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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	Robert	Allan	
2.	Address		re Drive # 52 La Mesa	Middle Calif.	92041
۷.		Street No.	City	State	Zip
3.	Date of Birth		Place of Bi	rth	series series of the series of
l he	ereby make app	lication for a license	to practice medicine in Neva	da on the basis of:	Company (
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ear application is made within the space provided.

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I hereby certify likeness of mys	that the attached pl elf taken within the given above is true	notograph is a true
RUCTIONS	Signature of Applicant	· , -

INST

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

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

FEB 24 1984

MEDICAL EXAM Post Office Box 7238 Reno, Nevada 895		·			
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	File No.		New [] ]	Renewal by	
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LAS VEGAS, NV	89109		٦		
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since your last registration?		March a detailed exp	planation	Military	
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3. Desert Springs 1	tospital Las Vega				
Make checks payable to BOARD OF MED (Foreign checks must indicate "U.S. FUNDS")	ICAL EXAMINERS	I certify that all	the above statements are	true	
(Foreign chécies must indicate "U.S. FUNDS")		Signature			M.D.
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## **APPLICATION FOR REGISTRATION** NEVADA STATE BOARD OF MEDICAL EXAMINERS

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	Last		fiddle	Bu	siness Phone 702	737- 320
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3	Women's Hosp	ital	4		•	
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			Signature			

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APPLICATION FOR REGISTRATION	Date Received by State Board	Nevada License No.
NEVADA STATE BOARD OF		File No.
MEDICAL EXAMINERS		New □ Renewal □
st Office Box 7238 Reno, Nevada 89510 Phone (702) 329-2559	This shaded se	ction for BOARD USE ONLY
□ RETIRED		
Delinquent after September 15, 1985.		
Robert A. GATLIN 2545 S Bruce #5 Las Vegas NV	٦	PRACTICE: (Check One Only)  Direct Patient Care
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турв о	R PRINT LEGIBLY	
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Last First	Middle	Business Phone (70) 2737-3200
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if you have retired or moved your practice, please indicate the local former patient's records below:	ation BOARD CERTIFIC	CATION:
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Primary Specialty (List only one) OB-Gyn	Sub-Specialties:	
SINCE YOUR LAST REGISTRATION:  1. Have you been investigated, charged or convicted of unprofession conduct, professional incompetence or gross or repeated malpritice by any medical licensing board or other agency, hospital medical society?  Yes \( \subseteq \) No \( \subseteq \) 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 \( \subseteq \) No \( \subseteq \) If "yes" attach a detailed explanation	ac- jurisdiction? or Yes □ 4. Have any malp	endered your license to practice medicine in anothe  No If "yes" attach a detailed explanation  practice settlements, awards or judgment been made any jurisdiction?  No If "yes" attach a detailed explanation
1. Humana Sunrise Las Vogo 3. Women's Hosp - Las Vogo	25 2 Deser	

I certify that all the above statements are true

\_ M.D.

Signature \_\_\_\_\_\_\_\_
No rubber stamps please

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

APPLICATION FOR REGISTRATION NEVADA STATE BOARD OF MEDICAL EXAMINERS Post Office Box 7238 Reno, Nevada 89510 Phone (702) 329-2559	by State Brand V.E.D. License No
ACTIVE STATUS \$300.00  □ INACTIVE STATUS \$150.00  □ RETIRED STATUS \$ 50.00  Robert A. GATLIN MD	NRS630 explanation of status on reverse side  VUICE: FEES ARE DUE JULY 1, 1987  HERE IS NO GRACE PERIOD
C 2545 S Bruce #5 Las Vegas NV 8910	Mate checks jewhile to:  BOAND OF MEDICAL EXAMINERS  (Foreign checks must indicate "U.A. FUNDS")
NAME Gatlin Robert Last First	A Han  Middle  Business Phone (702) 737 - 3200
BUSINESS OR MAILING ADDRESS 3901 Sp. Maryl Street Address of P. Okbox	and Pkun # 106 10810 101 10 101 101 89109 89109
If you have retired or moved your practice, please indicate the locat of former patient's records below:  'AME	YesNo
	hours of Continuing Medical Education, AMA-Category 1 and that I have in it is mandated by NRS 630.253 and NAC 630.153.  Date
SINCE YOUR LAST REGISTRATION: (If any question is answered "yes."  1. Have you been investigated, charged or convicted of unprofession conduct, professional incompetence or gross or repeated malpractic by any medical licensing board or other agency, hospital or medic society?  Yes  No.  2. Have you been arrested, fined (over \$100), charged with or convicted.	4. Have you been denied a medical license or surrendered your lice to practice in another jurisdiction or had your medical license revolution suspended or limited in another jurisdiction.  Yes   N  5. Have you had staff privileges in a hospital denied, suspended, limited in another jurisdiction.
of a crime, indicted, imprisoned or placed on probation? Yes \( \text{No} \)  3. Have you been investigated, arrested, charged or convicted for the possession, use of, or illegal sale or dispensing of controlled substance. Yes \( \text{No} \)  No.	of disciplinary or administrative action? Yes \( \text{Ves} \( \text{I} \) No he  6. Have any malpractice settlements, awards or judgments been many malpractice settlements.
STAFF PRIVILEGES: List all Nevada Hospitals in which you have any  1. Humana Hospital Sunrise  2. Womens Hospital  3. Desent Springs Hospita	y staff privileges: (Name and Location)  4. LV, NV.  5. LV, NV.
certify that all the above statements are true and that I have active	practiced in Nevada within the past 12 months.  Date May 25, 1487

PERSONAL STATES

# 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** 

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

File No. New □

Renewal

NEVADA STATE BEATHY & BOARD USE ONLY hereby apply for certificate of biennial registration and enclose the appropriate fee as indicated below:

**EXACTIVE STATUS** 

\$300.00

IN INACTIVE STATUS

915000

NOTE: NO GRACE PERIOD - LICENSES NOT RENEWED BY JULY 1

	CAUTOMATICALLY SUSPENDED FOR NON PAYMENT.
RETIRED STATUS \$ 50.00 FINAL NOTICE F	S630 explanation of status on reverse side
Robert A. GATLIN MD  3201 S Maryland Pky #406  Las Vegas NV 89109	Make checking with to  BOARD OF MEDICAL EXAMINERS  (Portula checks must indicate "U.S. FUNDS")
TIPE 94 PR	Control of the land of the land
NAME GATLIN ROBERT	Social Security Susiness Phone 103 - 737-3200
BUSINESS OR MAILING ADDRESS 3201 50. MC	Suffe No. City Kuy H406 Las Vegas NVq.
If you have retired or moved your practice, please indicate the location of former patient's records below:	BOARD OF CERTIFICATION Yes No No
ADDRESS	AM. Bd. of Obstetr: co & Gynecology
PHONE # ()	Date of Certification or Recertification F4-7, 1980
60 0	Sub-Specialties:
	40 hours of Continuing Medical Education, AMA-Category 1 and that I have nt is mandated by NRS 630.253 and NAC 630.153.
	Date June 15, 1989
SINCE YOUR LAST REGISTRATION: (If any question is answered "yes," attal. 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 \( \text{No } \text{V} \)  2. Have you been arrested, fined (over \$100), charged with or convicted of a crime, indicted, imprisoned or placed on probation? Yes \( \text{No } \text{No } \text{V} \)  3. Have you been investigated, arrested, charged or convicted for the possession, use of, or illegal sale or dispensing of controlled substances? Yes \( \text{No } \text{V} \)	ch a detailed explanation.)  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.  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 liet of disciplinary or administrative action, excluding failure to complet medical records?  Yes \Boxedom No \Boxedom  6. Have any malpractice settlements, awards or judgments been mad against you in any jurisdiction?  Yes \Boxedom No \Boxedom
STAFF PRIVILEGES: List all Nevada Hospitals in which you have any state of the stat	ff privileges: (Name and Location) 4. VOICY HOSP
3 Womens Hosp	6
ertify that all the above statements are true and that I have actively practice.  Signature (No rubber stamps)	Date Date

(No rubber stamps)

# 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)

NOTE: NO GRACE PERIOD - LICENSES NOT RENEWED BY JULY 1

Date.

## **APPLICATION FOR REGISTRATION**

# NEVADA STATE BOARD OF MEDICAL EXAMINERS

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

8400.00

ACTIVE STATUS

Signature: .

NOTE: Have you signed both "signature" lines.

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

☐ INACTIVE STATUS 8150.00 ARE AUTOMATICALLY SUSPENDED FOR NON PAYMENT. ☐ RETIRED STATUS 8 50.00 NRS630 explanation of status on reverse side Robert A. GATLIN. MD 3201 S Maryland Pky #406 Las Vegas NV 89109-0000 Social Security # NAME Business Phone ( 702 737- 3200 5. Mary 89109 Parkway **华46**6 BUSINESS OR MAILING ADDRESS Suite N If you have retired or moved your practice, please indicate the location of BOARD OF CERTIFICATION former patient's records for the last 5 years below: AME Gun e cologi **ADDRESS** AM. Bd. of... Feb PHONE # ( Date of Certification or Recertification Gynecole 14 Specialties Obstetrics Primary Specialty (List only one). 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. · W.D · Signature: (No rubber stamps) SINCE YOUR <u>LAST</u> 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 J 4. Have you been denied a medical license or surrendered your license to practice in another jurisdiction or had your medical license or right to practice medicine revoked, suspended or limited in another jurisdiction 2. Have you been arrested, fined (over \$100), charged with or convicted of a crime, indicted, imprisoned or placed on probation? Yes \(\sigma\) No \(\mathbb{E}\) 5. Have you had staff privileges in a hospital denied, suspended, limite evoked or not renewed, or have you resigned from a medical staff in lie of disciplinary or administrative action, excluding failure to complete 3. Have you been investigated, arrested, charged or convicted for the possession, use of, or illegal sale or dispensing of controlled substances? medical records? 6. Have any malpractice settlements, awards or judgments been mad against you in any jurisdiction? Yes No [ Yes □ No 🖫 STAFF PRIVILEGES: List all Nevada Hospitals in which you have any staff privileges: (Name and Location) Hospital Medical Hosait 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)

(No rubber stamps)

# 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);

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)

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## **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

INACTIVE STATUS

RETIRED STATUS

\$320.00\square
\$150.00
\$ 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 #100 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			<del></del>
Street			W- PS-U
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 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.

