

INSURER: ST. PAUL MEDICAL LIABILITY INSURANCE COMPANY
PHOENIX MEDICAL OFFICE - 02A
8900 N 22nd Avenue
Apt/ste 300
Phoenix, AZ 850216018

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FEB - 4 2002
NEVADA STATE BOARD OF
MEDICAL EXAMINERS

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MEDICAL EXAMINERS
P.O. Box 7238
Reno, NV 89510

Claim No.: DM06628927-02A001/YY00152 **Date:** January 31, 2002

Date of Loss: November 8, 1996 **Date of Claim:** November 3, 1998
Date Suit Filed: September 30, 1998 **Date Closed:** January 17, 2002

MLSP Complaint No: L98-10-1574
Findings: Reasonable probability of malpractice.
Other Dispositions: Case settled prior to trial.

INSURED: Frank P. Silver, M.D.
Address: 341 N Buffalo, Apt/ste B
Las Vegas, NV 89128

Settlement of
\$ 450,000.00

Loss Description Complaint alleges insured was negligent during ablation surgery and burned two holes in patient's bladder resulting in urine leak and sepsis in then 47 year old woman.

Loss Location: Lake Mead Hospital, Las Vegas, NV

CLAIMANT: [REDACTED]
Patient: Same as Claimant **DOB/Age:** [REDACTED] 53 years old
Address: c/o Daniel Marks, Esq., 302 E. Carson, Suite 702, Las Vegas, NV 89101

Person Making Report: Connie Heinsohn, Claim Specialist
Address: 8900 N 22nd Ave, Ste 300, Phoenix, AZ 85021
Phone: (602) 678-3424

Summons & Complaint Attached: If Summons & Complaint not attached, Case No.: A414074

INSURER: ST. PAUL FIRE & MARINE INSURANCE COMPANY
P.O. Box 39600
PHOENIX, AZ 85069-9600
(602) 678-3400

NEVADA STATE BOARD OF
MEDICAL EXAMINERS
P.O. Box 7238
Reno, NV 89510

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MEDICAL EXAMINERS

Claim No.: DM08900582-02A001 Date: DECEMBER 17, 1997

Date of Loss: 04/04/91 Date of Claim: 06/14/91
Date Suit Filed: _____ Date Closed: 10/29/97

MLSP Complaint No.: _____
Findings: _____
Other Dispositions: \$65,000

INSURED: FRANK SILVER, MD
Address: 2031 McDaniel St., Suite 210, North Las Vegas, NV 89030

Loss Description: Suit alleges insured negligently injured bowel of 44-year old woman during
hysterectomy procedure.

Loss Location: Las Vegas, NV

CLAIMANT: [REDACTED]
Patient: {Same as Claimant} DOB/Age: 44
Address: c/o Atty. Rick Petrone, 3900 Paradise Ln., #181, Las Vegas, NV 89109

Person Making Report: Connie Heinsohn - Claim Representative
Address: P.O. Box 39600, Phoenix, AZ 85069-9600
Phone: (602) 678-3400

Summons & Complaint Attached. If Summons & Complaint not attached, Case No.: N/A

CH/tlj

Nevada State Board of Medical Examiners

P.O. Box 7238

Reno, NV 89510

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NEVADA STATE BOARD OF
MEDICAL EXAMINERS

INSURER: St. Paul Fire & Marine Insurance Company

Address: P.O. Box 10291, Phoenix, AZ

Zip Code: 85064

Telephone: (602) 553-3400

Claim ID No.: DM06610233-02A003

Date Of Alleged Injury: 08/29/94

Date Of Claim: 08/21/95

MLSP Complaint Number: Unknown

Findings: Claim settled prior to being reviewed by the Medical Legal Screening Panel. Medical Legal Screening Panel case has been dismissed.

Date Suit Filed: N/A \$165,000

Date Closed: 11/05/96

Other Dispositions: Lump sum payment paid in exchange for full release of any and all claims against insured and dismissal of the Medical Legal Screening Panel complaint. Settlement includes release agreement with a confidentiality and non-disclosure.

INSURED'S NAME: Frank P. Silver, M.D.

Address: 2031 McDaniel Street, Suite 210, North Las Vegas, NV

Zip Code: 89030

Place Of Occurrence: Lake Mead Hospital Medical Center

Address: 1409 E. Lake Mead Blvd., North Las Vegas, NV

Zip Code: 89030

DESCRIPTION OF ACTION OR INJURY PRECIPITATING CLAIM OR SUIT:

Insured physician failed to diagnose tubal pregnancy in 31 year old woman, with subsequent rupture. Patient had to undergo removal of one tube. Patient now pregnant.

CLAIMANT'S NAME: [REDACTED]

PATIENT'S NAME: [REDACTED]

Birth Date: [REDACTED]

Address: c/o Anita A. Webster, Esq., 325 S. Maryland Parkway, Las Vegas, NV 89101

PERSON MAKING THIS REPORT: Connie Heinsohn

Address: P.O. Box 10291, Phoenix, AZ

Zip Code: 85064

Telephone: (602) 553-3400

Summons and Complaint Attached

If Summons And Complaint not attached, Case No.: N/A

Rev. 5/89

CH:mkl

Nevada State Board
of Medical Examiners
P.O. Box 7238
Reno, Nevada 89510

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JUN 08 1993
NEVADA STATE BOARD OF
MEDICAL EXAMINERS

REPORT OF MEDICAL MALPRACTICE CLAIM
PURSUANT TO NEVADA REVISED
STATUTES - §690b.045
NOT FOR PUBLICATION

INSURER: St. Paul Fire and Marine Insurance Company
Address: P.O. Box 10291, Phoenix, AZ Zip Code: 85064-0291
Telephone: (602) 553-3400 Claim ID No.: DM08900183-02A001
Date Of Alleged Injury: 12/9/86 Date Of Claim: 3/11/88
Date Suit Filed: 1/31/89
Settlement: \$ _____ Award: \$99,090.93 Date: 5/17/93
Other Dispositions: _____

INSURED'S NAME: Dr. Frank Silver
Address: _____ Zip Code: _____
Place Of Occurrence: Women's Hospital
Address: 2025 E. Sahara Ave., Las Vegas, NV Zip Code: 89106

OTHER DEFENDANTS NAMED IN SAME CLAIM OR SUIT:

1. Ranjit Jain, M.D.
2. John Dudek, M.D.
3. _____
4. _____

DESCRIPTION OF ACTION OR INJURY PRECIPITATING CLAIM OR SUIT:

Failure to diagnose and properly treat the plaintiff's vesicovaginal fistula resulting in urinary incontinence. Plaintiff originally underwent hysterectomy which resulted in the fistula that Insured tried to repair.

CLAIMANT'S NAME: _____
PATIENT'S NAME: _____ Birth Date: _____
Address: c/o Atty. Gerald Gillock, 43053 3rd St., Las Vegas, NV
Zip Code: 89101

PERSON MAKING THIS REPORT: Cindy R. Robertson
Address: P.O. Box 10291, Phoenix, AZ Zip Code: 85064-0291
Telephone: (602) 553-3400

[] Summons and Complaint Attached

If Summons And Complaint not attached, Case No.: 22646

JUN 23 2003

Nevada Medical Professional Liability Closed Claim Report

DIVISION OF INSURANCE
STATE OF NEVADA

I. Background

1. Name of Insurer ST. PAUL MEDICAL LIABILITY INSURANCE COMPANY		2. Insurer Claim No. DM06628927-02A002 / HT00145	
3. Injury Date (Date of Loss) 10/20/1997	4. Report Date 06/30/1999	5. Closure Date 04/30/2003	
6. Policy Type (choose a, b, or c) a) <input type="checkbox"/> Occurrence b) <input checked="" type="checkbox"/> Claims made c) <input type="checkbox"/> Tail/Reporting Endorsement			
7. Policy Limits (Per Claim/Aggregate) \$ 1 MIL. / \$ 3 MIL.		8. Date This Closed Claim Report Submitted 06/20/2003	
9. Type of Report (choose a or b) a) <input checked="" type="checkbox"/> Initial Report b) <input type="checkbox"/> Updated Report			

II. Defendant & Co-Defendants

1. Defendant's Name	Last SILVER	First FRANK	M.I. P	Credentials (e.g. MD, DO, DMD, DDS) M.D.
2. License Number 2641	3. Specialty Description OB/GYN ISO Code _____		4. Co-Defendant(s)? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
5. Number of Co-Defendant(s): _____ or _____ Unknown				
6. Name, License Number and Insurer of Each Co-Defendant, if known: N/A				

III. Injured & Injury

1. Injured Party's Name		Last [REDACTED]	First [REDACTED]	M.I.	2. Sex: <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female
3. Age 62	4. Date of Birth (MM/DD/YY) [REDACTED]	5. Malpractice code (per Appendix 1): PO		6. Injury Code (per appendix 2): ORG	
7. Description of Alleged Malpractice and Injuries (Attach Additional Sheet(s) if Necessary.) Claimant alleges she developed a rectovaginal fistula following a hysterectomy performed by insured. She also alleges lack of post-op care and other significant post-op complications as well.					
8. City Where Injury Occurred Las Vegas			9. Name of Institution (If Injury Occurred in Institution)		

IV. Medical/Dental Screening Panel (Hereafter, Panel)

1. Case Filed with Panel? <input checked="" type="checkbox"/> Yes , <input type="checkbox"/> No, <input type="checkbox"/> Unknown (IF YES, ANSWER QUESTIONS 2 AND 3)	
2. Panel Case Number L99-06-1706	
3. Panel Decision: Is there Reasonable Probability of Malpractice? a) <input checked="" type="checkbox"/> Yes b) <input type="checkbox"/> No c) <input type="checkbox"/> Unable to Decide d) <input type="checkbox"/> Case Dismissed e) <input type="checkbox"/> Other [case settled/withdrawn before panel met]	
4. Court Case Filed After Panel Decision <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

V. Court Case

1. Court Case Filed? <input checked="" type="checkbox"/> Yes , <input type="checkbox"/> No, <input type="checkbox"/> Unknown (IF YES, ANSWER QUESTIONS 2 - 7)			
2. Court Case Number A423093	3. Court Name Dist. Court, Clark County, Nevada	4. Court Department Number 21	
5. Date Court Case Was Filed 08/16/2000	6. Date Verdict Was Filed, if Applicable N/A	7. Date Settlement Offer Accepted, if Applicable 04/23/2003	

VI. Reserves (Amounts Attributed to this Defendant Only, If Multiple Defendants)

1. Reserves	Initial \$150,000	Highest \$350,000	Last \$350,000
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VII. Claim Disposition (Attributed to this Defendant Only)

1. Claim Disposition (check one)	a) <input type="checkbox"/> Decided By Trial in Favor of Plaintiff	a) <input type="checkbox"/> Decided By Trial in Favor of Defendant	b) <input type="checkbox"/> Decided by Arbitrator in Favor of Plaintiff	c) <input type="checkbox"/> Decided by Arbitrator in Favor of Defendant
d) <input checked="" type="checkbox"/> Settled w/o Court or Prior to Trial	e) <input type="checkbox"/> Claim Denied	f) <input type="checkbox"/> Claim Inactive	g) <input type="checkbox"/> Claim Withdrawn	h) <input type="checkbox"/> Other
2. If Claim Disposition is e, f, g or j, Please Explain				

Name of Insurer ST. PAUL MEDICAL LIABILITY INSURANCE COMPANY	Insurer Claim No. DM06628927-02A002 / HT00145
Defendant's Name (Last, First, M.I.) SILVER, FRANK M.D.	Date This Closed Claim Report Submitted 06/20/2003

