated and your **EXACT DATE** of graduation:

_____ _____
Medical School Name and Location Date of Graduation (Month / Day / Year)

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

**SCOPE OF PRACTICE SPECIALTY CODES**

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

| | Code | | Code | | Code |
|---|---|---|---|---|---|
| **Primary Specialty** | 48 | **Secondary Specialty** | 29 | **Tertiary Specialty** | |

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

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

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

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

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

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

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

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, 1999 through June 30, 2001;

_____ (b) I was initially licensed in Nevada during the time period January 1, 2000 through June 30, 2000, the second six months of the past biennial period, and completed a minimum of 30 hours of AMA Category I continuing medical education (CME), 2 hours of which were in medical ethics and 20 hours of which were in my scope of practice or specialty;

_____ (c) I was initially licensed in Nevada during the time period July 1, 2000 through December 31, 2000, the third six months of the past biennial period, and completed a minimum of 20 hours of AMA Category I continuing medical education (CME), 2 hours of which were in medical ethics and 18 hours of which were in my scope of practice or specialty;

_____ (d) I was initially licensed in Nevada during the time period January 1, 2001 through June 30, 2001, the fourth six months of the past biennial period, and completed a minimum of 10 hours of AMA Category I continuing medical education (CME), 2 hours of which were in medical ethics and 8 hours of which were in my scope of practice or specialty; **OR**

_____ (e) I am exempt from submitting proof of completion of continuing medical education (CME) because I have completed a full year of residency or fellowship training during the biennial period July 1, 1999 through June 30, 2001.

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

I HAVE ✓ 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).**

4/3/01 _____

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 2 8 2003
(For Board Use Only)

License No. 3436
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]

Robert A GATLIN M.D.
1701 Green Valley Pkwy Bldg 3 #B
Henderson, NV ~~89014~~ 89074

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 89074
Phone Number 702-737-3200 Fax Number 702-369-4727

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

(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).**

June 27, 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
JUN 24 2005
(For Board Use Only)

License No. #3436
File No. 10/7/77

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)

[redacted]

Robert Allan GATLIN M.D.
1701 Green Valley Pkwy Bldg 3 #B
Henderson NV 89014-

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 _____ JUN 28 2005
City _____ County _____ State _____ Zip 89074
Phone Number (702) 737-3200 Fax Number (702) 369-4727

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 | 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 | SURGERT, TRANSPLANT |
| 36 | LEGAL MEDICINE | 78 | PEDIATRIC, NEPHROLOGY | 120 | SURGERY, TRAUMATIC |
| 37 | MATERNAL/FETAL MEDICINE | 79 | PEDIATRIC, NEUROLOGY | 121 | SURGERY, UROLOGIC |
| 38 | MEDICAL ACUPUNCTURE | 80 | PEDIATRIC, OPHTHALMOLOGY | 122 | SURGERY, VASCULAR |
| 39 | MEDICAL ETHICS | 81 | PEDIATRIC, PHYSIATRY | 123 | TOXICOLOGY |
| 40 | MEDICAL GENETICS | 82 | PEDIATRIC, PULMONARY | 124 | TRANSPLANTATION |
| 41 | NEO/PERINATAL MEDICINE | 83 | PEDIATRIC, RADIOLOGY | 125 | URGENT CARE |
| 42 | NEOPLASTIC DISEASES | 84 | PEDIATRIC, RHEUMATOLOGY | 126 | UROLOGY |

**Code** **Code**

**Primary Scope of Practice** 53 **Secondary Scope of Practice** _____

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

| | Date of Initial Certification | Date of Last Recertification |
|---|---|---|
| **Board** American Board of Obstetrics & Gynecology | Feb 1980 (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 <u>ever</u> 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.) (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 | | | | |
| | | | | |
| | | | | |

**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).**

June 21, 2005 _____

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

| License Number | Licensee Name | Question Text | Answer | Date Answered |
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| 3436 | GATLIN, Robert Allan | 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 | 6/25/2007 |
| 3436 | GATLIN, Robert Allan | 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 | 6/25/2007 |
| 3436 | GATLIN, Robert Allan | 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 | 6/25/2007 |
| 3436 | GATLIN, Robert Allan | Have you failed to initiate the performance of public service within one year after the date the public service is required to begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local government for your medical education? | N | 6/25/2007 |
| 3436 | GATLIN, Robert Allan | 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 | 6/25/2007 |