ı.	Are you currently	y active in medic	ine?				
	a. ( ) YES, in	training.					
	b. (X) YES, wo	orking full-time.					
	c. ( ) YES, wo	orking part-time.					
	d. ( ) NO, reti	ired.					
	e. ( ) NO, oth	er (specify			)	•	
2.	Please indicate ye codes:	our primary, seco				t in each, using the following	g
	. ADOLDOODE ME	antonia	SPECIALTY	Y CODE:	DAIN MANACEMENT	72 PULMONARY DISEASES	
	1 ADOLESCENT ME 2 AEROSPACE ME 2 AEROSPACE ME 3 ALLERGY/IMMUN 4 ANESTHESIOLOG 5 BLOODBANKING 6 BRONCO-ESOPH 7 CARDIOVASC DIS 8 CATSCAN/ULTRA 9 CHILD NEUROLO 10 CHILD PSYCHIAT 11 CLINICAL PHARM 12 CRITICAL CARE 13 DERMATOLOGY 14 EMERGENCY ME 15 ENDOCRINOLOGY 16 FAMILY PRACTIC 17 GASTROENTEROI 18 GENERAL PRACTI 19 GERIATRICS 20 GYNECOLOGY 21 HEMATOLOGY 21 HEMATOLOGY 22 HYPNOSIS 23 IMMUNOLOGY 24 INFECTIOUS DISI	DICINE WOLOGY Y AGOLOGY SEASES SOUND GY RY LACOL DICINE Y E LOGY	48 OTOLOGY		PAIN MANAGEMENT PATHOLOGY PATHOLOGY, ANATOMIC PATHOLOGY, CLINICAL PATHOLOGY, FORENSIC PED, ALLERGY PED, CARDIOLOGY PED, ENDOCRINOLOGY PED, INTEMST/ONCOLOGY PED, INTENSIVIST PED, RADIOLOGY PED, PHYSIATRY PED, RADIOLOGY PED, UROLOGY PED, UROLOGY PED, UROLOGY PED, UROLOGY PED, UROLOGY PED, UROLOGY PED, ED, UROLOGY PED, UROLOGY PED, UROLOGY PED, ED, UROLOGY PED, UROLOGY PED	73 RADIOLOGY 74 RADIOLOGY, DIAGNOSTIC 75 RADIOLOGY, NUCLEAR 76 RADIOLOGY, THERAPEUT 77 RHEUMATOLOGY 78 SLEEP DISORDERS 80 SURGERY, ABDOMINAL 81 SURGERY, CARDIOVASC 82 SURGERY, CARDIOVASC 82 SURGERY, CARDIOVASC 83 SURGERY, HAND 85 SURGERY, HAND 85 SURGERY, HEAD/NECK 86 SURGERY, MEUROLOGICAL 88 SURGERY, NEUROLOGICAL 88 SURGERY, ORTHOPEDIC 89 SURGERY, TRAUMATIC 90 SURGERY, TRAUMATIC 91 SURGERY, UROLOGIC 91 SURGERY, UROLOGIC 93 SURGERY, VASCULAR 94 UROLOGY	
	<b>-</b>	2 <b>%</b>	95	Board (	zerunea (maicate res/	NOJ	1
	Primary	30	<u> </u>				
	Secondary	10	<u>J</u>		<del></del>		
	Tertiary				The state of the s		
	PLEASE INDICAT Board	re american b Obstetric	oard of medical spe	CIALTIE	S BOARD CERTIFICAT	ΠΟΝ:	
•	Hour many hours	ner week de ver	ı spend in each of the fol	iloudna o	otivitles?		
<b>y</b> .	<i>•</i> • • •	atient care or se	=	roung a			
	<del></del>		chools, agencies, associa	Hon eta	1		
			_	LOII, ELC.	,		
		eaching medical esearch	COUISCS				
						•	
	hours O	mer (specify				,	
<b>1</b> .	Form of employm	nent is <b>[002</b> . (C	Jse the following codes.)				
	SELF-EMPLOY 1001 Solo Practice	TED		1008	Federal Government (civilian P	.H.S., etc.)	
		Group Practitioners		1009 1010	State Government County Government		
	1003 Individual Prac			1011 1012	Local Government Other (specify		
	1005 Group Health I 1006 Other Non-Gov	Plan Facility (such as H. vernment Employer (hos nment (armed services p	pital, school, etc.)	<del>-</del>			

1	All of the following questions refer to the time period of <b>July 1, 1991, through the present date</b> on RESPONSES, PLEASE EXPLAIN ON A SEPARATE SHEET AND RETURN WITH THE RENEWAL APPLICATION.	ly. FOR AI ATION.	L YES
5	5. Have you been rejected for membership by any medical society?	Yes 🔾	No 🏲
. 6	6. Have you been denied a license to practice medicine?	Yes 🔾	No S
	'. Have you been denied staff membership with any licensed hospital, nursing home or other hospital care facility with an organized medical staff?	Yes 🔾	No Q
•	3. 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 🗽
g	Have you lost American Board certification because of disciplinary action?	Yes 🖸	No V
1	O. 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 □	
1	1. 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 S
1	2. 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 D
1	3. Have you been diagnosed or treated for any physical illness that would serve to hinder your ability to practice medicine?	Yes 🗆	No
1	4. Have you been diagnosed or treated for mental illness?	Yes 🖸	No D
	5. Have you been chemically dependent?	Yes 🔾	No 🔀
1	6. Have you interrupted your training because of illness or impairment?	Yes 🖸	Nova
1	7. Have you been unable to practice medicine because of illness or impairment?	Yes 🗅	No
1	8. 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
1	9. 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 🕽
	O. 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
	1. Have you been denied provider participation in any State Medicaid or Federal Medicare Program?	Yes 🗅	No
2	2. 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 Spring Hospital		
	Name Address		
	Women's Hospital		
	Name Address		
	St. Rose Pominican		
	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 registration immediately preceding the submission of the	residency or fellowship ar e application for bienni	ny time during the period al registration is exem	for biennial pt from the
requirements set forth in subsection 1.  3. If the holder of a license fails to submit evidence of his and in the manner prescribed by subsection 1, his license wi of medicine unless, within 2 years after the end of the biens (a) Pays a fee to the board which is twice the fee for biens are a considered.	ll not be renewed. Such a nial period of registration	person may not resume n, he:	the practice
630.290; (b) Submits to the board, in such form as it requires, evidereducation in addition to that otherwise required by subsect (c) Is found by the board to be otherwise qualified for active 630 of NRS.  (Added to NAC by Bd. of Medical Exam'rs, 7-31-85, eff. 8-	ion 1 or NAC 630.157; a status pursuant to the p	nd rovisions of this chapter	
PLEASE CHECK ONE OF THE FOLLOWING:			,
1. I have earned a minimum of 40 hours approved AM. July 1, 1991, through June 30, 1993.	A Category I continuing n	edical education (CME) f	or the period
2. I am exempt because I have completed a full year of registration immediately preceding the submission	n of this application.	raining during the period	l for biennial
3. I am exempt as I am applying for INACTIVE or RI	ETIRED status.		
Signature			
(SIGNATURE STAMP UNACCEPTABLE)		•	
IMPORTANT: ATTACH COPIES OF CER PROOF OF CME CREDITS	TIFICATES OF DECLAR WILL NOT BE RETURE	RED CME CREDITS	
Date of Birth: 1947 Social Securit	y Number:	-	
Dute of Different	AG 77876	35	
. •••	·		
Medical School: The George Washington	n University	Washington	D.C.
	City	~ · · · · ·	State
Internship: Cincinneti alniversity	Ved: col Center City	Cincin nati	(Jb '
	City		State
	\	_	State
Residency: The George Washington U		lashington, 1	State  State
Residency: The George Washington U	Iniversity City	_	).e.
Residency: The George Washington U		_	).e.
Residency: The George Washington U	City	_	State
Residency: The George Washington U	City	_	State State
	City  City  City  City  tion for renewal of license at I am the original and I am the I	se to practice medicine in	State  State  State  State  n the state of erson named
Fellowship:  I hereby certify that I am the person named in this application Nevada; that all statements I have made herein are true; the in the various documents and credentials furnished to the I HAVE HAVE NOT  ACTIVELY PRACTICED IN INTERIOR OF THE PRACTICED IN INTERIOR OF T	City  City  City  tion for renewal of licens at I am the original and leads to be a second to the connection with the connecti	se to practice medicine in awful possessor of and ph this renewal application	State  State  State  State  n the state of erson named on.
Fellowship:  I hereby certify that I am the person named in this application Nevada; that all statements I have made herein are true; the in the various documents and credentials furnished to the I HAVE HAVE NOT  ACTIVELY PRACTICED IN INTERIOR OF THE PRACTICED IN INTERIOR OF T	City  City  City  City  tion for renewal of licens at I am the original and I am the I	se to practice medicine in awful possessor of and ph this renewal application.  AST 12 MONTHS. (CHE	State  State  State  State  n the state of erson named on.
Fellowship:  I hereby certify that I am the person named in this applicate Nevada; that all statements I have made herein are true; the in the various documents and credentials furnished to the	City  City  City  City  tion for renewal of licens at I am the original and I am the I	se to practice medicine in awful possessor of and ph this renewal application	State  State  State  State  n the state of erson named on.

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



. 1	Post Office Box 7238 Reno, Nevada 89510 Phone (702) 688-255	59	gillolden in	San
	creby apply for renewal of biennial registration and	i enclose the appro	priate fees as	indicated below:
	ACTIVE STATUS \$420 INACTIVE STATUS \$150 (see attached NRS 6 RETIRED STATUS \$ 50 (see attached NRS 6 P.A. SUPERVISING PHYSICIAN \$200	330.255 & 630.25 <b>7</b> )	DELICE NOT BE	NEVADA HAS NO GRACE PERIC LICENSES NOT RENEWED BY JU 1, 1995 ARE AUTOMATICALLY SI PENDED FOR NON-PAYMENT.
	Robert A. Gatlin, MD		7	
	2080 E Flamingo Rd #100 Las Vegas NV 89119-0000	1		
	INSTRUCTIONS	- TYPE OR PR	INT LEGI	BLY
1.	YOUR CURRENT M.D. LICENSE EXPIRES ON	JUNE 30, 1995.	тніѕ іѕ тні	NOTICE TO RENEW YOUR M
0	LICENSE.  To be eligible to act as a supervising physici	ian for a nhysicia	n aggigtant	complete the enclosed Appli
2.	tion for Approval as Supervising Physician for		n assistant,	complete the cholosed Appn
3.	ACTIVE STATUS REGISTRATION RENEWAL	REQUIRES THE		
	CATEGORY I, CONTINUING MEDICAL EDUCA Submit your proof of CME with your comple			
_	In order to provide sufficient time for process	seu Application i ssing, please com	ol Registrati	turn your Application for Res
	tration Renewal form and Application for Ap	proval as Supervi	sing Physic	an form (if applicable) with yo
	proof of 40 hours AMA Category I CME and t			JULY 1, 1995. Use the enclos
ĸ	self-addressed envelope to return your comp If your name and/or address has changed from	pleted form(s) and m that printed on	1 iee(s). this form, c	early indicate that change in t
<b>J</b> .	space provided. A notarized or certified cop			
	license, divorce decree, etc.) must be includ	ed.		
	Nama			
	Name			
	Street			
	au /	_	4-4-	Tin Code
	City County	s	tate	Zip Code
6.	IF YOU HAVE RETIRED OR MOVED YOUR I PATIENT RECORDS BELOW:	PRACTICE, PLEA	SE INDICAT	TE THE LOCATION OF FORM
	Name			
	Street			
	Succi			
	City County /	· e	tota	7in 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. ( > ) YES, working full-time. c. ( ) YES, working part-time. d. ( ) NO, retired. e. ( ) NO, other (specify	?	~					(
2.	Please indicate your primary, second codes.	ary and tertiary	specialt	ies and perce	nt of time spent	in ea	ch, usi	ng the following
		SPEC	IALTY (	CODE:				
1	ADOLESCENT MEDICINE	35 NEUF	CORADIOL	OGY		64	PED. UR	OLOGY
2	AEROSPACE MEDICINE	36 NUCL	EAR MED			65	PEDIATE	RICS
3	ALLERGY / IMMUNOLOGY ANESTHESIOLOGY		union Terric / c	YNECOLOGY				al med / rehab An assistant
5	BLOODBANKING	(39) OBS1	ETRICS					TIVE MED
6	BRONCO-ESOPHAGOLOGY	40 OCCU	<b>IPATIONA</b>	L MED			PSYCHI/	
7 8			LOGY O	NECOLOGIC				Analysis Matic Medicine
9	CHILD NEUROLOGY			MATOLOGY			PUBLIC	
10		43 ONCC				72	PULMON	VARY DISEASES
12	CLINICAL PHARMACOL CRITICAL CARB		DLOGY, SU THALMOL			73 74	RADIOL	ogy ogy, diagnostic
	DERMATOLOGY	47 OTOL				75	RADIOL	OGY, NUCLEAR
	EMERGENCY MEDICINE ENDOCRINOLOGY	48 OTOL 49 PAIN	OGY MANAGEI	/#****		76	RADIOL	OGY, THERAPEUT
16	PAMILY PRACTICE		MARAGE! OLOGY	HEVI.			RHEUMA	
	GASTROENTEROLOGY	51 PATH	OLOGY, A			79	SLEEP I	SORDERS
18 19	General Practice Geriatrics	52 PATH 53 PATH				100		MEDICINE Y, ABDOMINAL
20)	GYNECOLOGY	54 PED,				81		Y. CARDIOVASC
27 22	HEMATOLOGY HYPNOGIS	55 PED,				91		Y, COLON/RECTAL
	IMMUNOLOGY	99 PED, 97 PED, 1				82 83		Y, GENERAL Y. HAND
24	INFECTIOUS DISEASES	56 PED,	ENDOCRE	NOLOGY		84	SURGER	Y, HEAD/NECK
25 26	INFERTILITY INTERNAL MEDICINE	57 PED, 1 58 PED, 1		ONCOLOGY		92 93	SURGER	Y, MAXILLOFAC
27	LARYNGOLOGY	59 PED,				85	SURGER	Y, NEUROLOGICAL Y, ORTHOPEDIC
28	LEGAL MEDICINE	60 PED,	NEPHROL	OGY			Surger	Y, PLASTIC
	MATERNAL / FETAL MED NEO / PERINATAL MED	98 PED, 1 101 PED, 0				87 88		Y, THORACIC Y, TRAUMATIC
31	Neoplastic diseases	61 PED,				89		Y, UROLOGIC
32 33	NEPHROLOGY NEUROLOGY	96 PED, 1				90	SURGER	y, vascular 🥤
34	NEUROPATHOLOGY	62 PED. 1 63 PED. 1				94	UROLOG	Y.
				•				
		Code	Pe	rcent of Time	Board	Cert		dicate Yes/No)
Pri	imary	<u>38</u>		100%			yes	·
Se	condary							
	•			<del></del>		_		
161	rtiary							
	PLEASE INDICATE AMERICAN  and American Board of			`		lection	Date of	Last Recertification
	·		•	W	(Mo.Yr.)			(Mo-Yr)
G1	Lhand						•	
ou!	bboard				(Mo-Yr.)			(Mo/Yr.)
								(20/1/)
	How many hours per week do you sp	end in each of t	he follo	wing activities	1?			
6	5 hours Patient care or services							
	hours Administration (schools,	agencies, assoc	iations	etc.)				
	hours Teaching medical course	•		, ====,				
	hours Research	_						
								_
	hours Other (specify						-	)
4.	Form of employment is 1001.	Use the following	g codes.	.)				
	SELF-EMPLOYED				<del></del>		_	
	1001 Solo Practice	lonoss	1006	Otner Non-G	overnment Emp	loye	r (hospit	al, school, et
	1002 Partnership or Group Practiti	MUCIS	1007					rsonnel only
	SALARIED, EMPLOYED BY		1008 1009	State Govern	ernment (civilis	n, P.	n.3., etc	E. <b>,</b>
	1003 Individual Practitioner		1010	County Gov				
	1004 Partnership or Group of Prac	titioners	1010	Local Gover	nment			
	1005 Group Health Plan Facility (s		1012	Other (speci				1
				,-,-				