VIII. Verdict Information (Attributed to All Defendants in Case)

1. Verdict Awarded \$ _____ or N/A

IX. Claim Information (Amounts Attributed to this Defendant Only, If Multiple Defendants)

1. Verdict or Settlement Awarded \$550,000 or <input type="checkbox"/> N/A	2. Verdict or Settlement Paid \$550,000 or <input type="checkbox"/> N/A
3. Reasons for Amount Awarded (1) Not Being Equal to Amount Paid (2), if Applicable (Check More than One, if Applicable) a) _____ Post Verdict Settlement b) _____ Award Reduced to Present Value c) _____ Interest Awarded d) _____ Court Costs Awarded e) _____ Non-economic damages limited by Judge to \$350,000 f) _____ Award Capped by Judge at Policy Limit g) _____ Other (Explain)	
4. How Will/Did Plaintiff Receive Payments?	a) <input checked="" type="checkbox"/> Lump Sum b) <input type="checkbox"/> Periodic Payments c) <input type="checkbox"/> N/A
5. If Periodic Payments, What is the Present Value (as of Date of Award) of the Payments? \$ N/A	
6. Sources of Award Payments	a) Company \$550,000 b) Defendant \$ _____ c) Other (describe) \$ _____
7. Allocated Loss Adjustment Expenses	Total \$53,113.23 Attorney's Fees \$40,655.00 Other \$12,458.23

X. Claim Information (Amounts Attributed to Other Defendants)

1. Co-Defendant's Name	Last	First	M.I.	Credentials (e.g. M.D., D.O)
2. License Number	3. Specialty Description _____		4. Verdict Awarded	
		ISO Code _____	a) <input type="checkbox"/> Yes b) <input type="checkbox"/> No c) <input type="checkbox"/> Unknown	
5. Settlement Made			6. Verdict or Settlement Awarded \$ _____ or <input type="checkbox"/> N/A	
a) <input type="checkbox"/> Yes b) <input type="checkbox"/> No c) <input type="checkbox"/> Unknown				

1. Co-Defendant's Name	Last	First	M.I.	Credentials (e.g. M.D., D.O)
2. License Number	3. Specialty Description _____		4. Verdict Awarded	
		ISO Code _____	a) <input type="checkbox"/> Yes b) <input type="checkbox"/> No c) <input type="checkbox"/> Unknown	
5. Settlement Made			6. Verdict or Settlement Awarded \$ _____ or <input type="checkbox"/> N/A	
a) <input type="checkbox"/> Yes b) <input type="checkbox"/> No c) <input type="checkbox"/> Unknown				

1. Co-Defendant's Name	Last	First	M.I.	Credentials (e.g. M.D., D.O)
2. License Number	3. Specialty Description _____		4. Verdict Awarded	
		ISO Code _____	a) <input type="checkbox"/> Yes b) <input type="checkbox"/> No c) <input type="checkbox"/> Unknown	
5. Settlement Made			6. Verdict or Settlement Awarded \$ _____ or <input type="checkbox"/> N/A	
a) <input type="checkbox"/> Yes b) <input type="checkbox"/> No c) <input type="checkbox"/> Unknown				

1. Co-Defendant's Name	Last	First	M.I.	Credentials (e.g. M.D., D.O)
2. License Number	3. Specialty Description _____		4. Verdict Awarded	
		ISO Code _____	a) <input type="checkbox"/> Yes b) <input type="checkbox"/> No c) <input type="checkbox"/> Unknown	
5. Settlement Made			6. Verdict or Settlement Awarded \$ _____ or <input type="checkbox"/> N/A	
a) <input type="checkbox"/> Yes b) <input type="checkbox"/> No c) <input type="checkbox"/> Unknown				

(Attach Additional Sheet(s) if Necessary.)

XI. Closed Claim Report Information

1. Contact Person's Name (Last, First) Heinsohn, Connie
2. Contact Person's Phone Number ((999) 999-9999) (602) 678-3424
3. Contact Person's Address 8900 N. 22nd Avenue, #300 Phoenix, AZ 85021-6018

Name of Person Responsible for Report (Last, First) Todd, Theodore
Signature of Person Responsible for Report <i>Theodore Todd / EW</i>

ST. PAUL DOES NOT UTILIZE ISO CODES



Hudson Insurance Company | 851 Napa Valley Corporate Way
Hudson Specialty Insurance Company | Suite N
Napa, CA 94558
T 707 225.3300
F 707 225.3333
www.hudsoninsgroup.com

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JUN 13 2011

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June 10, 2011

NEVADA STATE BOARD OF
MEDICAL EXAMINERS

Douglas Cooper
Nevada State Board of Medical Examiners
P.O. Box 7238
Reno, NV 89510

RE: ██████████ vs. Silver, Frank P., MD

Dear Mr. Cooper,

Pursuant to NRS 630.306, enclosed please find:

- A copy of the lawsuit which was served on _____.
- A copy of the lawsuit associated with the subject matter which was submitted to arbitration or mediation on _____.
- A copy of the Nevada Medical Professional Liability Close Claim Report for the subject matter which reached its final disposition.

If you have any questions or concerns, please contact the undersigned.

Regards,

Sandra Gish
Sr. Claims Support Specialist
Hudson Healthcare
851 Napa Valley Corporate Way, Suite N
Napa, CA 94558
SGish@Hudsoninsgroup.com
(707) 225-3339

Nevada Medical Professional Liability Closed Claim Report

I. Background

1. Name of Insurer: <u>Hudson Insurance</u>		2. Claim No.: <u>67551</u>	
3. Injury Date (Date of Loss): <u>05/23/07</u>	4. Report Date: <u>02/13/08</u>	5. Closure Date: <u>06/02/11</u>	
6. Policy Type (choose a, b, or c): a) <input type="checkbox"/> Occurrence b) <input checked="" type="checkbox"/> Claims made c) <input type="checkbox"/> Tail/Reporting Endorsement			
7. Policy Limits (Per Claim/Aggregate): <u>\$1MM /\$3MM</u>		8. Date This Closed Claim Report Submitted: <u>06/10/11</u>	
9. Type of Report (choose a or b): a) <input checked="" type="checkbox"/> Initial Report b) <input type="checkbox"/> Updated Report			

II. Defendant & Co-Defendants

1. Defendant's Name:	Last: <u>Silver</u>	First: <u>Frank</u>	M.I.: <u>P.</u>	Credentials (e.g. MD, DO, DMD, DDS): <u>MD</u>
2. License Number: <u>2641, NV</u>	3. Specialty: Gynecology – Description: <u>major surgery</u> ISO Code: <u>80167</u>		4. Co-Defendant(s)? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
5. Number of Co-Defendant(s): <u>N/A</u> or <input type="checkbox"/> Unknown				
6. Name, License Number and Insurer of Each Co-Defendant, if known:				

III. Injured & Injury

1. Injured Party's Name:	Last: <u>[REDACTED]</u>	First: <u>[REDACTED]</u>	M.I.:	2. Sex: <input type="checkbox"/> Male or <input checked="" type="checkbox"/> Female
3. Age: <u>24</u>	4. Date of Birth (MM/DD/YY): <u>03/14/86</u>	5. Malpractice code (per Appendix 1): <u>MP</u>		6. Injury Code (per Appendix 2): <u>FnB</u>
7. Description of Alleged Malpractice and Injuries (Attach Additional Sheet(s) if Necessary.): <u>The claimant incurred septic shock due to retained fragments of a laminaria placed in her cervix by the insured.</u>				
8. City Where Injury Occurred: <u>Las Vegas</u>		9. Name of Institution (If Injury Occurred in Institution):		

IV. Medical/Dental Screening Panel (Hereafter, Panel)

1. Case Filed with Panel? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No or <input type="checkbox"/> Unknown (IF YES, ANSWER QUESTIONS 2 AND 3)	
2. Panel Case Number:	
3. Panel Decision: Is there Reasonable Probability of Malpractice? a) <input type="checkbox"/> Yes b) <input type="checkbox"/> No c) <input type="checkbox"/> Unable to Decide d) <input type="checkbox"/> Case Dismissed e) <input type="checkbox"/> Other [case settled/withdrawn before panel met]	
4. Court Case Filed After Panel Decision: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

V. Court Case

1. Court Case Filed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown (IF YES, ANSWER QUESTIONS 2-7)			
2. Court Case Number: <u>A556577</u>	3. Court Name: <u>District Court Clark County, Nevada</u>	4. Court Department Number: <u>22</u>	
5. Date Court Case Was Filed: <u>02/04/08</u>	6. Date Verdict Was Filed, if Applicable: <u>N/A</u>	7. Date Settlement Offer Accepted, if Applicable: <u>12/20/10</u>	

V. Reserves (Amounts Attributed to this Defendant Only, If Multiple Defendants)

1. Reserves:	Initial: <u>\$10,000</u>	Highest: <u>\$ 240,000</u>	Last: <u>\$ 240,000</u>
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VI. Claim Disposition (Attributed to this Defendant only)

1. Claim Disposition (check one)	a) <input type="checkbox"/> Decided By Trial in Favor of Plaintiff	b) <input type="checkbox"/> Decided By Trial in Favor of Defendant	c) <input type="checkbox"/> Decided by Arbitrator in Favor of Plaintiff	d) <input type="checkbox"/> Decided by Arbitrator in Favor of Defendant
e) <input checked="" type="checkbox"/> Settled w/o Court or Prior to Trial	f) <input type="checkbox"/> Claim Denied	g) <input type="checkbox"/> Claim Inactive	h) <input type="checkbox"/> Claim Withdrawn	i) <input type="checkbox"/> Other
2. If Claim Disposition is e, f, g, h or I, Please Explain: <u>The case settled at the MSC on 12/20/10.</u>				

Name of Insurer: Hudson Insurance	Claim No.: <u>67551</u>
Defendant's Name (Last, First, M.I.): <u>Silver, Frank P., MD</u>	Date This Closed Claim Report Submitted: <u>06/10/11</u>

VIII. Verdict Information (Attributed to All Defendants in Case)

1. Verdict Awarded: \$ or <input checked="" type="checkbox"/> N/A

IX. Claim Information (Amounts Attributed to this Defendant Only, If Multiple Defendants)

1. Verdict or Settlement Awarded: <u>\$240,000</u> or ___N/A	2. Verdict or Settlement Paid: <u>\$240,000</u> or ___N/A
3. Reasons for Amount Awarded (1) Not Being Equal to Amount Paid (2), if Applicable (Check more than one if Applicable): a) ___ Post Verdict Settlement b) ___ Award Reduced to Present Value c) ___ Interest Awarded d) ___ Court Costs Awarded e) ___ Non-economic damages limited by Judge to \$350,000 f) ___ Award Capped by Judge at Policy Limit g) ___ Other (Explain):	
4. How Will/Did Plaintiff Receive Payments?:	a) <input checked="" type="checkbox"/> Lump Sum b) ___ Periodic Payments c) ___ N/A
5. If Periodic Payments, What is the Present Value (as of Date of Award) of the Payments?: \$	
6. Sources of Award Payments:	a) Company: <u>\$240,000</u> b) Defendant: \$ c) Other (describe): \$
7. Allocated Loss Adjustment Expenses:	Total: <u>\$82,140.04</u> Attorney's Fees: <u>\$63,214.50</u> Other: <u>\$18,925.54</u>

X. Claim Information (Amounts Attributed to Other Defendants)

1. Co- Defendant's Name:	Last:	First:	M.I.:	Credentials (e.g. MD, DO):
2. License Number:	3. Specialty: Description: ISO Code:		4. Verdict Awarded: a) ___ Yes b) ___ No c) ___ Unknown	
5. Settlement Made: a) ___ Yes b) ___ No c) ___ Unknown			6. Verdict or Settlement Awarded: \$ or ___ N/A	


1. Co- Defendant's Name:	Last:	First:	M.I.:	Credentials (e.g. MD, DO):
2. License Number:	3. Specialty: Description: ISO Code:		4. Verdict Awarded: a) ___ Yes b) ___ No c) ___ Unknown	
5. Settlement Made: a) ___ Yes b) ___ No c) ___ Unknown			6. Verdict or Settlement Awarded: \$ or ___ N/A	

1. Co- Defendant's Name:	Last:	First:	M.I.:	Credentials (e.g. MD, DO):
2. License Number:	3. Specialty: Description: ISO Code:		4. Verdict Awarded: a) ___ Yes b) ___ No c) ___ Unknown	
5. Settlement Made: a) ___ Yes b) ___ No c) ___ Unknown			6. Verdict or Settlement Awarded: \$ or ___ N/A	

(Attach Additional Sheet(s) if Necessary.)