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| 3436 | GATLIN, Robert Allan | 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 | 6/25/2007 |
| 3436 | GATLIN, Robert Allan | 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 | 6/25/2007 |

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| 3436 | GATLIN, Robert Allan | 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 | 6/25/2007 |
| 3436 | GATLIN, Robert Allan | 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 | 6/25/2007 |
| 3436 | GATLIN, Robert Allan | 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 | 6/25/2007 |
| 3436 | GATLIN, Robert Allan | 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 | 6/25/2007 |

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| 3436 | GATLIN, Robert Allan | 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 | 6/25/2007 |
| 3436 | GATLIN, Robert Allan | 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 | 6/25/2007 |
| 3436 | GATLIN, Robert Allan | 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 | 6/25/2007 |
| 3436 | GATLIN, Robert Allan | 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 | 6/25/2007 |

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| 3436 | GATLIN, Robert Allan | 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 | 6/25/2007 |
| 3436 | GATLIN, Robert Allan | 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 | 6/25/2007 |
| 3436 | GATLIN, Robert Allan | Do you want to change your scope of practice or specialty? If you answer "Yes" during the time period July 1, 2005 - June 30, 2007 email your request to elicensensbme@medboard.nv.gov | N | 6/25/2007 |
| 3436 | GATLIN, Robert Allan | 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 | 6/25/2007 |
| 3436 | GATLIN, Robert Allan | 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 | 6/25/2007 |
| 3436 | GATLIN, Robert Allan | I have actively practiced medicine in Nevada within the past 24 months. | Y | 6/25/2007 |
| 3436 | GATLIN, Robert Allan | I hereby request my license to be placed on Inactive status. I will not physically practice in the state of Nevada. | N | 6/25/2007 |

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| 3436 | GATLIN, Robert Allan | 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 | 6/25/2007 |
| 3436 | GATLIN, Robert Allan | 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 | 6/27/2009 |
| 3436 | GATLIN, Robert Allan | 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 | 6/27/2009 |
| 3436 | GATLIN, Robert Allan | 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 | 6/27/2009 |
| 3436 | GATLIN, Robert Allan | 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. | Y | 6/27/2009 |
| 3436 | GATLIN, Robert Allan | For the above question if your answer is "Yes" for the time period July 1, 2007 - June 30, 2009, or since your last renewal, please type your explanation in this text box. | | 6/27/2009 |

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| 3436 | GATLIN, Robert Allan | 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 | 6/27/2009 |
| 3436 | GATLIN, Robert Allan | 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 | 6/27/2009 |
| 3436 | GATLIN, Robert Allan | 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 | 6/27/2009 |
| 3436 | GATLIN, Robert Allan | 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 | 6/27/2009 |
| 3436 | GATLIN, Robert Allan | 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 | 6/27/2009 |

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| 3436 | GATLIN, Robert Allan | 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 | 6/27/2009 |
| 3436 | GATLIN, Robert Allan | Have you been denied membership, been asked to resign or expelled from a medical society or other professional medical organization (including the ABMS)? | N | 6/27/2009 |
| 3436 | GATLIN, Robert Allan | 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 | 6/27/2009 |
| 3436 | GATLIN, Robert Allan | Have you surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? | N | 6/27/2009 |
| 3436 | GATLIN, Robert Allan | 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 | 6/27/2009 |

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| 3436 | GATLIN, Robert Allan | 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 | 6/27/2009 |
| 3436 | GATLIN, Robert Allan | 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 | 6/27/2009 |
| 3436 | GATLIN, Robert Allan | 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 | 6/27/2009 |
| 3436 | GATLIN, Robert Allan | 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 | 6/27/2009 |
| 3436 | GATLIN, Robert Allan | 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 | 6/27/2009 |