# AH 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 acactice 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 légitimate 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.
- "Hiegal 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 acc	ordance with the terms of the loan, any	direct loan or loan which is insured or guaran	leed by the Federa	1				
	Government or a state or local	government which you received to finan	ce all or any part of your medical education?		☐ Yes	No			
2.	Do you have a medical condition	a which in any way impairs or limits yo	ur ability to practice medicine with reasonable	skill and safety?	☐ Yes	No			
3.	Does your use of chemical sub	stance(s) in any way impair or limit you	r ability to practice medicine with reasonable s	kili 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?  5. Have you been diagnosed as having, or have you been treated for pedophilia, exhibitionism, or voyeurism?									
									6.
7.	Have you been a defendant in a	legal action involving professional liabi	llity (maipractice) or had a professional liability	ciaim paid in 🗸	1	-			
• • •	your behalf or paid such a clais				Yes	O No			
8.			olo contendere to a violation of any federal, sta	te or local	~				
		, distribution, prescribing, or dispensin			🛚 Yes	No			
9.	Have you been arrested, investi	gated for, charged with or convicted of,	or pled nolo contendere to any offense, misder	neanor or	•	-			
•	felony in any state, the United		•		O Yes	No			
	Have you previously applied for	medical licensure in Nevada (including	a residency program)?		TYes	□ No			
U	Have you failed to taillate the p	erformance of public service within one	year after the date the public service is requir	ed to begin to	•				
	satisfy a requirement of your re	celving a loan or scholarship from the i	lederal government or a state or local governm	ent for your					
	medical education?			•	☐ Yes	No			
12.	Have you been denied a license	, permission to practice medicine or an	y other healing arts, or permission to take an			•			
	examination to practice medici	ne or any other healing arts in any state	e, country or U.S. territory?		🔾 Yes	D'No			
13.	Have you had a medical license	revoked, suspended, limited, or restric	ted in any state, country or U.S. territory?		O Yes	Mo			
14.	Have you voluntarily surrender	ed a license to practice in the healing as	rts in any state, country or U.S. territory?		Q Yes	No No			
15.	Have you been denied members	thip or expelled from a medical society	or other professional medical organization?		☐ Yes	galo			
16.	List all hospitals where you have	re had staff privileges denied, suspende	d, limited, revoked or not renewed by the hosp	ital. List any and					
	all regions floor from any medic	eal staff in lieu of disciplinary or admini	strative action. (Please Note: Do not include st	spensions or					
	restrictions for failure to compl	ete hospital medical records, attend hos	pital department or staff meetings, or maintain	required malpract	ice insu	rance.)			
	•	Mailing	Type of	Dates of A					
	Hospital	Address	Action	From (Mo./Yr.)	To (Mo./	YE)			
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_		about with a consisted of any state	tion of a statute, rule or regulation governing t	a acachica of					
17.	HAVE YOU DEER INVESTIGATED FOR	CHARGON WITH, OF CONVICTION OF ANY VIOLEN	recommended and the or other edenous?	in historica or	O Yes	PNo			
	medicine by any medical licens	sing board, hospital, medical society, go	vernmental entity of other agency (		Q Yes	T			
18.	Have you surrendered your sta	te or sederal controlled anderrace tellar	tration or had it revoked or restricted in any w	y.	₩ 148	X			

#### 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

(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 Lisison 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 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 blennial 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 STAME 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 X 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 6-14-95 X
Business Telephone 8 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 blennial 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)

630.255 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 12 consecutive months must be placed on inactive status.
  - 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)

630.256 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)

630.257 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		
APPLICATION FOR RENEWAL REGISTRATION		4144	License N	lo
NEVADA STATE BOARD OF		JUN 16 1997		
MEDICAL EXAMINERS	2550	(Penni Line Onto)	File N	lo
ost Office Box 7238 Reno, Nevada 89510 Phone (702) 688	-2009	(Board Use Only)		
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Robert A. Gatlin, MD 2110 E Flamingo Rd #202 Las Vegas NV 89	9119	NEVADA STATE BO	checks payable to: ARD OF MEDICA must indicate "U.S. Ft	
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YOUR LICENSE REGISTRATION WILL NOT BE RENEWED WITHOUT SUBMISSION OF THE CORRECT FEE(S),

\_\_\_\_State\_

\_\_\_County\_\_\_

\_\_\_\_Zip\_\_

PROPERLY COMPLETED FORM(S) AND PROOF OF 40 HOURS OF AMA CATEGORY I, CME'S

<u>ALL</u> PAGES OF THE FORM(S) MUST BE COMPLETED AND RETURNED

**ALL FEES ARE NON-REFUNDABLE** 

DO NOT SEND CASH THROUGH THE MAIL

	a. ( c. (	: :	YES, in training. YES, working part-time	_	.[ <b>'</b> ] .[	•	YES, working full-ti NO, retired.	me			
	е.	: :	NO, other (specify	· · · · · · · · · · · · · · · · · · ·					)		
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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. Are you currently active in medicine?

- 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.
- "Currentty" 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	
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 received because of the field of practice, the setting, or the manner in which you have chosen to practice?	duced or ameliorated
If you use chemical substances, does your use of chemical substance(s) in any way impair or limit your ability to practice medicine and safety?	with reasonable skillNoN/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 of your receiving a loan or scholarship from the federal government or a state or local government for your medical education?	satisfy a requirementYesNo
5. Have you been a defendant in a legal action involving professional liability (malpractice) or had a professional liability claim paid such a claim yourself?	in your behalf or paid YesNo
6. Have you ever been investigated for, charged with, convicted of, or plead guilty or noto contendere to, any offense and altitude and local law, including any foreign country, which is a misdemeanor, gross misdemeanor, or felony, excluding any minor traffic offense of a motor vehicle while under the influence of any substance is not considered a minor traffic offense) or which is related to the many prescribing, or dispensing of controlled substances?	(Driving or in control
7. Have you ever been denied a license, permission to practice medicine or any other healing arts, or permission to take an examination or any other healing arts in any state, country or U.S. territory?	n to practice medicine YesNo
8. Have you ever had a medical license revoked, suspended, limited, or restricted in any state, country or U.S. territory?	YesNo
9. Have you ever voluntarily surrendered a license to practice a healing art in any state, country or U.S. territory?	YesNo
10. Have you ever been denied membership or expelled from a medical society or other professional medical organization?	YesNo
11. Have you ever been investigated for, charged with, or convicted of any violation of a statute, rule or regulation governing the pranty medical licensing board, hospital, medical society, governmental entity or other agency?	ractice of medicine by YesNo
12. Have you ever surrendered your state or federal controlled substance registration or had it revoked or restricted in any way?	YesNo
medical records, attend hospital department or staff meetings, or maintain required malpractice insurance).	
Mailing Type of Dates of Action Hospital Address Action From (Mo./Yr.) To (Mo./Yr.)	
The Man To Man Man	
The Man To Man Man	
Hospital Address Action From (Mo./Yr.) To (Mo./Yr.)	
Hospital Address Action From (Mo./Yr.) To (Mo./Yr.)  If more space is needed, attach separate sheet.	d July 1, 1995, through
Hospital Address Action From (Mo./Yr.) To (Mo./Yr.)  If more space is needed, attach separate sheet.  PLEASE CHECK ONE OF THE FOLLOWING:  I have earned a minimum of 40 hours approved AMA Category I continuing medical education (CME) for the biennial period 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.	
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Hospital Address Action From (Mo./Yr.) To (Mo./Yr.)  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 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.  3. I was initially licensed in Nevada during the third six months of the biennial period July 1, 1995, through June 30, 1997.  3. I was initially licensed in Nevada during the third six months of the biennial period July 1, 1995, through June 30, 1997.	97 and have earned a
Hospital Address Action From (Mo./Yr.) To (Mo./Yr.)  If more space is needed, attach separate sheet.  PLEASE CHECK ONE OF THE FOLLOWING:  I have earned a minimum of 40 hours approved AMA Category I continuing medical education (CME) for the biennial period 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.  3. I was initially licensed in Nevada during the third six months of the biennial period July 1, 1995, through June 30, 1997.  4. I was initially licensed in Nevada during the fourth six months of the biennial period July 1, 1995, through June 30, 1997.  4. I was initially licensed in Nevada during the fourth six months of the biennial period July 1, 1995, through June 3, 1997.	97 and have earned a 97 and have earned a 97 and have earned 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 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, 199 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, 199 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, 199 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 residence during the biennial period July 1, 1995, through June 30, 1997.	97 and have earned a 97 and have earned a 97 and have earned a
Hospital Address Action From (Mo./Yr.) To (Mo./Yr.)  If more space is needed, attach separate sheet.  PLEASE CHECK ONE OF THE FOLLOWING:  I have earned a minimum of 40 hours approved AMA Category I continuing medical education (CME) for the blennial period June 30, 1997.  2. I was initially licensed in Nevada during the second six months of the blennial period July 1, 1995, through June 30, 1991 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 blennial period July 1, 1995, through June 30, 1991 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 blennial period July 1, 1995, through June 3, 1991 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 residence during the blennial period July 1, 1995, through June 30, 1997.	97 and have earned a 97 and have earned a 97 and have earned a
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Hospital Address Action From (Mo./Yr.) To (Mo./Yr.)  If more space is needed, attach separate sheet.  PUEASE CHECK ONE OF THE FOLLOWING:  I have earned a minimum of 40 hours approved AMA Category I continuing medical education (CME) for the blennial period June 30, 1997.  2. I was initially licensed in Nevada during the second six months of the blennial period July 1, 1995, through June 30, 199 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 blennial period July 1, 1995, through June 30, 199 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 blennial period July 1, 1995, through June 3, 199 minimum of 10 hours approved AMA Category I continuing medical education (CME).  5. I am exempt from submitting proof of continuing medical education (CME).  Signature  Signature stamp unacceptable  IMPORTANT: ATTACH COPIES OF PROOF OF DECLARED CME CREDITS. PROOF OF CME CREDITS WILL IN HAVE AND 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 LICENSE TO PRACTICE MEDICINE IN THE STATE OF NEVADA AND THAT ALL STATEMENTS I HAVE	97 and have earned a 98 or fellowship training NOT BE RETURNED.