XI. Closed Claim Report Information

1. Contact Person's Name (Last, First): <u>Gish, Sandra</u>
2. Contact Person's Phone Number: <u>(707) 225-3339</u>
3. Contact Person's Address: <u>851 Napa Valley Corporate Way, Suite N, Napa, CA 94558</u>

Name of Person Responsible for Report (Last, First): <u>Gish, Sandra</u>
Signature of Person Responsible for Report: 

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In The Matter of Charges and
Complaint Against
Frank Silver, M.D.,
Respondent.

NO. Case No. 06-4041-1

FILED 13 July 2006


EXECUTIVE DIRECTOR

COMPLAINT

The Investigative Committee of the Board of Medical Examiners of the State of Nevada, composed of Sohail U. Anjum, M.D., Chairman, Mrs. Marlene J. Kirch, Member, and S. Daniel McBride, M.D., Member, by and through Lyn E. Beggs, Deputy General Counsel for the Nevada State Board of Medical Examiners, having a reasonable basis to believe that Frank Silver, M.D., hereinafter referred to as "Respondent," has violated the provisions of NRS Chapter 630, hereby issues its formal Complaint, stating the Investigative Committee's charges and allegations, as follows:

1. Respondent is currently licensed in active status, and at all times alleged herein, was so licensed by the Nevada State Board of Medical Examiners, pursuant to the provisions of Chapter 630 of the Nevada Revised Statutes.

2. Patient A was a thirty-year-old female at the time of the incident in question. Her true identity is not disclosed to protect her privacy, but her identity is disclosed in the Patient Designation served on Respondent along with a copy of this Complaint.

3. Patient A initially presented to Respondent in September 2004 and Respondent performed a total abdominal hysterectomy on Patient A in October 2004.

4. Subsequent to the surgery, Patient A developed discomfort on her right side which was suspected to be an ovarian cyst and/or adhesions. Diagnostic laparoscopy with possible aspiration of

1 the ovarian cyst with lysis of adhesions was recommended after failing to resolve Patient A's symptoms
2 with anti-inflammatory medications.

3 5. Patient A underwent the recommended surgical procedure on June 17, 2005, during
4 which lysis of the adhesions was completed as well as drainage of the right ovarian cyst.

5 6. Patient A began experiencing abdominal pain and illness on June 18, 2005, and
6 presented to the emergency room at North Vista Hospital on June 19, 2005, with these symptoms.
7 Patient A's condition worsened and an exploratory laparotomy was to be performed, however, Patient A
8 expired before undergoing surgery.

9 7. An autopsy was performed which stated the cause of death to be fibrinous peritonitis due
10 to perforation of the sigmoid colon during the laparoscopic procedure and made the specific finding that
11 the sigmoid colon showed an open defect with darkened, curled, and what appear to be, burnt edges.

12 **Count I**

13 8. All of the allegations in the above paragraphs are incorporated herein as if set forth in
14 full.

15 9. Respondent was overly aggressive in his efforts to lyse Patient A's adhesions resulting in
16 an injury to the sigmoid colon and thus his care of Patient A fell below the accepted standard of care.

17 10. Respondent's failure to provide Patient A with the accepted standard of care constitutes
18 malpractice and thus violates Section 630.301(4) of the Nevada Revised Statutes.

19 11. By reason of the foregoing, Respondent is subject to discipline by the Nevada State
20 Board of Medical Examiners as provided in Section 630.352 of the Nevada Revised Statutes.

21 **Count II**

22 12. All of the allegations in the above paragraphs are incorporated herein as if set forth in
23 full.

24 13. Respondent failed to recognize the injury to Patient A's sigmoid colon during the
25 laparoscopic procedure and take immediate action to repair the injury and thus his care fell below the
26 standard of care.

27 14. Respondent's failure to provide Patient A with the accepted standard of care constitutes
28 malpractice and thus violates Section 630.301(4) of the Nevada Revised Statutes.

1 15. By reason of the foregoing, Respondent is subject to discipline by the Nevada State
2 Board of Medical Examiners as provided in Section 630.352 of the Nevada Revised Statutes.

3 WHEREFORE, the Investigative Committee prays:

4 1. That the Nevada State Board of Medical Examiners fix a time and place for a formal
5 hearing;

6 2. That the Nevada State Board of Medical Examiners give respondent notice of the
7 charges herein against him, the time and place set for the hearing, and the possible sanctions against
8 him;

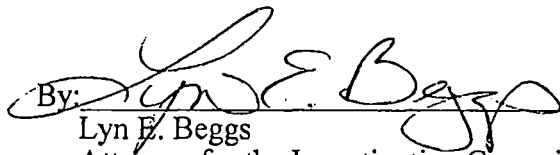
9 3. That the Nevada State Board of Medical Examiners determine what sanctions it
10 determines to impose for the violation or violations committed by Respondent;

11 4. That the Nevada State Board of Medical Examiners make, issue and serve on
12 Respondent its findings of facts, conclusions of law and order, in writing, that includes the sanctions
13 imposed; and

14 5. That the Nevada State Board of Medical Examiners take such other and further action as
15 may be just and proper in these premises.

16 DATED this 7th day of July, 2006.

17 INVESTIGATIVE COMMITTEE OF
18 THE NEVADA STATE BOARD OF MEDICAL EXAMINERS

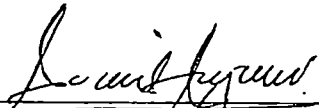
19
20 By: 
21 Lyn E. Beggs
22 Attorney for the Investigative Committee of the Nevada
23 State Board of Medical Examiners
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1 VERIFICATION

2 STATE OF NEVADA)
3 COUNTY OF CLARK) : ss.

4
5 SOHAIL U. ANJUM, M.D., having been duly sworn, hereby deposes and states under penalty of
6 perjury that he is the Chairman of the Investigative Committee of the Nevada State Board of Medical
7 Examiners that authorized the complaint against the Respondent herein; that he has read the foregoing
8 Complaint; and that based upon information discovered in the course of the investigation into a
9 complaint against Respondent, he believes that the allegations and charges in the foregoing Complaint
10 against Respondent are true, accurate, and correct.

11 DATED this 12th day of July, 2006.

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14 _____
15 SOUHAIL U. ANJUM, M.D.

ORIGINAL

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

In The Matter of Charges and
Complaint Against
Frank Silver, M.D.,
Respondent.

NO. _____
FILED Case No. 06-4041-1 8 Dec 06

Shirley A. Clark
EXECUTIVE DIRECTOR

AMENDED COMPLAINT

The Investigative Committee of the Board of Medical Examiners of the State of Nevada, composed of Sohail U. Anjum, M.D., Chairman, Mrs. Marlene J. Kirch, Member, and S. Daniel McBride, M.D., Member, by and through Lyn E. Beggs, Deputy General Counsel for the Nevada State Board of Medical Examiners, having a reasonable basis to believe that Frank Silver, M.D., hereinafter referred to as "Respondent," has violated the provisions of NRS Chapter 630, hereby issues its formal Amended Complaint, stating the Investigative Committee's charges and allegations, as follows:

1. Respondent is currently licensed in active status, and at all times alleged herein, was so licensed by the Nevada State Board of Medical Examiners, pursuant to the provisions of Chapter 630 of the Nevada Revised Statutes.

2. Patient A was a thirty-year-old female at the time of the incident in question. Her true identity is not disclosed to protect her privacy, but her identity is disclosed in the Patient Designation served on Respondent along with a copy of this Complaint.

3. Patient A initially presented to Respondent in September 2004 and Respondent performed a total abdominal hysterectomy on Patient A in October 2004.

4. Subsequent to the surgery, Patient A developed discomfort on her right side which was suspected to be an ovarian cyst and/or adhesions. Diagnostic laparoscopy with possible aspiration of

1 the ovarian cyst with lysis of adhesions was recommended after failing to resolve Patient A's symptoms
2 with anti-inflammatory medications.

3 5. Patient A underwent the recommended surgical procedure on June 17, 2005, during
4 which lysis of the adhesions was completed as well as drainage of the right ovarian cyst.

5 6. Patient A began experiencing abdominal pain and illness on June 18, 2005, and
6 presented to the emergency room at North Vista Hospital on June 19, 2005, with these symptoms.
7 Patient A's condition worsened and an exploratory laparotomy was to be performed, however, Patient A
8 expired before undergoing surgery.

9 7. An autopsy was performed which stated the cause of death to be fibrinous peritonitis due
10 to perforation of the sigmoid colon during the laparoscopic procedure and made the specific finding that
11 the sigmoid colon showed an open defect with darkened, curled, and what appear to be, burnt edges.

12 **Count I**

13 8. All of the allegations in the above paragraphs are incorporated herein as if set forth in
14 full.

15 9. Respondent was overly aggressive in his efforts to lyse Patient A's adhesions resulting in
16 an injury to the sigmoid colon and thus his care of Patient A fell below the accepted standard of care.

17 10. Respondent's failure to provide Patient A with the accepted standard of care constitutes
18 malpractice and thus violates Section 630.301(4) of the Nevada Revised Statues.

19 11. By reason of the foregoing, Respondent is subject to discipline by the Nevada State
20 Board of Medical Examiners as provided in Section 630.352 of the Nevada Revised Statutes.

21 WHEREFORE, the Investigative Committee prays:

22 1. That the Nevada State Board of Medical Examiners fix a time and place for a formal
23 hearing;

24 2. That the Nevada State Board of Medical Examiners give respondent notice of the
25 charges herein against him, the time and place set for the hearing, and the possible sanctions against
26 him;

27 3. That the Nevada State Board of Medical Examiners determine what sanctions it
28 determines to impose for the violation or violations committed by Respondent;

1 4. That the Nevada State Board of Medical Examiners make, issue and serve on
2 Respondent its findings of facts, conclusions of law and order, in writing, that includes the sanctions
3 imposed; and

4 5. That the Nevada State Board of Medical Examiners take such other and further action as
5 may be just and proper in these premises.

6 DATED this 17th day of December, 2006.

7 INVESTIGATIVE COMMITTEE OF
8 THE NEVADA STATE BOARD OF MEDICAL EXAMINERS

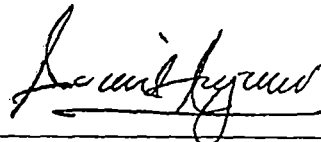
9
10 By: Lyn E. Beggs
11 Lyn E/ Beggs
12 Attorney for the Investigative Committee of the Nevada
13 State Board of Medical Examiners

1 VERIFICATION

2 STATE OF NEVADA)
3 COUNTY OF CLARK) : ss.

4
5 SOHAIL U. ANJUM, M.D., having been duly sworn, hereby deposes and states under penalty of
6 perjury that he is the Chairman of the Investigative Committee of the Nevada State Board of Medical
7 Examiners that authorized the complaint against the Respondent herein; that he has read the foregoing
8 Complaint; and that based upon information discovered in the course of the investigation into a
9 complaint against Respondent, he believes that the allegations and charges in the foregoing Complaint
10 against Respondent are true, accurate, and correct.

11 DATED this 8th day of December, 2006.

12
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14 _____
15 SOUHAIL U. ANJUM, M.D.

COPY

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In The Matter of Charges and)
Complaint Against)
FRANK SILVER, M.D.,)
Respondent.)

NO. Case No. 06-4041-1
FILED 24 June 2008
[Signature]
EXECUTIVE DIRECTOR

ORDER OF DISMISSAL

The above-entitled matter came on regularly for decision before the Nevada State Board of Medical Examiners, hereinafter "Board," on June 13, 2008, at the Board's Offices located at 1105 Terminal Way, Reno, Nevada, on the complaint filed herein pursuant to Nevada's Open Meeting Laws, NRS and NAC chapters 630, and NRS Chapter 233B. Neither Frank Silver, M.D. ("Respondent") nor his attorney, John Cotton, Esq., were present for the proceedings.