System Automation

Reports Home Page

## Renewal Questions for License Number 3436

| Licensee | Question | Answer | Date |
|---|---|---|---|
| GATLIN, Robert Allan | 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 | 6/28/2011 |
| GATLIN, Robert Allan | **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.** | | |
| GATLIN, Robert Allan | 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 | 6/28/2011 |
| GATLIN, Robert Allan | **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.** | | |
| GATLIN, Robert Allan | 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 | 6/28/2011 |
| GATLIN, Robert Allan | **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.** | | |
| GATLIN, Robert Allan | 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. | Y | 6/28/2011 |
| | **Explanation 4: For the above question if your** | | |

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| GATLIN, Robert Allan | **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.** | | 6/28/2011 |
| GATLIN, Robert Allan | 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?<br><br>If "Yes" during the time period July 1, 2009 - June 30, 2011 type an explanation in the textbox directly below this question. | N | 6/28/2011 |
| GATLIN, Robert Allan | **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.**<br>Please fax a copy of the complaint, civil or otherwise to 775-688-2551. | | |
| GATLIN, Robert Allan | 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 | 6/28/2011 |
| GATLIN, Robert Allan | **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.** | | |
| GATLIN, Robert Allan | 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 | 6/28/2011 |
| GATLIN, Robert Allan | **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.** | | |

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| GATLIN, Robert Allan | 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 | 6/28/2011 |
| GATLIN, Robert Allan | **Explanation 8: For the above question if your answer is "Yes" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box.** | | |
| GATLIN, Robert Allan | 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 | 6/28/2011 |
| GATLIN, Robert Allan | **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.** | | |
| GATLIN, Robert Allan | Have you been denied membership, been asked to resign or expelled from a medical society or other professional medical organization (including the ABMS)? | N | 6/28/2011 |
| GATLIN, Robert Allan | **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.** | | |
| GATLIN, Robert Allan | 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 | 6/28/2011 |
| GATLIN, Robert Allan | **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.** | | |
| GATLIN, Robert Allan | Have you surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? | N | 6/28/2011 |
| GATLIN, Robert Allan | **Explanation 12: For the above question if your answer is "Yes" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box.** | | |
| | Have you had hospital staff privileges denied, suspended, limited, revoked or not renewed by the | | |

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| | hospital, including any and all resignations from any medical staff in lieu of disciplinary or administrative action? | | |
| GATLIN, Robert Allan | 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.<br><br>**(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 | 6/28/2011 |
| GATLIN, Robert Allan | **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.** | | |
| GATLIN, Robert Allan | Are you out of compliance with court ordered child support? **If this does not apply to you, please answer "no".**<br><br>If "Yes" during the time period July 1, 2009 - June 30, 2011 type an explanation in the textbox directly below this question. | N | 6/28/2011 |
| GATLIN, Robert Allan | **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.** | | |
| GATLIN, Robert Allan | I hereby request my license to be placed on Inactive status, which means I will not physically practice in the state of Nevada.<br><br>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 | 6/28/2011 |
| GATLIN, Robert Allan | **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.** | | |
| GATLIN, Robert Allan | 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 | 6/28/2011 |
| GATLIN, | **Explanation 16: For the above question if your** | | |

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| Robert Allan | **answer is "YES" , please type your new scope of practice or specialty in this text box.** | | |
| GATLIN, Robert Allan | Do you want to change your scope of practice or specialty?<br><br>If you answer "Yes" type your current scope of practice or specialty in the textbox directly below this question. | N | 6/28/2011 |
| GATLIN, Robert Allan | **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.** | | |
| GATLIN, Robert Allan | I have completed the required amount of AMA Category 1 CME within the current biennial. (Review CME information online at www.medboard.nv.gov)<br><br>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.<br><br>If renewing to an Inactive status, CME is not required and "No" can be selected. | Y | 6/28/2011 |
| GATLIN, Robert Allan | 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 | 6/28/2011 |

# Nevada State Board of Medical Examiners

## Renewal Responses Report

Thursday, August 20, 2015

| License Number | Licensee | License Type |
|---|---|---|
| **3436** | Robert Allan GATLIN | Medical Doctor |

| Question | Answer | Date |
|---|---|---|

**NSBME Renewal Responses Report** 8/20/2015

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| Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety?<br>**If you do not have a medical condition, select No.** | N | 06/18/2013 |
| If you have a medical condition which in any way impairs or limits your ability to practice medicine, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice?<br>**If you do not have a medical condition, select No.** | N | 06/18/2013 |