	Date Rece	ived by	Board
PHYSICIAN APPLICATION FOR RENEWAL REGISTRATION			License No
NEVADA STATE BOARD OF	JUN 2 3 Y	999	
MEDICAL EXAMINERS			File No
Post Office Box 7238 Reno, Nevada 89510 Phone (775) 688-2559 ereby apply for renewal of biennial registration and enclos	(Board Use Only	e fee(s)	as indicated below:
ACTIVE STATUS	\$600.00	(.,	
INACTIVE STATUS	\$200.00	_	
RETIRED STATUS	\$ 50.00	F	
SUPERVISING/COLLABORATING PHYSICIAN	\$200.00		
		м	ake checks payable to:
Robert A. Gatlin, MD	NEVADA :	STATE	BOARD OF MEDICAL EXAMINERS
Flaming Da Hoss		eign che	cks must indicate "U.S. FUNDS")
Las Vegas Nu corre		1	
NV 89119			
		: OT D	ENEWED BY IIII V 4 4000
NEVADA HAS NO GRACE PERIOD	LICENSES.		ENEVED DI JULI I, 1999 I DAVMENT
ARE AUTOMATICALLY SUS			
EXTENSIONS OF TIME ARE N			
YOUR LICENSE WILL NOT BE RENEWED	WITHOUT A	15WE	KING ALL QUESTIONS.
ALL YES ANSWERS			
YOU MUST INCLUDE PROOF OF 40 HOURS	S OF AMA CA	TEGC	RY 1 CME WHICH INCLUDES
2 HOURS IN MEDICAL ETHICS AND 20 HOURS	S IN YOUR SO	COPE	OF PRACTICE OR SPECIALTY
ALL FEES MUST BE PAID	AND ARE NO	N-RE	FUNDABLE.
DO NOT SEND CAS	H THROUGH	THE	MAIL.
PLEASE ALLOW SIXTY (60) DAYS FO			
PLEASE TYPE			
1. YOUR CURRENT M.D. LICENSE EXPIRES ON JUN LICENSE.	NE 30, 1999. T	HIS IS	THE NOTICE TO RENEW YOUR M.D
2. To be eligible to act as a supervising physician for a physician for a physician for a physician of nursing, complete the enclosed Application for	sician's assistant or Approval as S	, or as a upervisi	collaborating physician for an advanced ng/Collaborating Physician.
3. ACTIVE STATUS REGISTRATION RENEWAL REQU CATEGORY 1 CONTINUING MEDICAL EDUCATION which of practice or specialty completed during the period July 1, 1 completed Application for Registration Renewal form.	ch includes 2 hou	urs of m	edical ethics and 20 hours in your scop
4. In order to provide sufficient time for processing, please co		n vour l	Application for Posistration Renowal for
and Application for Approval as Supervising/Collaborating Category I CME and the correct fee(s) BY JUNE 30, 19 completed form(s) and fee(s).	ı Physician form	(if appl	icable) with your proof of 40 hours AMA
and Application for Approval as Supervising/Collaborating Category I CME and the correct fee(s) BY JUNE 30, 19	y Physician form 199. `Use the el ed on this form, «	if appl) nciosed clearly ir	icable) with your proof of 40 hours AM, self-addressed envelope to return you ndicate the change in the space provided
and Application for Approval as Supervising/Collaborating Category I CME and the correct fee(s) BY JUNE 30, 19 completed form(s) and fee(s).  5. If your name and/or address has changed from that printe A notarized or certified copy of the document authorizing you included.	y Physician form 199. `Use the el ed on this form, «	if appl) nciosed clearly ir	icable) with your proof of 40 hours AM, self-addressed envelope to return you ndicate the change in the space provided
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and Application for Approval as Supervising/Collaborating Category I CME and the correct fee(s) BY JUNE 30, 19 completed form(s) and fee(s).  5. If your name and/or address has changed from that printed A notarized or certified copy of the document authorizing you included.  Name Robert A. Getlin, A.D.  Street 1701 Green Valley Park was	ed on this form, our name change	if appl) nciosed clearly ir	self-addressed envelope to return you ndicate the change in the space provided age license, divorce decree, etc.) must be specified by the space provided age license.
and Application for Approval as Supervising/Collaborating Category I CME and the correct fee(s) BY JUNE 30, 19 completed form(s) and fee(s).  5. If your name and/or address has changed from that printe A notarized or certified copy of the document authorizing you included.  Name Robert A. Gettin A.D.	p Physician form 199. `Use the en ed on this form, o our name change	(if appl nclosed clearly ir (marris	icable) with your proof of 40 hours AM self-addressed envelope to return you ndicate the change in the space provide
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and Application for Approval as Supervising/Collaborating Category I CME and the correct fee(s) BY JUNE 30, 19 completed form(s) and fee(s).  5. If your name and/or address has changed from that printed A notarized or certified copy of the document authorizing you included.  Name  Robert A. Getlin M.D.  Street 170   Green Valley Park was City Henderson County Clark  3. IF YOU HAVE RETIRED OR MOVED YOUR PRACTICE,	ed on this form, our name change	(if appl nclosed clearly in (marria	self-addressed envelope to return you ndicate the change in the space provided age license, divorce decree, etc.) must be space provided by the space prov
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7. Are you currently active in m	edicine?		•		
a. [ ] YES, in trainir		b.[X]	YES, working full-tin	ne	<b>`-</b>
c. [ ] YES, working		d.[ ]	NO, retired.		
e.[ ] NO, other (sp			· · · · · · · · · · · · · · · · · · ·		)
	<del>-</del>				
8. Please indicate your prima	ıry, secondai	y and tertiary	specialties and perce	ent of practice time spe	nt in each, using the
following codes:			E OF PRACTICE		
		SPEC	CIALTY CODES		
102 ADDICTION MEDICINE	31	NEOPLASTIC I	DISEASES	62 PEDIATRIC, RADIO	LOGY
1 ADOLESCENT MEDICINE		NEPHROLOGY		63 PEDIATRIC, SURGI	
2 AEROSPACE MEDICINE		NEUROLOGY		64 PEDIATRIC, UROLO	OGY .
3 ALLERGY/IMMUNOLOGY		NEUROPATHO		65 PEDIATRICS	IE/DELIADII ITATIĞLI
104 ALTERNATIVE MEDICINE 4 ANESTHESIOLOGY		NEURORADIO NUCLEAR MEI		66 PHYSICAL MEDICIN 67 PREVENTIVE MEDI	
5 BLOODBANKING		NUTRITION	JIOII1E	68 PSYCHIATRY	
6 BRONCO-ESOPHAGOLOGY	38	OBSTETRICS/	GYNECOLOGY	69 PSYCHOANALYSIS	
7 CARDIOVASCULAR DISEASES		OBSTETRICS		70 PSYCHOMATIC ME	DICINE
8 CATSCAN/ULTRASOUND 9 CHILD NEUROLOGY		OCCUPATION ONCOLOGY	AL MEDICINE	71 PUBLIC HEALTH 72 PULMONARY DISE	ACEC
10 CHILD PSYCHIATRY			SYNECOLOGICAL	73 RADIOLOGY	101.0
11 CLINICAL PHARMACOLOGY	42	ONCOLOGY, H	SYNECOLOGICAL HEMATOLOGY RADIATION	74 RADIOLOGY, DIAG	NOSTIC
12 CRITICAL CARE				75 RADIOLOGY, NUCL	.EAR
13 DERMATOLOGY		ONCOLOGY, S	BURGICAL	76 RADIOLOGY, THER	APEUTIC
14 EMERGENCY MEDICINE 15 ENDOCRINOLOGY		OPHTHALMOL OTOLARYNGO		77 RHEUMATOLOGY 78 RHINOLOGY	•
16 FAMILY PRACTICE	48		,	79 SLEEP DISORDERS	3
17 GASTROENTEROLOGY		PAIN MANAGE	MENT	100 SPORTS MEDICINE	
18 GENERAL PRACTICE		PATHOLOGY		80 SURGERY, ABDOM	
19 GERIATRICS		PATHOLOGY,		103 SURGERY, CARDIO	THORACIC
20 GYNECOLOGY 21 HEMATOLOGY		PATHOLOGY, PATHOLOGY,		81 SURGERY, CARDIC 91 SURGERY, COLON	
105 HOMEOPATHY		PEDIATRIC, A		82 SURGERY, GENER	
22 HYPNOSIS	55	PEDIATRIC, CA	ARDIOLOGY	83 SURGERY, HAND	
23 IMMUNOLOGY	99	PEDIATRIC, C	RITICAL CARE	84 SURGERY, HEAD/N	
24 INFECTIOUS DISEASES	97 50	PEDIATRIC, EI	MERGENCY MEDICINE	92 SURGERY, MAXILL	
25 INFERTILITY 26 INTERNAL MEDICINE			NDOCRINOLOGY EMATOLOGY/ONCOLOGY	93 SURGERY, NEURO 85 SURGERY, ORTHO	
27 LARYNGOLOGY			IFECTIOUS DISEASES	86 SURGERY, PLASTI	
28 LEGAL MEDICINE	59	PEDIATRIC, IN	ITENSIVIST	87 SURGERY, THORA	CIC
29 MATERNAL/FETAL MEDICINE	60	PEDIATRIC, N	EPHROLOGY	88 SURGERY, TRAUM	ATIC .
106 MEDICAL ACUPUNCTURE		PEDIATRIC, NI		89 SURGERY, UROLO	
107 MEDICAL ETHICS 30 NEO/PERINATAL MEDICINE	101 61	PEDIATRIC, DI	PHTHALMOLOGY Hysiatry	90 SURGERY, VASCU 94 UROLOGY	LAK
		PEDIATRIC, PI		o. oo.	
	Code 38		of Time	Board Certified (Indic	cate Yes/No)
Primary	38		<u>o                                      </u>	<u>Yes</u>	<u> </u>
Secondary					
Tertiary					
			<del> </del>		
PLEASE INDICATE ALL AMEI	RICAN BOA	RD OF MEDIC	CAL SPECIALTIES B	OARD OR SUBBOARD	CERTIFICATIONS:
,				Date of	Date of
,			In	itial Certification	Last Certification
Board Anner: can Be	and of	Obstetu	ice A	02/1980	
Double Market	6	~		(Mo./Yr.)	(Mo./Yr.)
Subboard		byneu	999	(11104111)	(11102111)
Cubboaid			<del>- 4 /</del>	(Mo./Yr.)	(Mo/Yr.)
Board				(110311.)	(1110/11.)
Duaru				(Mo./Yr.)	(Mo./Yr.)
Subboard				(1410311.)	(110311.)
Subboalu				(Mo./Yr.)	(Mo./Yr.)
				(.11.0.011.)	(111.711.)
0 Form of ampleument is	1001	(Lle	one of the following	andas \	
9. Form of employment is SELF-EMPLOYED:		<i>(</i> USI		Codes.) MPLOYED BY: (continu	uad)
1001 Solo Practice	D			overnment Employer (h	
1002 Partnership or Group				rnment (armed services	
SALARIED, EMPLOYE				rnment (civilian, P.H.S.,	etc.)
1003 Individual Practitione			1009 State Governm		
1004 Partnership or Group			1010 County Gover		
1005 Group Health Plan F	acility (such a	as H.M.O.)	1011 Local Govern	ment	
	• •				
	Other (spec	_			