The members of the Board participating in the decision were Jean Stoess, M.A., Cindy Lamerson, M.D., Benjamin Rodriguez, M.D., Charles Held, M.D. and Javaid Anwar, M.D. Rene West was absent and thus did not participate in the adjudication of the matter. All other remaining members of the Board, being members of the Investigative Committee that issued the complaint in this matter, were excused from participating and took no part in the proceedings of the Board.

The Board having received and read the Synopsis of the Hearing Officer of the hearing conducted in this matter, having received and read a copy of the hearing transcript, and having been provided with the complaint and exhibits in this matter, and having reviewed and read all the above, proceeded to make a decision pursuant to the provisions of NRS 630.352.

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1 The Board, after due consideration of the record, evidence and law, and being fully advised in
2 the premises, hereby finds Respondent not guilty of the count alleged against him in the above
3 identified matter.

4 **IT IS HEREBY ORDERED** that the complaint against Frank Silver, M.D., is hereby
5 dismissed.

6 Done in open session this 13th day of June, 2008.

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9 _____
10 Javid Anwar, M.D., President
11 Nevada State Board of Medical Examiners
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APPLICATION FOR CERTIFICATE TO PRACTICE MEDICINE IN NEVADA

No certificate will be issued except in strict accordance with reciprocal agreements. The fee of TWO HUNDRED (\$200) must accompany the application, together with State certificate, intern certificate, and college diploma. (Photocopies are acceptable.) No certificate as to the possession of these credentials will be accepted in lieu thereof. Applications must be on file with the Secretary of this Board at least ONE MONTH prior to the date of Board meeting.

.....Frank P. Silver, M.D......, depose and say that I am an applicant for a certificate to practice medicine, surgery and obstetrics in the State of Nevada under reciprocal agreements with the State of Pennsylvania.....

That I am a citizen of United States..... and a native of Pennsylvania.....

If not a citizen of the United States, have you applied for U. S. citizenship?

Aged 37 years, and a resident of 715 Martin Road, Elkins Park.....

County of Philadelphia....., State of Pennsylvania....., where

I have been engaged in the practice of medicine for a period of 7 years preceding the date of this application. That I received my medical education in

Thomas Jefferson Medical College - 1957 - 1961
(Give names of all medical schools and dates of attendance)

That I was granted a diploma as a graduate in Medicine by Thomas Jefferson Medical College, 11th and Walnut Streets
(Give the name of your medical school of graduation)

located in Philadelphia State of Pennsylvania on the

6th day of June, 1961; That I was granted Certificate No. 028394 by the

Pennsylvania State Board of Medical Examiners

dated July 16, 1962, upon Written Examination
(Written examination or diploma)

That I am the identical person to whom said Diploma and Certificate were originally granted.

Signed, Applicant
(Name must be signed in full, use no initials)

DECLARATION AS TO PREVIOUS REGISTRATION OR EXAMINATIONS

I, Frank P. Silver, M.D., hereby declare that I am the applicant who signed the foregoing application; that the photograph of myself hereunto attached was taken on or about the 12th day of April, 1972, my age then being 37 years. I further state that I am not registered as a physician in any other State except as follows:

and that no certificate issued to me by any State Board has even been revoked or suspended.

I further state that I have not, previous to this date, applied for examination, license or registration to any State Examining Board except as follows:

Signed, Applicant
(Name must be signed in full, use no initials)

AFFIDAVIT AS TO MORAL AND PROFESSIONAL CHARACTER

(To be filled in by two physicians in applicant's county)

Lester Bauer, M.D., being duly sworn, deposes and says:

I reside at 5030 Oxford Avenue, in the County of Philadelphia,

in the State of Pennsylvania, and am personally acquainted with

Dr. Frank P. Silver, and know him to be the identical person

named in the accompanying diploma, and he is of good moral and professional character.

Subscribed and sworn to before me this 28th Name Lester Bauer M.D.

day of April, A.D. 1972 Address 5030 Oxford Avenue

Notary Public, Philadelphia, Philadelphia Co.
My Commission Expires 1972

Philadelphia, Pa. 19124

(Suggestion: Endorsement by the Secretary of County Medical Society)

Charles Q. Griffith, M.D., being duly sworn, deposes and says:

I reside at 1789 Washington Lane, in the County of Montgomery,

in the State of Pennsylvania, and am personally acquainted with

Dr. Frank P. Silver, and know him to be the identical person

named in the accompanying diploma, and he is of good moral and professional character.

Subscribed and sworn to before me this 28th Name Charles Q. Griffith, M.D.

day of April, A.D. 1972 Address 1789 Washington Lane

Notary Public, Philadelphia, Philadelphia Co.
My Commission Expires November 19, 1972

Meadowbrook, Pennsylvania

DO NOT FILL THE BLANKS BELOW

RECIPROcity

With

NEVADA STATE BOARD OF MEDICAL EXAMINERS

Certificate No.

Issued _____, 19__

Filed _____, 19__

Approved by board _____, 19__

Fee paid _____, 19__

Nevada Basic Science Certificate No.

issued _____, 19__

Temporary permit (if any): No.

issued _____, 19__

Credentials verified _____, 19__

By _____ Secretary

Secretary

Credentials returned _____, 19__

By _____

APPLICANT MUST FILL FOLLOWING BLANKS

Address 715 Martin Road

Elkins Park, Pa.

Age 37 Date of birth 8/23/34

Place of birth Philadelphia,

Pennsylvania

Name of college issuing medical diploma:

Thomas Jefferson Medical College

11th and Walnut Sts., Phila. 19107

located at

Date of graduation 1961

Internship Nazareth Hospital

Located at 2601 Holme Avenue

from July 1, 61 to June 30, 1962

Total years of practice 7 years

your specialty Ob-Gyn

Certificate No. 028394 issued by:

Pennsylvania State Board of

Medical Examiners

on July 16, 1962



Signature of applicant

The above photograph and signature must be certified by your State Board of Endorsement.

PHOTOGRAPH NOT AVAILABLE FOR COMPARISON.

Signature of the Secretary

FINGER PRINTS OF RIGHT HAND

CERTIFICATE OF STATE ENDORSEMENT

I, Alva R. Cockley of Harrisburg, Pennsylvania Secretary of the Pennsylvania State Board of Medical Education & Licensure hereby certify that Dr. Frank Silver of Philadelphia, Pennsylvania was granted on the 20th day of July, 1962, Certificate No. 28394 by the Pennsylvania State Board of Medical Education & Licensure upon examination by the said Board in

the following subjects:

Table with 2 columns: Subject, Rating/Percent. Includes Anatomy & Bacteriology (77), Pathology (83), Chemistry, Symptomatology & Therapeutics (75), Public Health, Sanitation & Medical Jurisprudence (79), Obstetrics, Surgery, etc.

I further certify that the ratings herein given are true and correct and that the said applicant was awarded a general average of 80.9 percent thereon. I further certify that no certificate issued by this Board to the said Frank Silver has ever been revoked or suspended, and that from the records now on file in this office I believe him to be of good moral character and worthy of professional recognition, and recommend him to the Nevada State Board of Medical Examiners as a fit and proper person to receive reciprocal recognition by the Nevada State Board of Medical Examiners. In testimony thereof witness my hand and seal.

Signature of Alva R. Cockley, Secretary of the Pennsylvania State Board of Medical Education & Licensure

[SEAL]

Post office address 279 Boas Street, Harrisburg, Pennsylvania 17120

Dated at Harrisburg, Pennsylvania

this 10th day of May, 1972

NOTE - The applicant should, in all cases, fill in the information required in this application, certify to the same before the Clerk of a court of record and then forward the application to the Secretary of the Board issuing his original certificate for verification and certification.

STATE OF Pennsylvania

Philadelphia County } ss.

Before me personally appeared FRANK Paul SILVER, whose signature, recent photograph, and fingerprints of right hand on page 4 of this form and made oath and says that all of the foregoing statements are true and correct.

Sworn and subscribed to this 28th day of April, A.D. 1965

William J. Fournier
Clark of the Notary Public Court

[SEAL]

of Philad County, State of Pennsylvania

The above deposition must in all cases be duly acknowledged before a Notary Public or other proper officer: Diploma, State Certificate, Intern Certificate, Nevada Basic Sciences Certificate, fee and application should in all cases be sent together, if possible, to the Nevada State Board of Medical Examiners, 3660 Baker Lane, Reno, Nevada. (Photostatic copies are acceptable.)

HISTORY OF YEARS OF PRACTICE SINCE GRADUATION (Including Residences)

Where?	What Dates?
Nazareth Hospital (Internship)	1961-1962
Episcopal Hospital	1962 - 1965
Ob-Gyn Residency	
Private Practice Philadelphia, Pa.	1965 through present time

Have you ever been convicted of a felony? No Morals charge? No

Have you ever been addicted to the use of narcotics? No Alcohol? No

Have you ever been expelled from a Medical Society Yes Yes or No No

If Yes, please give details on separate sheet.

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

- American Medical Association
- Philadelphia County Medical Society
- Philadelphia Obstetrics Society
- American College of Obstetrics-Gynecology

Give the name and address of all Hospitals of which you are, or have been, a Staff member. (Do not give Residences.)

- Episcopal Hospital, Front St. and Lehigh Ave., Phila., Pa. 19125
- Nazareth Hospital, 2601 Holme Avenue, Philadelphia, Pa. 19152
- Northeastern Hospital, 2301 E. Allegheny Ave., Philadelphia, Pa. 19134
- Temple University Hospital, Instructor, 3401 N. BroadSt., Phila., Pa. 19140

List Special Societies and Boards of which you are a member.

- American Board of Obstetrics-Gynecology

APPLICATION FOR REGISTRATION
NEVADA STATE BOARD OF
MEDICAL EXAMINERS

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

Date Received
by State Board

Nevada License No. _____

File No. _____

New Renewal

This shaded section for BOARD USE ONLY

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

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

Delinquent after September 15, 1985.

4041

Frank P SILVER

1401 E Lake Mead Blvd
N Las Vegas NV

89030

PRACTICE: (check One Only)

- Direct Patient Care Resident
- Administration Military
- Medical Teaching Retired

TYPE OR PRINT LEGIBLY

NAME Silver Frank P.
Last First Middle

Social # _____

Business Phone 702 642-4001

BUSINESS OR MAILING ADDRESS 1401 E. Lake Mead No. Las Vegas, Nevada 89030
Street Address or P.O. Box Suite No. City State Zip Code

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

ADDRESS WILL CHANGE ON: _____ 19____

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

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

NAME _____

ADDRESS _____

PHONE # () _____

BOARD CERTIFICATION:

Yes No

AM. Bd. of Obstetrics & Gynecology

Date of Certification or Recertification 11-2-67

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

SINCE YOUR LAST REGISTRATION:

1. Have you been investigated, charged or convicted of unprofessional conduct, professional incompetence or gross or repeated malpractice by any medical licensing board or other agency, hospital or medical society? No Yes 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? No Yes If "yes" attach a detailed explanation

3. Have you surrendered your license to practice medicine in another jurisdiction? Yes No If "yes" attach a detailed explanation

4. Have any malpractice settlements, awards or judgment been made against you in any jurisdiction? Yes No If "yes" attach a detailed explanation

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

1. Southern Nevada Memorial
2. Valley Hospital
3. Community Hospital
4. _____

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

I certify that all the above statements are true

Signature _____
No rubber stamps please

M.D.

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

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

NOV 13 1984

Inquent after March 2, 1985

Nevada License No. NV 2641

File No.