**NSBME Renewal Responses Report** 8/20/2015

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| If you use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety?<br>**If you do not use chemical substances, select No.** | N | 06/18/2013 |
| 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?<br>Please include: who, what, where (provide state), and when in the textbox directly below this question. | N | 06/18/2013 |

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| 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?<br>If "Yes" during the time period July 1, 2011 - June 30, 2013 type an explanation in the textbox directly below this question. | N | 06/18/2013 |
| 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 | 06/18/2013 |

**NSBME Renewal Responses Report** 8/20/2015

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| 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 | 06/18/2013 |
| 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 | 06/18/2013 |

**NSBME Renewal Responses Report**

8/20/2015

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|---|---|---|
| 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 | 06/18/2013 |
| 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 | 06/18/2013 |

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| **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.<br>**http://www.cdc.gov/injectionsafety/IP07_standardPrecaution.html** | Y | 06/18/2013 |
| **Explanation 11: For the above question if your answer is "Yes" for the time period July 1, 2011 - June 30, 2013, or since your last renewal, please type your explanation in this text box.** | ALLEGED HIPPA VIOLATIONS BME CASE # 13-14362 | 06/18/2013 |

**NSBME Renewal Responses Report** 8/20/2015

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| Have you surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? | N | 06/18/2013 |
| 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 | 06/18/2013 |

**NSBME Renewal Responses Report** 8/20/2015

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|---|---|---|
| Have you actively practiced medicine in Nevada within the past 12 months? | Y | 06/18/2013 |
| I hereby request my license to be placed on Inactive status, which means I will not physically practice in the state of Nevada.<br>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 | 06/18/2013 |

**NSBME Renewal Responses Report** 8/20/2015

| | | |
|---|---|---|
| **The submission of the in-office surgery/procedure forms is required for <u>all</u> medical doctors, whether in state, out of state, active or inactive status! THIS IS NOT OPTIONAL. DO NOT answer this attestation until <u>you have completed</u> 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. | Y | 06/18/2013 |
| Are you out of compliance with court ordered child support? **If this does not apply to you, please answer "no".** | N | 06/18/2013 |

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

**NSBME Renewal Responses Report** 8/20/2015

| | | |
|---|---|---|
| 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.<br>(Review CME information online at www.medboard.nv.gov)<br>If renewing to an Inactive status, CME is not required and "No" can be selected. | Y | 06/18/2013 |
| 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 | 06/18/2013 |

System Automation

MyLicense Transaction Reports

Reports Home Page

**Renewal Questions for License Number 3436**

Powered by MyLicense

| Licensee | Question | Answer | Date |
|---|---|---|---|
| GATLIN, Robert Allan | 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 | 5/16/2015 |
| GATLIN, Robert Allan | 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 | 5/16/2015 |
| GATLIN, Robert Allan | 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 | 5/16/2015 |
| GATLIN, Robert Allan | 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 | 5/16/2015 |
| GATLIN, Robert Allan | 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 | 5/16/2015 |
| GATLIN, Robert Allan | 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 | 5/16/2015 |
| GATLIN, Robert Allan | 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 | 5/16/2015 |
| GATLIN, Robert Allan | 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 | 5/16/2015 |
| | | N | 5/16/2015 |

| | | | |
|---|---|---|---|
| GATLIN, Robert Allan | 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? | | |
| GATLIN, Robert Allan | 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 | 5/16/2015 |
| GATLIN, Robert Allan | 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? | Y | 5/16/2015 |
| GATLIN, Robert Allan | **Explanation 11: For the above question if your answer is "Yes" for the time period July 1, 2013 - June 30, 2015, or since your last renewal, please type your brief explanation in this text box (Fields are space limited to 256 characters). Lengthy explanations or additional information may be faxed to 775-688-2551 or scanned and Email to elicensensbme@medboard.nv.gov!.** | See BME Case Number 12-13632 | 5/16/2015 |
| GATLIN, Robert Allan | Have you surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? | N | 5/16/2015 |
| GATLIN, Robert Allan | 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?<br><br>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.<br><br>**(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 | 5/16/2015 |
| GATLIN, Robert Allan | Have you actively practiced medicine in Nevada within the past 12 months? | Y | 5/16/2015 |
| GATLIN, Robert Allan | OPTION TO CHANGE LICENSE STATUS FROM ACTIVE TO INACTIVE:<br><br>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."<br><br>I hereby request my license to be placed on Inactive status, which means I will not physically practice in the state of Nevada.<br><br>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 | 5/16/2015 |
| GATLIN, Robert Allan | **If you believe that you are in compliance with the Centers for Disease Control safe injection practices, your answer should be "YES".** | Y | 5/16/2015 |