# '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

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

13. List all hospitals where you have had staff privileges denied, suspended, limited, revoked or not renewed by the hos List any and all resignations from any medical staff in lieu of disciplinary or administrative action. (Please Note: Do not inc suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff insetting maintain required malpractice insurance).  Mailing Type of Dates of Action From (Mo./Yr.) To (Mo./Yr.) Hospital Address Action From (Mo./Yr.) To (Mo./Yr.) To (Mo./Yr.) Hospital Address Action From (Mo./Yr.) To (Mo./Yr.) To (Mo./Yr.) 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 a lam subject to a court order for the support of one or more children and am NOT in compliance with the order 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 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 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 plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount or pursuant to the order.  Signature (SIGNATURE STAMP UNACCEPTABLE)  **QLEASE CHECK ONE OF THE FOLLOWING:  **QLEASE CHECK ONE OF THE FOLLOWING:  **QLEASE CHECK ONE OF THE FOLLOWING:  **QLIANGER STAMP UNACCEPTABLE}**  **QLIANGER STAMP UNACCEPTABLE**  **QLIANGER STAMP UN	12. Have you ever surre	endered vour state or fede	eral controlled substance red	istration or had it roughed on restricted in
Last any sind all respansions from any medical staff in lieu of disciplinary or administrative action. (Please Note: Do not included in the control of the c	way?	,	conduited babblance reg	YesYes
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DINGGLAN		
PHYSICIAN APPLICATION FOR REGISTRATION RENEWAL	Date Received by Board	License No. 343Le
FOR THE BIENNIAL REGISTRATION PERIOD 2001-2003	JUN 2 6 2001	License No.
NEVADA STATE BOARD OF MEDICAL EXAMINERS Post Office Box 7238 Reno, Nevada 89510 Phone (775) 688-2559		File No
I hereby apply for renewal of biennial registration and enclose t	(For Board Use Only) the appropriate fee(s) as indi	cated below:
INACTIVE STATUS	\$600.00 <b>(RETIRED</b> ST	ATUS REQUIRES THAT THE
RETIRED STATUS	, , , , , , , , , , , , , , , , , , , ,	NOT PRACTICE MEDICINE
SUPERVISING/COLLABORATING PHYSICIAN	\$200.00 <u>ANYWHERE</u>	
Robert A GATLIN M.I	D. Make	. checks payable to:
1701 Green Valley Pkwy Bldg 3 #B	NEVADA STATE BO	ARD OF MEDICAL EXAMINERS
Henderson, NV 89014	(Foreign checks	s must indicate "U.S. FUNDS")
PLEASE NOTE:  YOUR CURRENT M.D. LICENSE EXPIRES ON JUNE 30, RENEWAL FORMS NOT RECEIVED AT THE BOARD OF SUSPENDED FOR NON-PAYMENT. EXTENSIONS OF THAS NO GRACE PERIOD. (USE THE ENCLOSED ENVEREGISTRATION RENEWAL FORM.)  YOUR LICENSE WILL NOT BE RENEWED UNLESS YOUR REGISTRATION RENEWAL FORM. YOU MUST PROVID ANSWERED "YES."  ALL INFORMATION YOU PROVIDE ON THIS APPLICATION INFORMATION.  PLEASE TYPE OF  1. To be eligible to act as a SUPERVISING PHYSICIAN FOR PHYSICIAN FOR AN ADVANCED PRACTITIONER OF NURSING YOU must complete the enclosed Application for Approval as payment in the amount of \$200.00 in the enclosed envelope.  2. Active status registration renewal requires the submission of predical education (CME), which includes 2 hours of CME in mespecially completed during the period July 1, 1999 through a your completed Application for Registration Renewal form. (See 3. If your name and/or address has changed from that printed on provided below. Also, please indicate your current telephone and document authorizing your convent to the provided below. Also, please indicate your current telephone and document authorizing your convent to the provided below. Also, please indicate your current telephone and document authorizing your convent authorizing your convent authorizing your convent authorizing your convent authorizing your current telephone and document authorizing your convent authorizing your conven	INCE BY JULY 1, 2001 AT 5 IME ARE NOT ALLOWED F ILOPE TO MAIL YOUR CON JANSWER ALL QUESTION DE WRITTEN EXPLANATION ON FOR REGISTRATION R R PRINT LEGIBLY A PHYSICIAN ASSISTANT, NG for the biennial period of J Supervising/Collaborating Proof of completion of 40 hou odical ethics and 20 hours of June 30, 2001. Submit your e last page of this form, clearly of the label on this form, clearly	coo P.M. ARE AUTOMATICALLY OR ANY REASON, AS NEVADA IPLETED APPLICATION FOR SON THIS APPLICATION FOR SON THIS APPLICATION FOR SON THIS APPLICATION FOR SON ALL QUESTIONS  ENEWAL FORM IS PUBLIC  and/or as a COLLABORATING uly 1, 2001 through June 30, 2003, Physician and return it with your lines of AMA Category 1 continuing CME in the space of completion of CME with ME statement.)  y indicate the change in the space a notarized or certified corporation.
document authorizing your name change (marriage license, dive	orce decree, etc.) must be in	cluded.]
Name		
Street		
City County	State	Zip
Phone Number Fax Num	ber	
4. IF YOU HAVE RETIRED OR MOVED YOUR PRACTICE, ind		
Name		
Street		
CityCounty	State	7in
Phone Number		
5. Indicate below the <b>EXACT NAME AND LOCATION</b> of the Med of graduation:	lical School from which you g	raduated and your EXACT DATE
Medical School Name and Location	Date of Grad	duation (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	40	NEUROLOGY	79	
2	ADOLESCENT MEDICINE	41	NEURO-OPHTHALMOLOGY	80	PEDIATRICS .
3	AEROSPACE MEDICINE	42	NEUROPATHOLOGY	81	• • • • • • • • • •
4	ALLERGY	43	NEURORADIOLOGY	82	PREVENTIVE MEDICINE
5	ALLERGY/IMMUNOLOGY	44	NON-CONVENTIONAL MEDICINE	83	
6	ANESTHESIOLOGY	45	NUCLEAR MEDICINE	84	PSYCHOANALYSIS
7	BLOODBANKING	46	NUTRITION	85	PSYCHOMATIC MEDICINE
8	BRONCO-ESOPHAGOLOGY	47	OBSTETRICS	86	PUBLIC HEALTH
9	CARDIOVASCULAR DISEASES	48	OBSTETRICS/GYNECOLOGY	87	
10	CATSCAN/ULTRASOUND	49	OCCUPATIONAL MEDICINE	88	
11	CHILD NEUROLOGY	50	ONCOLOGY	89	RADIOLOGY, DIAGNOSTIC
12	CHILD PSYCHIATRY	51	ONCOLOGY, GYNECOLOGICAL	90	RADIOLOGY, INTERVENTIONAL
13	CLINICAL PHARMACOLOGY	52	ONCOLOGY, HEMATOLOGY	91	
14	CRITICAL CARE	53	ONCOLOGY, RADIATION		RADIOLOGY, THERAPEUTIC
15	DERMATOLOGY	54	ONCOLOGY, SURGICAL	93	RADIOLOGY, VASCULAR
16	DERMATOPATHOLOGY	55	OPHTHALMOLOGY	94	
17	EMERGENCY MEDICINE	56	OTOLARYNGOLOGY		RHINOLOGY
18	ENDOCRINOLOGY	57	OTOLOGY	96	SLEEP DISORDERS
19	FAMILY PRACTICE	58	PAIN MANAGEMENT	97	
20	GASTROENTEROLOGY	59	PATHOLOGY	98	
21	GENERAL PRACTICE	60	PATHOLOGY, ANATOMIC	99	= = : : = = : : · •
22	GERIATRICS	61	PATHOLOGY, CLINICAL		SURGERY, CARDIOVASCULAR
23	GYNECOLOGY	62	* * * * * * * * * * * * * * * * * * * *		SURGERY, COLON/RECTAL
24	HEMATOLOGY	63	PEDIATRIC, ALLERGY		SURGERY, GENERAL .
25	HOMEOPATHY	64	PEDIATRIC, CARDIOLOGY	103	
26	HYPNOSIS	65	PEDIATRIC, CRITICAL CARE		SURGERY, HEAD/NECK
27	IMMUNOLOGY	66	PEDIATRIC, EMERGENCY MEDICINE		SURGERY, MAXILLOFACIAL
28	INFECTIOUS DISEASES	67	PEDIATRIC, ENDOCRINOLOGY		SURGERY, NEUROLOGICAL
29	INFERTILITY	68	PEDIATRIC, GASTROENTEROLOGY	107	SURGERY, ORTHOPEDIC
30	INTERNAL MEDICINE	69	PEDIATRIC, HEMATOLOGY/ONCOLOGY		SURGERY, PLASTIC
31	LARYNGOLOGY	70	PEDIATRIC, INFECTIOUS DISEASES		SURGERY, THORACIC
32	LEGAL MEDICINE	71	PEDIATRIC, INTENSIVIST		SURGERY, TRANSPLANT
33	MATERNAL/FETAL MEDICINE		PEDIATRIC, NEPHROLOGY		SURGERY, TRAUMATIC
34	MEDICAL ACUPUNCTURE	73	PEDIATRIC, NEUROLOGY		SURGERY, UROLOGIC
35	MEDICAL ETHICS	74	PEDIATRIC, OPHTHALMOLOGY		SURGERY, VASCULAR
36	MEDICAL GENETICS	75	PEDIATRIC, PHYSIATRY		URGENT CARE
37	NEO/PERINATAL MEDICINE	76	PEDIATRIC, PULMONARY	115	UROLOGY
38	NEOPLASTIC DISEASES	77	· —- · · · · · · ·		
39	NEPHROLOGY	78	PEDIATRIC, SURGERY		
	Code		Code		Code
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Pri	mary Specialty	260	condary Specialty <u>Q</u>	1	ernary opecially