Date of License

New Renewal

This shaded section for BOARD USE ONLY

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

2641
SILVER, FRANK P MD
1401 E LAKE MEAD BLVD
NO LAS VEGAS NV 89030

PRACTICE: (Check One Only)

Direct Patient Care Resident
 Administration Military
 Medical Teaching Retired

TYPE OR PRINT LEGIBLY

NAME Silver, Frank P.
Last First Middle

Social Secur

702-842-4091

BUSINESS OR MAILING ADDRESS 1401 E. Lakemead Blvd. N. Las Vegas, NV 89030
Street Address or P.O. Box Suite No. City State Zip Code

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

ADDRESS WILL CHANGE ON: 19

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

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

BOARD CERTIFICATION:

NAME Yes No

ADDRESS AM. Bd. of

PHONE # 1 Date of Certification or Recertification

Primary Specialty (List only one) Ob-GYN Sub-Specialties:

SINCE YOUR LAST REGISTRATION:

1. Have you been investigated, charged or convicted of unprofessional conduct, professional incompetence or gross or repeated malpractice by any medical licensing board or other agency, hospital or medical society?
Yes No If "yes" attach a detailed explanation

2. Have you been investigated, charged or convicted for the possession, use of, or illegal sale or dispensing of controlled substances?
Yes No If "yes" attach a detailed explanation

3. Have you surrendered your license to practice medicine in another jurisdiction?

Yes No If "yes" attach a detailed explanation

4. Have any malpractice settlements, awards or judgment been made against you in any jurisdiction?

Yes No If "yes" attach a detailed explanation

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

1. Southern Nevada Memorial Hosp. Las Vegas, NV 2. Valley Hospital Las Vegas, NV

3. North Las Vegas Community Hosp. N. Las Vegas, NV 4.

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

I certify that all the above statements are true

Signature
No rubber stamps please

M.D.

APPLICATION FOR REGISTRATION
NEVADA STATE BOARD OF
MEDICAL EXAMINERS

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

NOV 29 1983

Delinquent after March 1, 1984

Nevada License No. 2641

Date of License 8/8/72

File No. _____

New Renewal

This shaded section for BOARD USE ONLY

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

2641

SILVER, FRANK P MD
 1401 E LAKE MEAD BLVD
 NO LAS VEGAS NV 89030

TYPE OR PRINT LEGIBLY

NAME Silver Frank P.
Last First Middle

Social Security # _____

Business Phone # 702-642-4091

BUSINESS ADDRESS 1401 E. Lake Mead North Las Vegas, Nevada 89030
City State Zip Code

MAILING ADDRESS 1401 E. Lake Mead North Las Vegas, Nevada 89030
City State Zip Code

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

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

ADDRESS WILL CHANGE ON: _____ 19____

BUSINESS ADDRESS _____
City State Zip Code

MAILING ADDRESS _____
City State Zip Code

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

BOARD CERTIFICATION:

NAME _____ Yes No _____

ADDRESS _____ AM. Bd. of _____

PHONE # () _____ Date of Certification or Recertification _____

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

Has any disciplinary action been taken against you in any jurisdiction since your last registration?

Yes No
 If "yes" attach a detailed explanation

Has any malpractice action been taken against you in any jurisdiction since your last registration?

Yes No
 If "yes" attach a detailed explanation

PRACTICE: (Check One Only)

Direct Patient Care

Administration

Medical Teaching

Military

Retired

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

1. Southern Nevada Memorial
2. Valley Hospital
3. North Las Vegas
4. _____

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

I certify that all the above statements are true

Signature _____
 No rubber stamps please

M.D.

APPLICATION FOR REGISTRATION

NEVADA STATE BOARD OF MEDICAL EXAMINERS

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

RECEIVED

JUN 05 1987

NEVADA STATE BOARD OF MEDICAL EXAMINERS

License No.

File No.

New

Renewal

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

- ACTIVE STATUS \$300.00
INACTIVE STATUS \$150.00
RETIRED STATUS \$ 50.00

NRS630 explanation of status on reverse side

Frank P. SILVER MD

1401 E. Lake Mead Blvd
Las Vegas NV

89030

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

TYPE OR PRINT LEGIBLY

NAME Silver, Frank P. Last First Middle

Social Security #

Business Phone (702) 642-4091

BUSINESS OR MAILING ADDRESS 1401 E. Lake Mead Blvd. No. Las Vegas, Nevada 89030

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

NAME Frank P. Silver, M.D. ADDRESS 1401 E. Lake Mead Blvd. N. LV, NV 89030 PHONE # (702) 642-4091

BOARD OF CERTIFICATION

Yes X No 67-2-564 AM. Bd. of OB/GYN Date of Certification or Recertification 11/12/67

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

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

Signed: [Signature] Date 5/28/87 (No rubber stamps please)

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

- 1. Have you been investigated, charged or convicted of unprofessional conduct... Yes [] No [x]
2. Have you been arrested, fined (over \$100), charged with or convicted of a crime... Yes [] No [x]
3. Have you been investigated, arrested, charged or convicted for the possession, use of, or illegal sale or dispensing of controlled substances? Yes [] No [x]
4. Have you been denied a medical license or surrendered your license to practice in another jurisdiction... Yes [] No [x]
5. Have you had staff privileges in a hospital denied, suspended, limited, revoked or not renewed... Yes [] No [x]
6. Have any malpractice settlements, awards or judgments been made against you in any jurisdiction? Yes [x] No []

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

- 1. University Medical Center, LV, NV
2. Valley Hospital, LV, NV
3. Community Hospital, LV, NV

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

Signature: [Signature] Date 5/28/87 (No rubber stamps please)

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

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

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

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

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

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

(d) Pay the applicable fee for biennial registration.

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

(Added to NRS by 1985, 2222)

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

(Added to NRS by 1985, 2222)

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

(Added to NRS by 1985, 2222)

APPLICATION FOR REGISTRATION
NEVADA STATE BOARD OF
MEDICAL EXAMINERS

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

RECEIVED
License No. 2641
APR 24 1989

License No. 2641

File No. _____

New

Renewal

NEVADA STATE BOARD OF
 MEDICAL EXAMINERS

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

- ACTIVE STATUS \$300.00
- INACTIVE STATUS \$150.00
- RETIRED STATUS \$ 50.00

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

NRS630 explanation of status on reverse side

4041
 Frank P. SILVER MD
 1401 E Lake Mead Blvd
 Las Vegas NV 89030

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

TYPE OR PRINT LEGIBLY

NAME Silver Frank P.
Last First Middle

Social Security # _____

Business Phone (702) 642-4091

BUSINESS OR MAILING ADDRESS 1401 E. Lake Mead Blvd, C-1 Las Vegas Nevada 89030
Street Address or P.O. Box Suite No. City State Zip Code

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

BOARD OF CERTIFICATION

NAME _____ Yes _____ No _____
 ADDRESS _____ AM. Bd. of _____
 PHONE # (____) _____ Date of Certification or Recertification _____

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

I certify that within the past 24 months, I have completed a minimum of 40 hours of Continuing Medical Education, AMA-Category I and that I have in my files documentation of such. I understand that the CME requirement is mandated by NRS 630.253 and NAC 630.159.

Signed: [Signature] Date 4/19/89
(No rubber stamps)

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

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

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

1. UMC
2. Community
3. Valley
4. _____
5. _____
6. _____

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

Signature [Signature] Date 4/19/89
(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)**

APPLICATION FOR REGISTRATION

NEVADA STATE BOARD OF MEDICAL EXAMINERS

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

Date Received
by State Board
APR 12 1991

License No. _____

File No. _____

New

Renewal

This shaded section for BOARD USE ONLY

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

- ACTIVE STATUS \$400.00
- INACTIVE STATUS \$150.00
- RETIRED STATUS \$ 50.00

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

NRS630 explanation of status on reverse side

Frank P. SILVER, MD
1401 E Lake Mead Blvd C1
N Las Vegas NV 89030-0000

0004041

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

TYPE OR PRINT LEGIBLY

NAME Silver, Frank P.

Last

First

Middle

Social Security # _____

Business Phone (702 642 4091)

BUSINESS OR MAILING ADDRESS 1401 E. Lake Mead Blvd. N. Las Vegas, NV 89030

Street Address or P.O. Box

Suite No.

City

State

Zip Code

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

BOARD OF CERTIFICATION

NAME _____ Yes No

ADDRESS _____ AM. Bd. of The American Board of OB-GYN

PHONE # (_____) _____ Date of Certification or Recertification 1967

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

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

Signature [Signature] Date 4/4/91
(No rubber stamps)

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

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

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

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

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

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

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

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

1. Community Hospital N. Las Vegas, NV 89030

2. Valley Hospital Las Vegas, NV 89102

3. University Medical Center Las Vegas, NV 89102

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

Signature [Signature] Date 4/4/91
(No rubber stamps)

NOTE: Have you signed both "signature" lines.

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

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

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

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

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

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

(d) Pay the applicable fee for biennial registration.

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

(Added to NRS by 1985, 2222)

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)

APPLICATION FOR REGISTRATION

**NEVADA STATE BOARD OF
MEDICAL EXAMINERS**

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

Date Received
by State Board

APR 5 1993

License No. 2641

File No. _____

New

Renewal

This shaded section for BOARD USE ONLY

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

- ACTIVE STATUS \$320.00
- INACTIVE STATUS \$150.00
- RETIRED STATUS \$ 50.00

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

Frank P. Silver, MD
2031 McDaniel St #210
H Las Vegas NV 89030-0000

0004041

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

INSTRUCTIONS - TYPE OR PRINT LEGIBLY

1. YOUR CURRENT LICENSE EXPIRES ON **JUNE 30, 1993**. This is the notice to renew your M.D. license. You may apply for your license renewal upon receipt of this notice.
2. IN ORDER TO PROVIDE SUFFICIENT TIME FOR PROCESSING, PLEASE RETURN THIS RENEWAL APPLICATION WITH THE CORRECT RENEWAL FEE PRIOR TO **JULY 1, 1993**.
3. Use the enclosed self-addressed envelope to return this renewal notice and registration fee. ACTIVE registration requires submission of proof of 40 hours AMA Category I CME. If you register your license INACTIVE or RETIRED, you may not practice medicine in Nevada, including the writing of prescriptions.
4. All fees are non-refundable. Do not send cash through the mail.
5. If your name and/or address has changed from that printed on this notice, clearly indicate that change in the space provided. A NOTARIZED or CERTIFIED copy of the document authorizing your name change (marriage license, divorce decree, etc.) must be included.

Name _____

Street _____

City _____ County _____ State _____ Zip Code _____

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

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

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

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

1. Are you currently active in medicine?

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

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

SPECIALTY CODE:

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

	Code	Percent of Time	Board Certified (Indicate Yes/No)
Primary	<u>20</u>	<u>90-70</u>	<u>yes</u>
Secondary	_____	_____	_____
Tertiary	_____	_____	_____

PLEASE INDICATE AMERICAN BOARD OF MEDICAL SPECIALTIES BOARD CERTIFICATION:

Board Am. Board Ob-gyn.

Subboard _____

3. How many hours per week do you spend in each of the following activities?

- 40 hours Patient care or services
- _____ hours Administration (schools, agencies, association, etc.)
- _____ hours Teaching medical courses
- _____ hours Research
- _____ hours Other (specify _____)

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

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

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

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

PLEASE LIST CURRENT HOSPITAL AFFILIATION(S):

Name	LAKE MEAD	Address	1401 LAKE MEAD BLVD N. LAS VEGAS
Name	Umc	Address	2015 Cheyenne Blvd. LAS VEGAS
Name	Valley	Address	Shore Lane Las Vegas
Name		Address	

CONTINUING MEDICAL EDUCATION

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

1. Except as otherwise provided in subsection 2 and NAC 630.157, each holder of a license to practice medicine shall, at the time of the biennial registration, submit to the board by the final date set by the board for submitting applications for biennial registration evidence, in such form as the board requires, that he has completed 40 full hours of continuing medical education during the preceding 2 years in one or more educational programs. Each educational program must:
 - (a) Offer, upon successful completion of the program, a certificate of Category 1 credit as recognized by the American Medical Association to the holder of the license;
 - (b) Be approved by the board; and
 - (c) Be sponsored in whole or in part by an organization accredited or deemed to be an equivalent organization to offer such programs by the American Medical Association or the Liaison Committee on Continuing Medical Education.

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

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

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

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

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

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

PLEASE CHECK ONE OF THE FOLLOWING:

- 1. I have earned a minimum of 40 hours approved AMA Category I continuing medical education (CME) for the period July 1, 1991, through June 30, 1993.
- 2. I am exempt because I have completed a full year of residency or fellowship training during the period for biennial registration immediately preceding the submission of this application.
- 3. I am exempt as I am applying for INACTIVE or RETIRED status.