| | | | |
|---|---|---|---|
| | 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.<br><br>**http://www.cdc.gov/injectionsafety/IP07_standardPrecaution.html** | | |
| GATLIN, Robert Allan | 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.<br><br>I HAVE SUBMITTED A "FORM A" OR "FORM B" REPORT TO THE BOARD.<br><br>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.<br><br>**If you have submitted your in-office surgery/procedure reporting forms (A/B Forms) to the Board and are in compliance with NRS 630.30665, your answer should be "YES."** | Y | 5/16/2015 |
| GATLIN, Robert Allan | Are you out of compliance with court ordered child support? **If this does not apply to you, please answer "no".**<br><br>If "Yes" during the time period July 1, 2013 - June 30, 2015 type an explanation in the textbox directly below this question. | N | 5/16/2015 |
| GATLIN, Robert Allan | 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".<br><br>**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.**<br><br>**www.leg.state.nv.us/NRS/NRS-432B.html#NRS432BSec220** | Y | 5/16/2015 |
| GATLIN, Robert Allan | Have you ever served in the United States Military (to include National Guard or Reserves)? | N | 5/16/2015 |
| GATLIN, Robert Allan | Do you hold a Nevada state business license issued in your individual name? | N | 5/16/2015 |
| GATLIN, Robert Allan | 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)<br><br>If renewing to an Inactive status, CME is not required and "No" can be selected. | Y | 5/16/2015 |
| GATLIN, Robert Allan | 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 | 5/16/2015 |

NML INSURANCE COMPANY



February 24, 1994

Nevada State Board of Medical Examiners
Post Office Box 7238
Reno, NV 89510

Re: Nevada Revised Statutes
Chapter 690B.045, Section 1

Gentlemen:

In accordance with NRS 690B.045, we submit the following information:

| | |
|---|---|
| Insured: | Robert A. Gatlin, M.D. |
| Claimant(s): | |
| Closed Date: | January 31, 1994 |
| Settled: | $75,000. |

Recap: This incident involved a 39 year old female with ruptured ectopic pregnancy. Alleged failure to diagnose in a timely way.

Very truly yours,

Carolyn Littlewood

Carolyn Littlewood
Vice President/Claims

CL:aw
Enclosure

1245 South Wells Avenue • P.O. Box 7456 Reno, Nevada 89510 • (702) 329-2246 • Fax (702) 329-2234

Report each claim closed on or after July 1, 1976. Submit a report for each defendant insured by filing insurer, including claims closed without payment. Complete all blocks on the form. If information is unknown, enter "UNK," if not applicable, enter "NA." When an item calls for a dollar amount and no amount is involved, enter 0 in the space after the $ sign. When you prepare a report on a reopened case on which a previous report has been made, mark "Previously Reported" at the top of the report. Record all amounts in whole dollars only, all dates as MM YY and all ages (on date of occurrence) as YY.

| | | | | | |
|---|---|---|---|---|---|
| 1a. Name of insurer: Nevada Medical Liability Insurance Company | | | 1b. Claim file identification: 0-84-0635-M | | |
| 2a. Date of injury: 11-9-84 | | 2b. Date reported to insurer: 4-28-86 | | 2c. Date reopened | |
| 3a. Insured's name: Robert Gatlin | 3b. Age: 40 | 3c. City: Las Vegas | | 3d. State: Nevada | 3e. Zip: 89109 |
| 4a. Profession or business (CODE): 1 | | 4b. Specialty (CODE): 80153 | | 4c. Type of practice (CODE): 2 | |
| 5a. Board certification (CODE): 1 | | 5b. Foreign medical graduate?: No | | 5c. Country | |
| 6a. Place where injury occurred (CODE): 1 | | 6b. City: Las Vegas | | 6c. State: Nevada | 6d. Zip |
| 7a. Name of institution (if injury occurred in institution): Humana Hospital-Sunrise | | 7b. Location in institution (CODE): 3 | | 7c. Hospital identification (Leave Blank) | |
| 8a. Injured person's name: [redacted] | | | | 8b. Age: 44 | 8c. Sex: F |
| 9a. Total defendants involved in claim: 1 | | 9b. Derivative claim (CODE) | | | |
| 10. Amount of reserve for indemnity if still outstanding: $ | | 11. Amount of reserve for expense if still outstanding: $ | | | |
| 12a. Plaintiff attorney's name: Richard Harris | | 12b. City: Las Vegas | | 12c. State: Nevada | 12d. Zip: 89101 |