# 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.

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?  YesNoNo	<ol> <li>Do you have a medical cosafety?</li> </ol>	ondition which in any v	way impairs or limits	your ability to practice m		easonable s Yes	
A. 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 or or your medical education?  Yes	limitation reduced or amelic	ondition which in any orated because of th	way impairs or lim e field of practice,	the setting, or the manı	ner in which yo	ou have cho	sen 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?  YesNoN/A	3. If you use chemical subst and safety?	tances, does your use	in any way impair d	r limit your ability to prac	tice medicine v Yes	vith reasona No _ <del>_</del>	ble skill N/A
Past in your behalf or paid such a claim yourself?  A yes	begin to satisfy a requiremen	nt of your receiving a l	public service with oan or scholarship	rom the federal governr	nent or a state o	or local gove	rnment
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?  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?  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?  9. Have you ever voluntarity surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory?  10. Have you ever been denied membership or expelled from a medical society or other professional medical organization?  11. Have you ever been: a) notified that you were under investigation for; b) investigated for; c) charged with; or d) convicted of any violation of a statute, rule or regulation governing your practice as a physician by any medical licensing board, hospital, medical society, governmental entity or other agency other than the Nevada State Board of Medical Examiners?  12. Have you ever surrendered your state or federal controlled substance registration or had it revoked or restricted in any way?  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	5. Have you been a defenda paid in your behalf or paid s	ant in a legal action in such a claim yourself?	volving professions	l liability (malpractice) o	r had a profess	ional liabilit	y claim No
examination to practice medicine or any other healing art in any state, country or U.S. territory?	of any federal, state or loca excluding any minor traffic of not considered <b>a minor tr</b> a	al law, including any ffense (driving or in co	foreign country, w ontrol of a motor vel	hich is a misdemeanor, icle while under the influ	, gross misden Jence of any che on, prescribing	neanor, or emical subst , or dispen	felony, ance is sing of
9. Have you ever voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory?  10. Have you ever been denied membership or expelled from a medical society or other professional medical organization?  11. Have you ever been: a) notified that you were under investigation for; b) investigated for; c) charged with; or d) convicted of any violation of a statute, rule or regulation governing your practice as a physician by any medical licensing board, hospital, medical society, governmental entity or other agency other than the Nevada State Board of Medical Examiners?  12. Have you ever surrendered your state or federal controlled substance registration or had it revoked or restricted in any way?  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	7. Have you ever been den examination to practice med	iled a license, permis dicine or any other he	sion to practice me aling art in any state	dicine or any other heal o, country or U.S. territor	ling art, or perr	mission to ta	ake an No
10. Have you ever been denied membership or expelled from a medical society or other professional medical organization?  YesNo  11. Have you ever been: a) notified that you were under investigation for; b) investigated for; c) charged with; or d) convicted of any violation of a statute, rule or regulation governing your practice as a physician by any medical licensing board, hospital, medical society, governmental entity or other agency other than the Nevada State Board of Medical Examiners?  YesNo  12. Have you ever surrendered your state or federal controlled substance registration or had it revoked or restricted in any way?  YesNo  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	8. Have you ever had a med any state, country or U.S. te	lical license or license rritory?	to practice any oth	er healing art revoked, s	uspended, limi	ted, or restri	icted in No
	9. Have you ever voluntarily territory?	y surrendered a licen	se to practice medi	cine or any other healing	g art in any sta	te, country o	or U.S. No
any violation of a statute, rule or regulation governing your practice as a physician by any medical licensing board, hospital, medical society, governmental entity or other agency other than the Nevada State Board of Medical Examiners?	10. Have you ever been de	nied membership or o	expelled from a me	dical society or other pro	ofessional med	lical organiz	ation? No
12. Have you ever surrendered your state or federal controlled substance registration or had it revoked or restricted in any way?  Yes No  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	any violation of a statute, rul	lle or regulation gove	rning your practice	as a physician by any n	nedical licensin	ng board, ho	ospital,
any and all resignations from any medical staff in lieu of disciplinary or administrative action. (Please Note: Do not include	12. Have you ever surrender	red your state or fede	ral controlled subst	ance registration or had i	it revoked or re	stricted in an	y way?
naintain required malpractice insurance).	any and all resignations from suspensions or restrictions f	m any medical staff i for failure to complete	n lieu of disciplinar	or administrative action	n. (Please Not	te: Do not in	nclude
Mailing Type of Dates of Action Hospital Address Action From (Mo./Yr.) To (Mo./Yr.)	Mai	iling .					
N/A	<u> </u>	Ą					

## **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 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 PENEWAL	Date Received by Board	License No. 3436
APPLICATION FOR REGISTRATION RENEWAL FOR THE BIENNIAL REGISTRATION PERIOD 2003- 2005	. JUN 2 8 2003	License No. 3×36
NEVADA STATE BOARD OF MEDICAL EXAMINERS	. JUN Z G J	File No.
Post Office Box 7238 Reno, Nevada 89510 Phone (775) 688-2559	(For Board Use Only)	
Physical Address: 1105 Terminal Way, Suite 301 Reno, Nevada 89502	· · · · · · · · · · · · · · · · · · ·	
I hereby apply for renewal of biennial registration and enclose to ACTIVE STATUS	ne apprøpriate tee(s) as indicate 00.00	d below:
INACTIVE STATUS \$20	00.00(INACTIVE STATUS D	
I REQUEST NON-RENEWAL OF MY LICENSE*		EDICINE <u>INCLUDING</u>
("IF YOU ARE REQUESTING NON-RENEWAL, SEE BELOW)	THE WRITING OF PRI	ESCRIPTIONS IN NEVADA)
		·
Robert A GATLIN M.I	Make check	ks payable to:
1701 Green Valley Pkwy Bldg 3 #B	NEVADA STATE BOARD	OF MEDICAL EXAMINERS
Henderson, NV 8 <del>9014</del>	(Foreign checks must	t indicate "U.S. FUNDS")
45068		
Request for NON-RENEWAL of Lice	se to Practice Medici	ine in Nevada
ricquest for Herriatival of Live		
I hereby represent that I am the person named in this API	PLICATION FOR REGISTRATIO	ON RENEWAL of license to
practice medicine in the state of Nevada.		NOT
By signing on the signature line below, I am requesting t		
renewed by the Nevada State Board of Medical Examiners.	i will return this signed form	to the board office.
Date Signature (SIGNATURE STA	MP UNACCEPTABLE)	
PLEASE NOTE:		
■ YOUR CURRENT M.D. LICENSE EXPIRES ON JUNE 30,		
RENEWAL FORMS NOT RECEIVED AT THE BOARD OF		
SUSPENDED FOR NON-PAYMENT. EXTENSIONS OF T		
HAS NO GRACE PERIOD. (USE THE ENCLOSED ENVI	ELOPE TO MAIL YOUR COMPL	LETED APPLICATION FOR
REGISTRATION RENEWAL FORM.)  YOUR LICENSE WILL NOT BE RENEWED UNLESS YOU	ANGWED ALL OLIECTIONS OF	NTUIS ADDI ICATION EOD
REGISTRATION RENEWAL FORM. YOU MUST PROVI		
ANSWERED "YES."		
- ALL INFORMATION YOU PROVIDE ON THIS APPLICAT	TON FOR REGISTRATION REP	VEWAL FORM IS <u>PUBLIC</u>
INFORMATION.		
PI FASE TYPE OF	R PRINT LEGIBLY	
Active status registration renewal requires the submission of		of AMA Category 1 continuing
medical education (CME), which includes 2 hours of CME in me	edical ethics and 20 hours of CMI	Em your scope of practice or
specialty completed during the period July 1, 2001 through	June 30, 2003. Submit your pro-	of of completion of CME with
your completed Application for Registration Renewal form. (Se		
<ol><li>If your name and/or address has changed from that printed space provided below. Also, please indicate your current telep</li></ol>		
copy of the document authorizing your name change (marriage		
oopy of the document during the field of the field of		
Name		
Street		00 hall
CityCounty	State	zip 89074
Phone Number 702-737-3200 Fax Num	nber <u>702 - 3UA - 47</u>	<u>71</u>
3. IF YOU HAVE RETIRED OR MOVED YOUR PRACTICE, i	ndicate the location of patient re	cords below:
Name		
Street		
	State	Zip
CityCounty	State	/ID

Phone Number\_

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

## SCOPES OF PRACTICE CODES

		•	2005E2 OF LUMOTICE CORES		
			•	81	PEDIATRIC, RHEUMATCLOGY
	ADDICTION MEDICINE	41		82	PEDIATRIC, SURGERY
	ADOLESCENT MEDICINE		NEPHROLOGY .		PEDIATRIC, UROLOGY
3	AEROSPACE MEDICINE	43	NEUROLOGY		PEDIATRICS
	ALLERGY	44	NEURO-OPHTHALMOLOGY	95	PHYSICAL MEDICINE/REHABILITATION
5	ALLERGY/IMMUNOLOGY	45	NEUROPATHOLOGY		PREVENTIVE MEDICINE
6	AMBULATORY MEDICINE	46	NEURORADIOLOGY		PSYCHIATRY
7	ANESTHESIOLOGY		NON-CONVENTIONAL MEDICINE	88	
8	BLOODBANKING		NUCLEAR MEDICINE		PUBLIC HEALTH
9	BRONCO-ESOPHAGOLOGY		NUTRITION		
10	CARDIOVASCULAR DISEASES	50	OBSTETRICS	90	
11	CATSCAN/ULTRASOUND	51	OBSTETRICS/GYNECOLOGY	91	PULMUNANT DISEASES
12	CHILD NEUROLOGY		OCCUPATIONAL MEDICINE		RADIOLOGY
13	CHILD PSYCHIATRY	53	ONCOLOGY	93	RADIOLOGY, DIAGNOSTIC
14	CLINICAL PHARMACOLOGY	.54	ONCOLOGY, GYNECOLOGICAL		RADIOLOGY, INTERVENTIONAL
15	CRITICAL CARE	55	ONCOLOGY, HEMATOLOGY		RADIOLOGY, NUCLEAR
16	DERMATOLOGY	56	ONCOLOGY, RADIATION	96	
	DERMATOPATHOLOGY	57			RADIOLOGY, VASCULAR
17	EMERGENCY MEDICINE		OPHTHALMOLOGY	98	
18	ENDOCRINOLOGY		OTOLARYNGOLOGY		RHINOLOGY
19	FAMILY PRACTICE		OTOLOGY	100	SLEEP DISORDERS
20	GASTROENTEROLOGY	61	PAIN MANAGEMENT	10	SPORTS MEDICINE
21	GENERAL PRACTICE		PATHOLOGY	103	SURGERY, ABDOMINAL
22	GERIATRIC PSYCHIATRY	63	PATHOLOGY, ANATOMIC	103	SURGERY, CARDIOTHORACIC
23	GERIATRICS STORIATE	64	PATHOLOGY, CLINICAL	10	4 SURGERY, CARDIOVASCULAR
24	GYNECOLOGY	65	PATHOLOGY, FORENSIC	10	5 SURGERY, COLON/RECTAL
25	HAIR TRANSPLANTATION	66	PEDIATRIC, ALLERGY	10	6 SURGERY, GENERAL
26		67	PEDIATRIC, CARDIOLOGY	10	7 SURGERY, HAND
27	HEMATOLOGY	68	PEDIATRIC, CRITICAL CARE	10	8 SURGERY, HEAD/NECK
28	HOMEOPATHY	69		10	9 SURGERY, MAXILLOFACIAL
29	HYPNOSIS	70	PEDIATRIC, ENDOCRINOLOGY	11	0 SURGERY, NEUROLOGICAL
30	IMMUNOLOGY	70	PEDIATRIC, GASTROENTEROLOGY	11	1 SURGERY, ORTHOPEDIC
31	INFECTIOUS DISEASES	79	PEDIATRIC, HEMATOLOGY/ONCOLOGY	11	2 SURGERY, PLASTIC
32	INFERTILITY	72	PEDIATRIC, INFECTIOUS DISEASES	11	3 SURGERY, THORACIC
33	INTERNAL MEDICINE		PEDIATRIC, INTENSIVIST	11	4 SURGERY, TRANSPLANT
34	LARYNGOLOGY		PEDIATRIC, NEPHROLOGY	11	5 SURGERY, TRAUMATIC
35	LEGAL MEDICINE	70	PEDIATRIC, NEUROLOGY	11	6 SURGERY, UROLOGIC
36	MATERNAL/FETAL MEDICINE	70	PEDIATRIC, OPHTHALMOLOGY	11	7 SURGERY, VASCULAR
37	MEDICAL ACUPUNCTURE	77	PEDIATRIC, PHYSIATRY		8 TOXICOLOGY
38	MEDICAL ETHICS	70	PEDIATRIC, PULMONARY		9 URGENT CARE
39	MEDICAL GENETICS				O UROLOGY
40	NEO/PERINATAL MEDICINE	80	PEDIATRIC, RADIOLOGI		
		<u>Code</u>			<u>Code</u>
	D. L On any of Depoting	51	Secondary Sc	cope of Pra	actice