Signature [Handwritten Signature]
(SIGNATURE STAMP UNACCEPTABLE)

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

Date of Birth: 8 23 34 month/day/year Social Security Number: _____
DEA Number: _____

Medical School: Thomas Jefferson Univ. Phila Pa
City State

Internship: Nazareth Hospital Phila Pa
City State

Residency: Episcopal Hospital Phila Pa
City State

City State

Fellowship: ACOG.
City State

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

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

642-4091 Business Telephone # 4/1/93 Date X [Handwritten Signature] Signature (SIGNATURE STAMP UNACCEPTABLE)

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

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

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

Date Received
by State Board

MAY 04 1995

License No. _____

File No. _____

This shaded section for BOARD USE ONLY

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

- ACTIVE STATUS \$420
- INACTIVE STATUS \$150 (see attached NRS 630.255 & 630.257)
- RETIRED STATUS \$ 50 (see attached NRS 630.256 & 630.257)
- P.A. SUPERVISING PHYSICIAN \$200

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

(POST NO. BY
TRAINING BOARD OF
N.M.S.A.P.)

Frank P. Silver, MD
2027 McDermott St. 7910
Las Vegas NV 89000-0000

0004041

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

INSTRUCTIONS - TYPE OR PRINT LEGIBLY

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

Name _____

Street _____

City _____ County _____ State _____ Zip Code _____

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

Name _____

Street _____

City _____ County _____ State _____ Zip Code _____

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

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

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

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

PLEASE PROVIDE ALL INFORMATION AS REQUESTED.

1. Are you currently active in medicine?

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

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

SPECIALTY CODE:

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

	Code	Percent of Time	Board Certified (Indicate Yes/No)
Primary	<u>20</u>	<u>100</u>	<u>YES</u>
Secondary	_____	_____	_____
Tertiary	_____	_____	_____

PLEASE INDICATE AMERICAN BOARD OF MEDICAL SPECIALTIES BOARD CERTIFICATION:

Date of Initial Certification Date of Last Recertification

Board	<u>OB/GYN</u>	<u>11/67</u>	_____
		(Mo./Yr.)	(Mo./Yr.)
Subboard	_____	_____	_____
		(Mo./Yr.)	(Mo./Yr.)

3. How many hours per week do you spend in each of the following activities?

- 40 hours Patient care or services
- _____ hours Administration (schools, agencies, associations, etc.)
- _____ hours Teaching medical courses
- _____ hours Research
- 10-15 hours Other (specify Surgery)

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

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

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

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

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

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

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

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

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

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

1. Have you failed to repay, in accordance with the terms of the loan, any direct loan or loan which is insured or guaranteed by the Federal Government or a state or local government which you received to finance all or any part of your medical education? Yes No
2. Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? Yes No
3. Does your use of chemical substance(s) in any way impair or limit your ability to practice medicine with reasonable skill and safety? Yes No
4. Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? Yes No
5. Have you been diagnosed as having, or have you been treated for pedophilia, exhibitionism, or voyeurism? Yes No
6. Are you currently engaged in the illegal use of controlled dangerous substances? Yes No
7. Have you been a defendant in a legal action involving professional liability (malpractice) or had a professional liability claim paid in your behalf or paid such a claim yourself? Yes No
8. Have you been investigated for, charged with or convicted of, or pled nolo contendere to a violation of any federal, state or local law relating to the manufacture, distribution, prescribing, or dispensing of controlled substances? Yes No
9. Have you been arrested, investigated for, charged with or convicted of, or pled nolo contendere to any offense, misdemeanor or felony in any state, the United States, or a foreign country? Yes No
10. Have you previously applied for medical licensure in Nevada (including a residency program)? Yes No
11. Have you failed to initiate the performance of public service within one year after the date the public service is required to begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local government for your medical education? Yes No
12. Have you been denied a license, permission to practice medicine or any other healing arts, or permission to take an examination to practice medicine or any other healing arts in any state, country or U.S. territory? Yes No
13. Have you had a medical license revoked, suspended, limited, or restricted in any state, country or U.S. territory? Yes No
14. Have you voluntarily surrendered a license to practice in the healing arts in any state, country or U.S. territory? Yes No
15. Have you been denied membership or expelled from a medical society or other professional medical organization? Yes No
16. List all hospitals where you have had staff privileges denied, suspended, limited, revoked or not renewed by the hospital. List any and all resignations from any medical staff in lieu of disciplinary or administrative action. (Please Note: Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance.)

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

17. Have you been investigated for, charged with, or convicted of any violation of a statute, rule or regulation governing the practice of medicine by any medical licensing board, hospital, medical society, governmental entity or other agency? Yes No
18. Have you surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? Yes No

CONTINUING MEDICAL EDUCATION

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

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

- (a) Offer, upon successful completion of the program, a certificate of Category 1 credit as recognized by the American Medical Association to the holder of the license;
- (b) Be approved by the board; and
- (c) Be sponsored in whole or in part by an organization accredited or deemed to be an equivalent organization to offer such programs by the American Medical Association or the Liaison Committee on Continuing Medical Education.

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

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

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

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

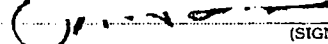
(b) Submits to the board, in such form as it requires, evidence that he has completed 40 full hours of continuing medical education in addition to that otherwise required by subsection 1 or NAC 630.157; and

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

(Added to NAC by Bd. of Medical Examiners, 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 biennial period July 1, 1993, through June 30, 1995 and have earned a minimum of 10 hours approved AMA Category I continuing medical education (CME).
5. I am exempt from submitting proof of continuing medical education (CME) because I have completed a full year of residency or fellowship training during the biennial period July 1, 1993 through June 30, 1995.

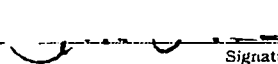
Signature:  (SIGNATURE STAMP UNACCEPTABLE)

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

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

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

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

Business Telephone # 642-4091 Date 4/25/95 X  Signature (SIGNATURE STAMP UNACCEPTABLE)

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

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

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

3. The board shall notify a licensee:

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

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

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

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

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

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

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

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

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

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

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

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

(Added to NRS by 1985, 2222; A 1987, 195; 1993, 2209)

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, 2223; A 1987, 2209)

I hereby apply for renewal of biennial registration and enclose the appropriate fees as indicated below:
 ACTIVE STATUS \$600.00
 INACTIVE STATUS \$150.00
 RETIRED STATUS \$ 50.00
 P.A. SUPERVISING PHYSICIAN \$200.00

PLEASE NOTE: NEVADA HAS NO GRACE PERIOD. LICENSES NOT RENEWED BY JULY 1, 1997 ARE AUTOMATICALLY SUSPENDED FOR NON-PAYMENT

Frank P. Silver, MD
 2031 McDaniel St #210
 N Las Vegas, NV 89030

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

INSTRUCTIONS - TYPE OR PRINT LEGIBLY

- 1. YOUR CURRENT M.D. LICENSE EXPIRES ON JUNE 30, 1997. THIS IS THE NOTICE TO RENEW YOUR M.D. LICENSE.**
- To be eligible to act as a supervising physician for a physician assistant, complete the enclosed Application for Approval as Supervising Physician form.
- 3. ACTIVE STATUS REGISTRATION RENEWAL REQUIRES THE SUBMISSION OF PROOF OF 40 HOURS OF AMA CATEGORY I, CONTINUING MEDICAL EDUCATION** completed during the period July 1, 1995 through June 30, 1997. Submit your proof of CME with your completed Application for Registration Renewal form.
- In order to provide sufficient time for processing, please complete and return your Application for Registration Renewal form and Application for Approval as Supervising Physician form (if applicable) with your proof of 40 hours AMA Category I CME and the correct fee(s) **PRIOR TO JULY 1, 1997**. Use the enclosed self-addressed envelope to return your completed form(s) and fee(s).
- If your name and/or address has changed from that printed on this form, clearly indicate the change in the space provided. A notarized or certified copy of the document authorizing your name change (marriage license, divorce decree, etc.) must be included.

Name Frank P. Silver, MD
 Street 2031 McDaniel St #210
 City N. Las Vegas County Clark State NV Zip 89030

6. IF YOU HAVE RETIRED OR MOVED YOUR PRACTICE, PLEASE INDICATE THE LOCATION OF FORMER PATIENT RECORDS BELOW:
 Name _____
 Street _____
 City _____ County _____ State _____ Zip _____

YOUR LICENSE REGISTRATION WILL NOT BE RENEWED WITHOUT SUBMISSION OF THE CORRECT FEE(S), PROPERLY COMPLETED FORM(S) AND PROOF OF 40 HOURS OF AMA CATEGORY I, CME'S
ALL PAGES OF THE FORM(S) MUST BE COMPLETED AND RETURNED
ALL FEES ARE NON-REFUNDABLE
DO NOT SEND CASH THROUGH THE MAIL
PLEASE ALLOW SIXTY (60) DAYS FOR THE PROCESSING OF YOUR REGISTRATION RENEWAL

1. Are you currently active in medicine?

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

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

SPECIALTY CODE:

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

	Code	Percent of Time	Board Certified (Indicate Yes/No)
Primary	<u>70</u>	<u>70</u>	<u>YES</u>
Secondary	<u>40</u>	<u>30</u>	<u> </u>
Tertiary	<u> </u>	<u> </u>	<u> </u>

PLEASE INDICATE AMERICAN BOARD OF MEDICAL SPECIALTIES BOARD CERTIFICATION:

Board	<u>The American Board of OB Gyn</u>	Date of Initial Certification	Date of Last Certification
Subboard	<u> </u>	<u>11/10/67</u>	<u> </u>
		(Mo./Yr.)	(Mo./Yr.)
		(Mo./Yr.)	(Mo./Yr.)

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

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

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

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

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

- The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments; and
- 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
- The physician capability to perform medical tasks such as physician examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

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

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

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

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

1. Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? Yes No
2. If you have a medical condition which in any way impairs or limits your ability to practice medicine is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? Yes No N/A
3. If you use chemical substances, does your use of chemical substance(s) in any way impair or limit your ability to practice medicine with reasonable skill and safety? Yes No N/A
4. Have you failed to initiate the performance of public service within one year after the date the public service is required to begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local government for your medical education? Yes No
5. Have you been a defendant in a legal action involving professional liability (malpractice) or had a professional liability claim paid in your behalf or paid such a claim yourself? Yes No
6. Have you ever been investigated for, charged with, convicted of, or plead guilty or nolo contendere to, any offense or violation of any federal, state or local law, including any foreign country, which is a misdemeanor, gross misdemeanor, or felony, excluding any minor traffic offense (Driving or in control of a motor vehicle while under the influence of any substance is not considered a minor traffic offense) or which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? Yes No
7. Have you ever been denied a license, permission to practice medicine or any other healing arts, or permission to take an examination to practice medicine or any other healing arts in any state, country or U.S. territory? Yes No
8. Have you ever had a medical license revoked, suspended, limited, or restricted in any state, country or U.S. territory? Yes No
9. Have you ever voluntarily surrendered a license to practice a healing art in any state, country or U.S. territory? Yes No
10. Have you ever been denied membership or expelled from a medical society or other professional medical organization? Yes No
11. Have you ever been investigated for, charged with, or convicted of any violation of a statute, rule or regulation governing the practice of medicine by any medical licensing board, hospital, medical society, governmental entity or other agency? Yes No
12. Have you ever surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? Yes No
13. List all hospitals where you have had staff privileges denied, suspended, limited, revoked or not renewed by the hospital. List any and all resignations from any medical staff in lieu of disciplinary or administrative action. (Please Note: Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance).

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

If more space is needed, attach separate sheet.