13. Describe action which caused claim to be made

Claimant underwent abortion and the products of conception were missed. Two months later had a saline abortion.

(Leave Blank)
14a.
14b.
15.
15.
16a.
16a.

14a. Final diagnosis for which treatment was sought or rendered (patient's actual condition): Pregnancy.

14b Describe misdiagnosis made, if any, of patient's actual condition

15. Operation, diagnostic or treatment procedure causing the injury

16a. Describe principal injury giving rise to the claim: Same as above.

16b. Severity of injury (CODE): 3

17a. Misadventures in procedures (CODE) | 17b. Misadventures in diagnosis (CODE)

18a. Others contributing to injury (CODE) | 18b. Associated issues (CODE): 7 | 18c. Coverage (CODE): 3

19 Companion claim file identification

| | 1. | 2. | 3. | 4. |
|---|---|---|---|---|
| 20a. Date of this payment or closure | | 4-29-87 | 20b. Claim disposition (CODE): 1 | 20c. Settlement (CODE): 2 |
| 21a. Court (CODE): 0 | | | 21b. Binding arbitration (CODE) | 21c. Review panel (CODE) |

| | |
|---|---|
| 22. Indemnity paid by you on behalf of this defendant | $ 4,500.00 |
| 23. Other indemnity paid by or on behalf of this defendant | $ D ☐ E ☐ |
| 24. Indemnity paid by all parties (for all defendants) | $ |
| 25. Loss adjustment expense paid to defense counsel | $ 559.00 |
| 26. All other allocated loss adjustment expense paid by you | $ |
| 27. Injured person's incurred medical expense | $ |
| 28. Injured person's anticipated future medical expense | $ |
| 29. Injured person's incurred wage loss | $ |
| 30. Injured person's anticipated wage loss | $ |
| 31. Injured person's other expense | $ |
| 32. Total amount allocated for future periodic payments (for all defendants) | $ |

Robert A. Byrd, President 329-2246
Contact Person and Telephone Number

Post Office Box 7456, Reno, Nevada 89510
Address

C. Littlewood
Person Responsible for Report

10/77

NEVADA MEDICAL LIABILITY INSURANCE COMPANY

November 12, 1985

Nevada State Board of Medical Examiners
Post Office Box 7238
Reno, Nevada 89510

Re: Nevada Revised Statutes
Chapter 690.B, Section 1

Gentlemen:

In accordance with NRS 690.B, wherein it is mandated that insurers who issue "a policy of insurance covering the liability of a practitioner licensed pursuant to chapters 630 and 640 inclusive of NRS for a breach of his professional duty toward a patient shall report to the board which licensed the practitioner..." we submit the following information:

| | |
|---|---|
| Insured: | Robert A. Gatlin, M.D. |
| Claimant: | |
| Occurrence Date: | July 26, 1980 |
| Settlement Date: | October 10, 1985 |
| Settlement Amount: | $410,000.00 |

Recap: Twenty-three year old nulligravida female with a history of pelvic inflammatory disease. She was admitted to the hospital and suspecting a ruptured tubal pregnancy, an exploratory laparotomy was performed. She then underwent a total abdominal hysterectomy and bilateral salpingo-oopherectomy rendering her sterile.

If you should require additional information, please do not hesitate to contact our office.

Very truly yours,

Carolyn Littlewood

Carolyn Littlewood
Vice-President/Claims

CL:mt

1245 South Wells Avenue • P.O. Box 7456 Reno, Nevada 89510 • (702) 329-2246