**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.

<ol> <li>Do you have a medical c safety?</li> </ol>	ondition which in any wa	y impairs or limits your abili	ity to practice medicine with reasonable skill andYesNo
2. If you have a medical c limitation reduced or amel practice?	ondition which in any wa orated because of the f	ay impairs or limits your abi	ility to practice medicine, is that impairment or g, or the manner in which you have chosen toN/A
3. If you use chemical sub skill and safety?	stances, does your use	in any way impair or limit yo	our ability to practice medicine with reasonableYesNo/_N/A
4. Have you failed to initial begin to satisfy a require government for your medic	ment of your receiving	ıblic service within one yea a loan or scholarship fror	tr after the date the public service is required to m the federal government or a state or local
5. Have you been a defend paid in your behalf or paid	dant in a legal action invo such a claim yourself?	lving professional liability (r	malpractice) or had a professional liability claimYesNo
violation of any federal, st	ate or local law, includir or traffic offense (driving red <b>a minor traffic off</b> e	ng any foreign country, whi or in control of a motor vel	ad guilty or nolo contendere to any offense or ich is a misdemeanor, gross misdemeanor, or hicle while under the influence of any chemical the manufacture, distribution, prescribing, or
7. Have you ever been de examination to practice me	nied a license, permissi edicine or any other heal	on to practice medicine or ling art in any state, country	any other healing art, or permission to take an y or U.S. territory?
8. Have you ever had a me any state, country or U.S.	edical license or license t territory?	to practice any other healing	g art revoked, suspended, limited, or restricted inYesNo
9. Have you ever voluntar territory?	ily surrendered a license	e to practice medicine or ar	ny other healing art in any state, country or U.S. YesNo
10. Have you ever been d	enied membership or ex	pelled from a medical soci	iety or other professional medical organization?
any violation of a statute	rule or regulation govern	ning vour practice as a DNV	nvestigated for; c) charged with; or d) convicted or rsician by any medical licensing board, hospital
12. Have you ever surrer way?	dered your state or fede	eral controlled substance re	egistration or had it revoked or restricted in any
I ist any and all regionation	is from any medical staff s for failure to complete	in lieu of disciplinary or adr	limited, revoked or not renewed by the hospital ministrative action. ( <u>Please Note</u> : Do not include attend hospital department or staff meetings, o
maintain required maiprad	Mailing	Type of	Dates of Action
Hospital	Address	Action	From (Mo./Yr.) To (Mo./Yr.)
	(If more spa	ace is needed, attach a sep	parate sheet.)

# 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 NOT \_\_\_\_ (CHECK ONE) ACTIVELY PRACTICED MEDICINE IN NEVADA WITHIN THE PAST 12 MONTHS.

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

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

Date Signature (SIGNATURE STAMP UNACCEPTABLE)

### Date Received by Board **PHYSICIAN APPLICATION FOR REGISTRATION RENEWAL** License No. FOR THE BIENNIAL REGISTRATION PERIOD 2005 - 2007 **NEVADA STATE BOARD OF MEDICAL EXAMINERS** File No. Post Office Box 7238 Reno, Nevada 89510 Phone (775) 688-2559 (For Board Use Only) Physical Address: 1105 Terminal Way, Suite 301 Reno, Nevada 89502 I hereby apply for renewal of biennial registration and enclose the appropriate fee(s) as indicated below: ACTIVE STATUS \$600.00 **ACTIVE STATUS** \$300.00.....(INACTIVE STATUS DOES NOT PERMIT **INACTIVE STATUS** THE PRACTICE OF MEDICINE INCLUDING I REQUEST NON-RENEWAL OF MY LICENSE<sup>4</sup> THE WRITING OF PRESCRIPTIONS IN NEVADA (\*IF YOU ARE REQUESTING NON-RENEWAL, SEE BELOW) achic fick to keep a Make checks payable to: NEVADA STATE BOARD OF MEDICAL EXAMINERS Robert Allan GATLIN M.D. (Foreign checks must indicate "U.S. FUNDS") 1701 Green Valley Pkwy Bldg 3 #B 89014-Henderson 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. Signature (SIGNATURE STAMP UNACCEPTABLE) Date **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 County State Fax Number

_	8			
Stree	ot			
City_	Cc	unty	State	Zip
Phor	e Number		·	•
<b>4. i</b> n	dicate below your primary a	nd second	 lary scopes of practice using the	following codes:
		S	COPES OF PRACTICE CODES	
1	ADDICTION MEDICINE	43	NEPHROLOGY	85 PEDIATRIC, SURGERY
2	ADOLESCENT MEDICINE	44	NEUROLOGY	86 PEDIATRIC, UROLOGY
3	AEROSPACE MEDICINE		NEURO-OPHTHALMOLOGY	87 PEDIATRICS
4	ALLERGY		NEUROPATHOLOGY	88 PHYSICAL MEDICINE/REHABILITATION
5 6	ALLERGY/IMMUNOLOGY AMBULATORY MEDICINE		NEURORADIOLOGY NEUROTOLOGY	89 PREVENTIVE MEDICINE
7	ANESTHESIOLOGY	40 40	NON-CONVENTIONAL MEDICINE	90 PSYCHIATRY 91 PSYCHOANALYSIS
8	BLOODBANKING	50	NUCLEAR MEDICINE	92 PSYCHOMATIC MEDICINE
9	BRONCO-ESOPHAGOLOGY		NUTRITION	93 PUBLIC HEALTH
10	CARDIOVASCULAR DISEASES		OBSTETRICS	94 PULMONARY DISEASES
11	CATSCANULTRASOUND	53	OBSTETRICS/GYNECOLOGY	95 OCCUPATIONAL MEDICINE
	CHILD NEUROLOGY		OCCUPATIONAL MEDICINE	96 RADIOLOGY
	CHILD PSYCHIATRY		ONCOLOGY	97 RADIOLOGY, DIAGNOSTIC
	CLINICAL PHARMACOLOGY CRITICAL CARE	50 57	ONCOLOGY, GYNECOLOGICAL ONCOLOGY, HEMATOLOGY	98 RADIOLOGY, INTERVENTIONAL
	DERMATOLOGY	58 58	ONCOLOGY, RADIATION	99 RADIOLOGY, NUCLEAR 100 RADIOLOGY, THERAPEUTIC
	DERMATOPATHOLOGY	59	ONCOLOGY, SURGICAL	101 RADIOLOGY, VASCULAR
	EMERGENCY MEDICINE	60	OPHTHALMOLOGY	102 RHEUMATOLOGY
	ENDOCRINOLOGY	61	OTOLARYNGOLOGY	103 RHINOLOGY
	FAMILY PRACTICE		OTOLOGY	104 SLEEP DISORDERS
	FORENSIC MEDICINE		PAIN MANAGEMENT	105 SPORTS MEDICINE
	GASTROENTEROLOGY CENERAL PRACTICE		PATHOLOGY	106 SURGERY, ABDOMINAL
	GENERAL PRACTICE GERIATRIC PSYCHIATRY	60	PATHOLOGY, ANATOMIC PATHOLOGY, CLINICAL	107 SURGERY, CARDIOTHORACIC
25	GERIATRICS	67	PATHOLOGY, CLINICAL PATHOLOGY, FORENSIC	108 SURGERY, CARDIOVASCULAR 109 SURGERY, COLON/RECTAL
	GYNECOLOGY	68	PEDIATRIC, ALLERGY	110 SURGERY, CRANIOFACIAL
	HAIR TRANSPLANTATION	69	PEDIATRIC, ANESTHESIOLOGY	111 SURGERY, GENERAL
	HEMATOLOGY	70	PEDIATRIC, CARDIOLOGY	112 SURGERY, HAND
	HOMEOPATHY	71	PEDIATRIC, CRITICAL CARE	113 SURGERY, HEAD/NECK
	HYPNOSIS	72	PEDIATRIC, EMERGENCY MEDICINE	114 SURGERY, MAXILLOFACIAL
	IMMUNOLOGY INFECTIOUS DISEASES	73	PEDIATRIC, ENDOCRINOLOGY	115 SURGERY, NEUROLOGICAL
	INFERTILITY	/4 75	PEDIATRIC, GASTROENTEROLOGY PEDIATRIC, HEMATOLOGY/ONCOLOGY	116 SURGERY, ORTHOPEDIC
	INTERNAL MEDICINE	76	PEDIATRIC, INFECTIOUS DISEASES	117 SURGERY, PLASTIC 118 SURGERY, THORACIC
	LARYNGOLOGY	77	PEDIATRIC. INTENSIVIST	119 SURGERT, TRANSPLANT
36	LEGAL MEDICINE		PEDIATRIC, NEPHROLOGY	120 SURGERY, TRAUMATIC
	MATERNAL/FETAL MEDICINE	79		121 SURGERY, UROLOGIC
	MEDICAL ACUPUNCTURE		PEDIATRIC, OPHTHALMOLOGY	122 SURGERY, VASCULAR
	MEDICAL ETHICS	81		123 TOXICOLOGY
	MEDICAL GENETICS NEO/PERINATAL MEDICINE		PEDIATRIC, PULMONARY	124 TRANSPLANTATION
	NEOPLASTIC DISEASES	83 84	PEDIATRIC, RADIOLOGY PEDIATRIC, RHEUMATOLOGY	125 URGENT CARE
		Code	FEDIATRIO, RITEUMATOLOGI	126 UROLOGY <u>Code</u>
		·		0000
Prir	mary Scope of Practice <u>3</u>	3	Secondary Sco	pe of Practice
PLF	ASE INDICATE AMERICAN R	OARD OF	MEDICAL SPECIAL TIES BOARD	CERTIFICATION & RECERTIFICATION
	4		Date of Initial Certif	fication Date of Last Recertification
3oare	American Board		bstetrics & Feb 19	80
		G	ynecology (Mo.Yr.)	(Mo./Yr.)
Subb	oard			
			(Mo./Yr.)	(Mo./Yr.)

# 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 dapability 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.

Mailing Type of Dates of Action From (Mo./Yr.) To (	
13. List all hospitals where you have had staff privileges denied, suspended, limited, revoked or not renewed by the List any and all resignations from any medical staff in lieu of disciplinary or administrative action. ( <u>Please Note</u> : Do no suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff medical required malpractice insurance.) (If more space is needed, attach a separate sheet)  Mailing  Type of	ot include etings, o
12. Have you ever surrendered your state or federal controlled substance registration or had it revoked or restrict way? Yes	ed in any
	hospital No
<ol> <li>Have you ever been denied membership or expelled from a medical society or other professional medical orga</li> <li>Yes</li> </ol>	<u> </u>
<ol> <li>Have you ever voluntarily surrendered a license to practice medicine or any other healing art in any state, count territory?</li> </ol>	N
<ol> <li>Have you ever had a medical license or license to practice any other healing art revoked, suspended, limited, or reany state, country or U.S. territory?</li> </ol>	estricted i
7. Have you ever been denied a license, permission to practice medicine or any other healing art, or permission to examination to practice medicine or any other healing art in any state, country or U.S. territory?Yes	N
6. Have you ever been investigated for, charged with, convicted of, or plead guilty or noto contendere to any eviolation of any federal, state or local law, including any foreign country, which is a misdemeanor, gress misdem 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, press dispensing of controlled substances?  YesYes	chemica cribing, c
5. Have you been a defendant in a legal action involving professional liability (malpractice) or had a professiona	bility clair
4. Have you failed to initiate the performance of public service within one year after the date the public service is r begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state government for your medical education?	e or loca
3. If you use chemical substances, does your use in any way impair or limit your ability to practice medicine with reskill and safety? YesNo	
2. If you have a medical condition which in any way impairs or limits your ability to practice medicine, is that imp limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have practice?  YesYes	chosen t
Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonab safety? Yes	ole skill ar

### 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; <b>OR</b>
(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 ar 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 blennial 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 are 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 are 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.
<ul> <li>ATTACH COPIES OF PROOF OF YOUR COMPLETION OF CONTINUING MEDICAL EDUCATION (CME) HOURS.</li> <li>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.</li> <li>YOUR COPIES OF PROOF OF CME OR TRAINING COMPLETION WILL NOT BE RETURNED TO YOU.</li> </ul>
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).