PLEASE CHECK ONE OF THE FOLLOWING:

1. I have earned a minimum of 40 hours approved AMA Category I continuing medical education (CME) for the biennial period July 1, 1995, through June 30, 1997.
2. I was initially licensed in Nevada during the second six months of the biennial period July 1, 1995, through June 30, 1997 and have earned a minimum of 30 hours approved AMA Category I continuing medical education (CME).
3. I was initially licensed in Nevada during the third six months of the biennial period July 1, 1995, through June 30, 1997 and have earned a minimum of 20 hours approved AMA Category I continuing medical education (CME).
4. I was initially licensed in Nevada during the fourth six months of the biennial period July 1, 1995, through June 3, 1997 and have earned a minimum of 10 hours approved AMA Category I continuing medical education (CME).
5. I am exempt from submitting proof of continuing medical education (CME) because I have completed a full year of residency or fellowship training during the biennial period July 1, 1995, through June 30, 1997.

Signature _____

signature stamp unacceptable

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

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

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

702-642-4091
Business Telephone #

5/30/99
Date

Signature (SIGNATURE STAMP UNACCEPTABLE)

PHYSICIAN
APPLICATION FOR RENEWAL REGISTRATION
NEVADA STATE BOARD OF
MEDICAL EXAMINERS

Date Received by Board

License No. 2641

~~MAY 14 1999~~

MAY 20 1999

File No. _____

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

(Board Use Only)

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

<input checked="" type="checkbox"/> ACTIVE STATUS	\$600.00
<input type="checkbox"/> INACTIVE STATUS	\$200.00
<input type="checkbox"/> RETIRED STATUS	\$ 50.00
<input type="checkbox"/> SUPERVISING/COLLABORATING PHYSICIAN	\$200.00

Frank P. Silver, MD
2031 McDaniel St #210
N Las Vegas NV 89030

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

0004041

PLEASE NOTE

NEVADA HAS NO GRACE PERIOD - - - - - LICENSES NOT RENEWED BY JULY 1, 1999
ARE AUTOMATICALLY SUSPENDED FOR NON-PAYMENT.

EXTENSIONS OF TIME ARE NOT ALLOWED FOR ANY REASON.

YOUR LICENSE WILL NOT BE RENEWED WITHOUT ANSWERING ALL QUESTIONS.

ALL YES ANSWERS MUST BE EXPLAINED.

YOU MUST INCLUDE PROOF OF 40 HOURS OF AMA CATEGORY 1 CME WHICH INCLUDES
2 HOURS IN MEDICAL ETHICS AND 20 HOURS IN YOUR SCOPE OF PRACTICE OR SPECIALTY.

ALL FEES MUST BE PAID AND ARE NON-REFUNDABLE.

DO NOT SEND CASH THROUGH THE MAIL.

PLEASE ALLOW SIXTY (60) DAYS FOR PROCESSING OF YOUR APPLICATION.

PLEASE TYPE OR PRINT LEGIBLY

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

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

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

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

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

Name FRANK P. SILVER, M.D.
Street 341 N. BUFFALO, STE. B
City LAS VEGAS County CLARK State NEVADA Zip 89145

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

Name FRANK P. SILVER, M.D.
Street 341 N. BUFFALO, STE. B
City LAS VEGAS County CLARK State NV Zip 89145

7. Are you currently active in medicine?

- a. YES, in training.
 c. YES, working part-time
 e. NO, other (specify _____)

- b. YES, working full-time
 d. NO, retired.

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

SCOPE OF PRACTICE
SPECIALTY CODES

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

Primary	Code <u>20</u>	Percent of Time <u>60</u>	Board Certified (Indicate Yes/No) <u>Yes</u>
Secondary	<u>40</u>	<u>40</u>	<u>Yes ABIME</u>
Tertiary			

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

	Date of Initial Certification	Date of Last Certification
Board <u>AMERICAN BOARD OB-GYN.</u>	<u>11/67</u> (Mo./Yr.)	 (Mo./Yr.)
Subboard _____	(Mo./Yr.)	(Mo./Yr.)
Board <u>AMERICAN BOARD INDEPENDENT MEDICAL EXAM.</u>	<u>6/97</u> (Mo./Yr.)	<u>6/97</u> (Mo./Yr.)
Subboard _____	(Mo./Yr.)	(Mo./Yr.)

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

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

1012 Other (specify _____)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PLEASE CHECK ONE OF THE FOLLOWING:

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

Signature _____ (SIGNATURE STAMP UNACCEPTABLE)

PLEASE CHECK ONE OF THE FOLLOWING:

- 1. I have earned a minimum of 40 hours approved AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics, and 20 hours of which were in my scope of practice or specialty during the biennial period July 1, 1997, through June 30, 1999.
- 2. I was initially licensed in Nevada during the second six months of the biennial period July 1, 1997, through June 30, 1999, and have earned a minimum of 30 hours approved AMA Category I continuing medical education (CME).
- 3. I was initially licensed in Nevada during the third six months of the biennial period July 1, 1997, through June 30, 1999, and have earned a minimum of 20 hours approved AMA Category I continuing medical education (CME).
- 4. I was initially licensed in Nevada during the fourth six months of the biennial period July 1, 1997, through June 30, 1999, and have earned a minimum of 10 hours approved AMA Category I continuing medical education (CME).
- 5. I am exempt from submitting proof of continuing medical education (CME) because I have completed a full year of residency or fellowship training during the biennial period July 1, 1997, through June 30, 1999.

IMPORTANT

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

Signature _____ (SIGNATURE STAMP UNACCEPTABLE)

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

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

102-228-4004 4-27-99
Business Telephone # Date Signature (SIGNATURE STAMP UNACCEPTABLE)

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

Date Received by Board

MAY 22 2001

License No. 2641
File No.

(For Board Use Only)

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

- | | | |
|---|----------|-----------------------------------|
| <input checked="" type="checkbox"/> ACTIVE STATUS | \$600.00 | |
| <input type="checkbox"/> INACTIVE STATUS | \$200.00 | (RETIRED STATUS REQUIRES THAT THE |
| <input type="checkbox"/> RETIRED STATUS | \$ 50.00 | APPLICANT NOT PRACTICE MEDICINE |
| <input checked="" type="checkbox"/> SUPERVISING/COLLABORATING PHYSICIAN | \$200.00 | ANYWHERE) |

file no. candidate no. 546

Frank P SILVER
341 N Buffalo #B
Las Vegas, NV 89145

M.D.

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

PLEASE NOTE:

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

PLEASE TYPE OR PRINT LEGIBLY

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

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

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

Name FRANK P. SILVER, M.D.
Street 341 N. Buffalo suite B
City LAS VEGAS County CLARK State NV. Zip 89145
Phone Number (702) 228-4004 Fax Number (702) 228-5653

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

Name _____
Street _____
City _____ County _____ State _____ Zip _____
Phone Number _____

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

JEFFERSON Medical College 1961

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

Code
Code
Code

Primary Specialty 23 Secondary Specialty 29 Tertiary Specialty 19

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

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

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

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

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

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

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

1. Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? _____ Yes No
2. If you have a medical condition which in any way impairs or limits your ability to practice medicine, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? _____ Yes _____ No _____ N/A
3. If you use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety? _____ Yes _____ No N/A
4. Have you failed to initiate the performance of public service within one year after the date the public service is required to begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local government for your medical education? _____ Yes _____ No N/A
5. Have you been a defendant in a legal action involving professional liability (malpractice) or had a professional liability claim paid in your behalf or paid such a claim yourself? _____ Yes No
6. Have you ever been investigated for, charged with, convicted of, or plead guilty or nolo contendere to any offense or violation of any federal, state or local law, including any foreign country, which is a misdemeanor, gross misdemeanor, or felony, excluding any minor traffic offense (driving or in control of a motor vehicle while under the influence of any chemical substance is **not** considered a **minor traffic offense**) or which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? _____ Yes No
7. Have you ever been denied a license, permission to practice medicine or any other healing art, or permission to take an examination to practice medicine or any other healing art in any state, country or U.S. territory? _____ Yes No
8. Have you ever had a medical license or license to practice any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory? _____ Yes No
9. Have you ever voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory? _____ Yes No
10. Have you ever been denied membership or expelled from a medical society or other professional medical organization? _____ Yes No
11. Have you ever been: a) notified that you were under investigation for; b) investigated for; c) charged with; or d) convicted of any violation of a statute, rule or regulation governing your practice as a physician by any medical licensing board, hospital, medical society, governmental entity or other agency other than the Nevada State Board of Medical Examiners? _____ Yes No
12. Have you ever surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? _____ Yes No

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

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

CHILD SUPPORT STATEMENT

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

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

CONTINUING MEDICAL EDUCATION (CME) STATEMENT

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

- (a) I completed a minimum of 40 hours of AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics and 20 hours of which were in my scope of practice or specialty, during the past biennial period of July 1, 1999 through June 30, 2001;
- (b) I was initially licensed in Nevada during the time period January 1, 2000 through June 30, 2000, the second six months of the past biennial period, and completed a minimum of 30 hours of AMA Category I continuing medical education (CME), 2 hours of which were in medical ethics and 20 hours of which were in my scope of practice or specialty;
- (c) I was initially licensed in Nevada during the time period July 1, 2000 through December 31, 2000, the third six months of the past biennial period, and completed a minimum of 20 hours of AMA Category I continuing medical education (CME), 2 hours of which were in medical ethics and 18 hours of which were in my scope of practice or specialty;
- (d) I was initially licensed in Nevada during the time period January 1, 2001 through June 30, 2001, the fourth six months of the past biennial period, and completed a minimum of 10 hours of AMA Category I continuing medical education (CME), 2 hours of which were in medical ethics and 8 hours of which were in my scope of practice or specialty; OR
- (e) I am exempt from submitting proof of completion of continuing medical education (CME) because I have completed a full year of residency or fellowship training during the biennial period July 1, 1999 through June 30, 2001.

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

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

BY SIGNING ON THE SIGNATURE LINE BELOW:

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

4/12/01 _____

PHYSICIAN

Date Received by Board

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

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

FEB 24 2003

(For Board Use Only)

License No. 2641

File No.

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

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

File no. License no. 2641

Frank P SILVER
341 N Buffalo #B
Las Vegas, NV 89145

M.D.

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

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

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

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

Date Signature (SIGNATURE STAMP UNACCEPTABLE)

PLEASE NOTE:

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

PLEASE TYPE OR PRINT LEGIBLY

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

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

Name
Street
City County State Zip
Phone Number (702) 228-9004 Fax Number (702) 228-5653

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

Name
Street
City County State Zip
Phone Number

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

SCOPE OF PRACTICE CODES

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

Primary Scope of Practice Code 25

Secondary Scope of Practice Code 12



All of the following questions refer to the time period July 1, 2001, through the present date only.