Signature (SIGNATURE STAMP UNACCEPTABLE)

Date Answered	6/25/2007	6/25/2007	6/25/2007	6/25/2007	6/25/2007
ver					•
Answer	Z	Z	Z	<u>.s</u>	z
Question Text	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	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	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	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?	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?
Licensee Name	GATLIN, Robert Allan	GATLIN, Robert Allan	GATLIN, Robert Allan	GATLIN, Robert Allan	GATLIN, Robert Allan
License Number Licensee Name	3436	3436	3436	3436	3436

with, convicted of, or plead guilty or nolo contendere to

Have you been investigated for, arrested for, charged

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

GATLIN, Robert Allan

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

elicensensbme@medboard.nv.gov.

Z

3436

3436

GATLIN, Robert Allan

6/25/2007	6/25/2007	6/25/2007	6/25/2007
Z	z	z	Z
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.	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 email explanation to email to elicensensbme@medboard.nv.gov.	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.	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.
GATLIN, Robert Allan	GATLIN, Robert Allan	GATLIN, Robert Allan	GATLIN, Robert Allan
3436	3436	3436	3436

,

6/25/2007	6/25/2007	6/25/2007	6/25/2007
Z	z	z	z
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.	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.	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.	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.
GATLIN, Robert Allan	GATLIN, Robert Allan	GATLIN, Robert Allan	GATLIN, Robert Allan
3436	3436	3436	3436

6/25/2007	6/25/2007	6/25/2007	6/25/2007	6/25/2007	6/25/2007
z	z	z	z	<b>&gt;</b>	> Z
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.	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.  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 elicensenshme@medboard and social	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	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.	I have actively practiced medicine in Nevada within the past 24 months. I hereby request my license to be placed on Inactive status. I will not physically practice in the state of Nevada.
GATLIN, Robert Allan	GATLIN, Robert Allan	GATLIN, Robert Allan	GATLIN, Robert Allan	GATLIN, Robert Allan	GATLIN, Robert Allan GATLIN, Robert Allan
3436	3436	3436	3436	3436	3436 3436

6/25/2007	6/27/2009	6/27/2009	6/27/2009	6/27/2009	6/27/2009
<b>&gt;</b>	Z	Z	Z	>-	
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.	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.  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.	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.  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.	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.
GATLIN, Robert Allan	GATLIN, Robert Allan	GATLIN, Robert Allan	GATLIN, Robert Allan	GATLIN, Robert Allan	GATLIN, Robert Allan
3436	3436	3436	3436	3436	3436

6/27/2009	6/27/2009	6/27/2009	6/27/2009	6/27/2009
Z	Z	Z	z	Z
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.	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.	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.	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?	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?
GATLIN, Robert Allan	GATLIN, Robert Allan	GATLIN, Robert Allan	GATLIN, Robert Allan	GATLIN, Robert Allan
3436	3436	3436	3436	3436

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

6/27/2009	6/27/2009	6/27/2009	6/27/2009	6/27/2009
Z	Z	Z	<b>&gt;</b>	<b>&gt;</b> -
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.	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.	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	I have completed the required amount of AMA Category I 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.	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.
GATLIN, Robert Allan	GATLIN, Robert Allan	GATLIN, Robert Allan	GATLIN, Robert Allan	GATLIN, Robert Allan
3436	3436	3436	3436	3436

# System Automation

Myllicense Transaction Reports

Reports Home Page

	Renewal Questions for License Number 3436	3		MVI Issues
Licens	ee Question		Anguer	
GATLIN Robert Allan	Do you have a medical condition which in any way	N	Answer	<b>Date</b> 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.	t 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	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?	Y		6/29/2011
Allan	Please include: who, what, where (provide state), and when in the textbox directly below this question.	•		6/28/2011

## Explanation 4: For the above question if your

answer is "Yes" for the time period July 1, 2009 -June 30, 2011, or since your last renewal, please GATLIN, type your explanation in this text box. Robert Allan 6/28/2011 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? GATLIN, Robert If "Yes" during the time period July 1, 2009 - June 30, N 6/28/2011 Allan 2011 type an explanation in the textbox directly below this question. Explanation 5: For the above question if your answer is "Yes" for the time period July 1, 2009 -June 30, 2011, or since your last renewal, please GATLIN. Robert type your explanation in this text box. Allan Please fax a copy of the complaint, civil or otherwise to 775-688-2551. 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 GATLIN, or being in control of a motor vehicle while under the Robert influence of a chemical substance, including alcohol, is N 6/28/2011 Allan 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. Explanation 6: For the above question if your GATLIN, answer is "Yes" for the time period July 1, 2009 -June 30, 2011, or since your last renewal, please Robert Allan type your explanation in this text box. Have you been denied a license, permission to practice medicine or any other healing art, or permission to take GATLIN, Robert an examination to practice medicine or any other 6/28/2011 Allan healing art in any state, country or U.S. territory? Explanation 7: For the above question if your GATLIN, answer is "Yes" for the time period July 1, 2009 -Robert June 30, 2011, or since your last renewal, please Allan type your explanation in this text box.

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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.		
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 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 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 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 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 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 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 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.	ı	
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

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

GATLIN Robert Allan	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 textb 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 maipractice insurance.)	n, Pox 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".  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		
GATLIN, Robert Allan	I hereby request my license to be placed on Inactive status, which means I will <u>not</u> physically practice in the state of Nevada.  If you choose to place your license on Inactive status, make certain to select "Yes" to this question <u>AND</u> 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		

Robert Allan	answer is "YES" , please type your new scope of practice or specialty in this text box.		
GATLIN,	Do you want to change your scope of practice or specialty?		
Robert Allan	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.		
	I have completed the required amount of AMA Category 1 CME within the current biennial. (Review CME information online at <a href="https://www.medboard.nv.gov">www.medboard.nv.gov</a> )		
GATLIN, Robert Allan	I understand that I may be included in a random audit following the July 1st, 2011 renewal. I agree to retain CME's taken between July 1, 2009 and June 30, 2011.	Y	6/28/2011
	If renewing to an <u>Inactive</u> status, CME is not required and "No" can be selected.		
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 3436 Robert Allan GATLIN





Answer	Kuestioii
	20110011

Z

8/20/2015

If you do not have a medical condition, select No. reasonable skill and safety?

Do you have a medical condition which in any way impairs or limits your ability to practice medicine with

**NSBME Renewal Responses Report** 

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.

06/18/2013

z

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.

**NSBME Renewal Responses Report** 

Z

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? Please include: who, what, where (provide state), and when in the textbox directly below this question.

06/18/2013

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

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

including any military tort claims if applicable?

Have you been arrested, investigated for, charged with, convicted of, or pled guilty or nolo contendere to below this question.

z

06/18/2013

substance, including alcohol, is not considered a minor traffic offense), or for any offense which is related 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 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 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 dismissal, or expungement. Page 51 of 58

**NSBME Renewal Responses Report** 

8/20/2015

z 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?

Z

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?

8/20/2015

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

06/18/2013

z

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?

>

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 of infectious agents through safe and appropriate injection practices. I also attest that any person who is guidelines of the Centers for Disease Control and Prevention concerning the prevention of transmission practices, your answer should be "YES". I hereby attest to knowledge of and compliance with the If you believe that you are in compliance with the Centers for Disease Control safe injection

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

http://www.cdc.gov/injectionsafety/IP07\_standardPrecaution.html

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

Have you surrendered your state or federal controlled substance registration or had it revoked or

**NSBME Renewal Responses Report** 

restricted in any way?

06/18/2013

Z

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

**NSBME Renewal Responses Report** 

06/18/2013

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

If you choose to place your license on Inactive status, make certain to select "Yes" to this question <u>AND</u> choose the Inactive status in the dropdown box located at the end of the questions.

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

instructions and complete the required form. Click on the following link for the instructions and forms:

site will retain your previous responses. Please go to the website, click on the following link for

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

enewal 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

defined in NRS 449.0151, or outside the state of Nevada. I hereby attest that I am in compliance with the

at his or her office or any other facility, excluding any surgical care performed at a medical facility as

reporting requirements of NRS 630.30665, and am aware that failure to submit a report or filing false

nformation in a report is grounds for disciplinary action under Nevada's Medical Practice Act.

action, you may proceed in answering the renewal attestations and questions. The online renewal

this attestation until you have completed the requisite form. Once you have completed this

**NSBME** Renewal Responses Report

06/18/2013

z

Are you out of compliance with court ordered child support? If this does not apply to you, please

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

answer "no".

below this question.

>

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

(Review CME information online at www.medboard.nv.gov) If renewing to an <u>Inactive</u> status, CME is not required and "No" can be selected.

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.

>

06/18/2013

Reports Home Page

Myllicense Transaction Reports

### Renewal Questions for License Number 3436

	1		MyLicense*
Licensee		Answei	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
Robert	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
Pohert	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
Robert	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?	Υ	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 <u>brief</u> 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 <u>Email to elicensensbme@medboard.nv.gov!</u> .	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?  If the answer is "Yes," type the name of the hospital, the hospital's mailing address, the type of action taken, and the date or dates of the actions taken in the textbox directly below this question.  (Please Note: Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance.)	N	5/16/2015
GATLIN, Robert Allan	Have you actively practiced medicine in Nevada within the past 12 months?	Y	5/16/2015
	OPTION TO CHANGE LICENSE STATUS FROM ACTIVE TO INACTIVE:  NOTE: If you choose to drop to Inactive status during this renewal, your status will be changed to "Inactive" as of the date of your renewal. If you do NOT wish to change your status to "Inactive" as of today, DO NOT COMPLETE YOUR RENEWAL UNTIL SUCH TIME AS YOU ARE PREPARED TO HAVE YOUR STATUS CHANGED (prior to JULY 1ST). For your information, your answers to the questions that you've already completed will remain, but you should not complete the renewal and pay until such time as you are prepared to change your status to "Inactive."  I hereby request my license to be placed on Inactive status, which means I will not physically practice in the state of Nevada.  If you choose to place your license on Inactive status, make certain to select "Yes" to this question AND choose the Inactive status in the dropdown box located at the end of the questions.	N	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.  http://www.cdc.gov/injectionsafety/IP07 standardPrecaution.html		
GATLIN,	I hereby attest that I am in compliance with the reporting requirements of NRS 630.30665, and am aware that failure to submit a report or filing false information in a report is grounds for disciplinary action under Nevada's Medical Practice Act.  I HAVE SUBMITTED A "FORM A" OR "FORM B" REPORT TO THE BOARD.		
Robert Allan	Instructions and Forms A and B for in-office surgery/procedure reporting can be located on the Board's website by clicking the red "In-Office Surgery Reporting" link on the home page of the Board's website:  www.medboard.nv.gov.  If you have submitted your in-office surgery/procedure reporting forms (A/B Forms) to the Board and are in compliance with NRS 630.30665, your answer should be "YES."	Y	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".  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".  I attest and affirm that I am aware of and understand the reporting requirements found in Nevada Revised Statute 432B.220 regarding the abuse or neglect of a child.  www.leg.state.nv.us/NRS/NRS-432B.html#NRS432BSec220	Y	5/16/2015
GATLIN, Robert Allan	Have you ever served in the United States Military (to include National	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 <a href="https://www.medboard.nv.gov">www.medboard.nv.gov</a> )  If renewing to an <a href="mailto:Inactive">Inactive</a> status, CME is not required and "No" can be selected.	<b>Y</b>	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



RECEIVED FEB 25 1994

NEVAGA STATE BUAND OF MEDICAL EXAMINED

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:

Claimant(s):

Closed Date:

Settled:

Robert A. Gatlin, M.D.

January 31, 1994

\$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 Vice President/Claims

CL:aw Enclosure

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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: Settlement Date:

July 26, 1980 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

Carolyn Littlewood Vice-President/Claims

CL:mt