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

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

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

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

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

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

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

2. If you have a medical condition which in any way impairs or limits your ability to practice medicine, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? _____ Yes _____ No N/A

3. If you use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety? _____ Yes _____ No N/A

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

5. Have you been a defendant in a legal action involving professional liability (malpractice) or had a professional liability claim paid in your behalf or paid such a claim yourself? Yes _____ No

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

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

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

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

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

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

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

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

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

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

CHILD SUPPORT STATEMENT

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

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

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

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

CONTINUING MEDICAL EDUCATION (CME) STATEMENT

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

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

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

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

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

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

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

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

BY SIGNING ON THE SIGNATURE LINE BELOW:

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

X 2/6/03
Date

X [Signature]
Signature (SIGNATURE STAMP UNACCEPTABLE)

PHYSICIAN

APPLICATION FOR REGISTRATION RENEWAL
FOR THE BIENNIAL REGISTRATION PERIOD 2005 - 2007
NEVADA STATE BOARD OF MEDICAL EXAMINERS

Date Received by Board **MAR 14 2005** License No. 2641
 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
 INACTIVE STATUS \$300.00.....(INACTIVE STATUS DOES NOT PERMIT
 I REQUEST NON-RENEWAL OF MY LICENSE* THE PRACTICE OF MEDICINE INCLUDING
 (*IF YOU ARE REQUESTING NON-RENEWAL, SEE BELOW) THE WRITING OF PRESCRIPTIONS IN NEVADA)

File No: _____ License No: **2641**

Frank Paul SILVER M.D. NEVADA STATE BOARD OF MEDICAL EXAMINERS
 341 N Buffalo #B (Foreign checks must indicate "U.S. FUNDS")
 Las Vegas NV 89145-

Make checks payable to:

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

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

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

Date _____ Signature (SIGNATURE STAMP UNACCEPTABLE) N/A

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 FRANK PAUL SILVER, MD
 Street 341 N. BUFFALO SUITE B
 City LAS VEGAS County CLARK State NV. Zip 89145
 Phone Number (702) 228-4004 Fax Number (702) 228-5653

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

Name _____
 Street _____
 City _____ County N/A State _____ Zip _____
 Phone Number _____

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

SCOPES OF PRACTICE CODES

1 ADDICTION MEDICINE	43 NEPHROLOGY	85 PEDIATRIC, SURGERY
2 ADOLESCENT MEDICINE	44 NEUROLOGY	86 PEDIATRIC, UROLOGY
3 AEROSPACE MEDICINE	45 NEURO-OPHTHALMOLOGY	87 PEDIATRICS
4 ALLERGY	46 NEUROPATHOLOGY	89 PHYSICAL MEDICINE/REHABILITATION
5 ALLERGY/IMMUNOLOGY	47 NEURORADIOLOGY	89 PREVENTIVE MEDICINE
6 AMBULATORY MEDICINE	48 NEUROTOLOGY	90 PSYCHIATRY
7 ANESTHESIOLOGY	49 NON-CONVENTIONAL MEDICINE	91 PSYCHOANALYSIS
8 BLOODBANKING	50 NUCLEAR MEDICINE	92 PSYCHOMATIC MEDICINE
9 BRONCO-ESOPHAGOLOGY	51 NUTRITION	93 PUBLIC HEALTH
10 CARDIOVASCULAR DISEASES	52 OBSTETRICS	94 PULMONARY DISEASES
11 CATSCAN/ULTRASOUND	53 OBSTETRICS/GYNECOLOGY	95 OCCUPATIONAL MEDICINE
12 CHILD NEUROLOGY	54 OCCUPATIONAL MEDICINE	96 RADIOLOGY
13 CHILD PSYCHIATRY	55 ONCOLOGY	97 RADIOLOGY, DIAGNOSTIC
14 CLINICAL PHARMACOLOGY	56 ONCOLOGY, GYNECOLOGICAL	98 RADIOLOGY, INTERVENTIONAL
15 CRITICAL CARE	57 ONCOLOGY, HEMATOLOGY	99 RADIOLOGY, NUCLEAR
16 DERMATOLOGY	58 ONCOLOGY, RADIATION	100 RADIOLOGY, THERAPEUTIC
17 DERMATOPATHOLOGY	59 ONCOLOGY, SURGICAL	101 RADIOLOGY, VASCULAR
18 EMERGENCY MEDICINE	60 OPHTHALMOLOGY	102 RHEUMATOLOGY
19 ENDOCRINOLOGY	61 OTOLARYNGOLOGY	103 RHINOLOGY
20 FAMILY PRACTICE	62 OTOTOLOGY	104 SLEEP DISORDERS
21 FORENSIC MEDICINE	63 PAIN MANAGEMENT	105 SPORTS MEDICINE
22 GASTROENTEROLOGY	64 PATHOLOGY	106 SURGERY, ABDOMINAL
23 GENERAL PRACTICE	65 PATHOLOGY, ANATOMIC	107 SURGERY, CARDIOTHORACIC
24 GERIATRIC PSYCHIATRY	66 PATHOLOGY, CLINICAL	108 SURGERY, CARDIOVASCULAR
25 GERIATRICS	67 PATHOLOGY, FORENSIC	109 SURGERY, COLON/RECTAL
26 GYNECOLOGY	68 PEDIATRIC, ALLERGY	110 SURGERY, CRANIOFACIAL
27 HAIR TRANSPLANTATION	69 PEDIATRIC, ANESTHESIOLOGY	111 SURGERY, GENERAL
28 HEMATOLOGY	70 PEDIATRIC, RADIOLOGY	112 SURGERY, HAND
29 HOMEOPATHY	71 PEDIATRIC, CRITICAL CARE	113 SURGERY, HEAD/NECK
30 HYPNOSIS	72 PEDIATRIC, EMERGENCY MEDICINE	114 SURGERY, MAXILLOFACIAL
31 IMMUNOLOGY	73 PEDIATRIC, ENDOCRINOLOGY	115 SURGERY, NEUROLOGICAL
32 INFECTIOUS DISEASES	74 PEDIATRIC, GASTROENTEROLOGY	116 SURGERY, ORTHOPEDIC
33 INFERTILITY	75 PEDIATRIC, HEMATOLOGY/ONCOLOGY	117 SURGERY, PLASTIC
34 INTERNAL MEDICINE	76 PEDIATRIC, INFECTIOUS DISEASES	118 SURGERY, THORACIC
35 LARYNGOLOGY	77 PEDIATRIC, INTENSIVIST	119 SURGERY, TRANSPLANT
36 LEGAL MEDICINE	78 PEDIATRIC, NEPHROLOGY	120 SURGERY, TRAUMATIC
37 MATERNAL/FETAL MEDICINE	79 PEDIATRIC, RADIOLOGY	121 SURGERY, UROLOGIC
38 MEDICAL ACUPUNCTURE	80 PEDIATRIC, OPHTHALMOLOGY	122 SURGERY, VASCULAR
39 MEDICAL ETHICS	81 PEDIATRIC, PHYSIATRY	123 TOXICOLOGY
40 MEDICAL GENETICS	82 PEDIATRIC, PULMONARY	124 TRANSPLANTATION
41 NEO/PERINATAL MEDICINE	83 PEDIATRIC, RADIOLOGY	125 URGENT CARE
42 NEOPLASTIC DISEASES	84 PEDIATRIC, RHEUMATOLOGY	126 UROLOGY

Code _____ Code _____
 Primary Scope of Practice 26 Secondary Scope of Practice 33

PLEASE INDICATE AMERICAN BOARD OF MEDICAL SPECIALTIES BOARD CERTIFICATION & RECERTIFICATION

Board AMERICAN BOARD OBGYN Date of Initial Certification 1967 Date of Last Recertification NO EXPIRATION
 (Mo./Yr.) (Mo./Yr.)
 Subboard _____ (Mo./Yr.) (Mo./Yr.)

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

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

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

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

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

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

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

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

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

2. If you have a medical condition which in any way impairs or limits your ability to practice medicine, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? _____ Yes _____ No N/A

3. If you use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety? _____ Yes _____ No N/A

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

5. Have you been a defendant in a legal action involving professional liability (malpractice) or had a professional liability claim paid in your behalf or paid such a claim yourself? _____ Yes No

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

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

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

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

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

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

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

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

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

CHILD SUPPORT STATEMENT

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

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

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

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

CONTINUING MEDICAL EDUCATION (CME) STATEMENT

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

(a) I completed a minimum of 44 hours of AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics and 20 hours of which were in my scope of practice or specialty, and an additional 4 hours of AMA Category 1 continuing medical education in acts of terrorism, during the past biennial period of July 1, 2003 through June 30, 2005;

(b) I was initially licensed in Nevada during the time period January 1, 2004 through June 30, 2004, the second six months of the past biennial period, and completed a minimum of 34 hours of AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics and 20 hours of which were in my scope of practice or specialty, and an additional 4 hours of AMA Category 1 continuing medical education in acts of terrorism;

(c) I was initially licensed in Nevada during the time period July 1, 2004 through December 31, 2004, the third six months of the past biennial period, and completed a minimum of 24 hours of AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics and 18 hours of which were in my scope of practice or specialty, and an additional 4 hours of AMA Category 1 continuing medical education in acts of terrorism;

(d) I was initially licensed in Nevada during the time period January 1, 2005 through June 30, 2005, the fourth six months of the past biennial period, and completed a minimum of 14 hours of AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics and 8 hours of which were in my scope of practice or specialty, and an additional 4 hours of AMA Category 1 continuing medical education in acts of terrorism; OR

(e) I am exempt from submitting proof of completion of continuing medical education (CME) because I have completed a full year of residency or fellowship training during the biennial period July 1, 2003 through June 30, 2005.

- **ATTACH COPIES OF PROOF OF YOUR COMPLETION OF CONTINUING MEDICAL EDUCATION (CME) HOURS.**
- **IF YOU COMPLETED A FULL YEAR OF RESIDENCY OR FELLOWSHIP TRAINING DURING THE BIENNIAL PERIOD JULY 1, 2003 THROUGH JUNE 30, 2005, ATTACH A COPY OF PROOF OF COMPLETION OF YOUR TRAINING.**
- **YOUR COPIES OF PROOF OF CME OR TRAINING COMPLETION WILL NOT BE RETURNED TO YOU.**

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

BY SIGNING ON THE SIGNATURE LINE BELOW:

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

2/17/05
Date

X
Signature (SIGNATURE STAMP UNACCEPTABLE)

Nevada State Board of Medical Examiners



Renewal Responses Report

Thursday, October 01, 2015

License Number	Licensee	License Type
2641	Frank Paul SILVER	Medical Doctor

Question	Answer	Date
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Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? If you answer "Yes" during the time period July 1, 2005 - June 30, 2007 email to alicensensbme@medboard.nv.gov	N	05/04/2007
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If you have a medical condition which in any way impairs or limits your ability to practice medicine, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? N
If you answer "Yes" during the time period July 1, 2005 - June 30, 2007 email to elicensbme@medboard.nv.gov

05/04/2007

If you use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety? N
If you answer "Yes" during the time period July 1, 2005 - June 30, 2007 email to elicensbme@medboard.nv.gov

05/04/2007

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

05/04/2007

Have you been named as a defendant, or been requested to respond as a defendant, to a legal action involving professional liability (malpractice), or had a professional liability claim paid on your behalf, or paid such a claim yourself?

Y

05/04/2007

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

N

05/04/2007

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

N

05/04/2007

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
If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to alicensensbme@medboard.nv.gov.

05/04/2007

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? N
If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to alicensensbme@medboard.nv.gov.

05/04/2007

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 nslicensbme@medboard.nv.gov.

N

05/04/2007

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 nslicensbme@medboard.nv.gov.

N

05/04/2007

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
nslicensensbme@medboard.nv.gov.

N

05/04/2007

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

N

05/04/2007

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 nslicensensbme@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
nslicensensbme@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 alicensensbme@medboard.nv.gov.

N

05/04/2007

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 alicensensbme@medboard.nv.gov.

N

05/04/2007

NSBME Renewal Responses Report

10/1/2015

Are you a foreign medical doctor, who holds a Conditional Resident Alien Card, Employment Authorization Card, or Visa with the Department of Homeland Security, Immigration and Naturalization Services?
If "yes" please fax a copy of proof to (775) 688-2551 ATTN:Online License Renewal.

N

05/04/2007

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 nlicensensbme@medboard.nv.gov.

N

05/04/2007

NSBME Renewal Responses Report

10/1/2015

Do you want to change your scope of practice or specialty?
If you answer "Yes" during the time period July 1, 2005 - June 30, 2007 email to
elicensensbme@medboard.nv.gov

N

05/04/2007

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

Y

05/04/2007

NSBME Renewal Responses Report

10/1/2015

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

Y

05/04/2007

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.

Y

05/04/2007

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

N

05/04/2007

HEREBY SWEAR OR AFFIRM UNDER THE PENALTIES OF PERJURY THAT I AM IN FULL COMPLIANCE WITH ANY AND ALL OBLIGATIONS, TERMS OR CONDITIONS OF MY NEVADA MEDICAL LICENSE SPECIFIED BY THE BOARD.

Y

05/04/2007

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

N

05/05/2009

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

Explanation 1: 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.

If you have a medical condition which in any way impairs or limits your ability to practice medicine, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? **N**
If you do not have a medical condition, select No.

05/05/2009

Explanation 2: 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.

Does your use in any way impair or limit your ability to practice medicine and safety? N
Do not use chemical substances, select No.

05/05/20

Explanation 3: 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.

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)?

N

05/05/2009

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

Explanation 4: 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.

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

05/05/2009

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

Please fax a copy of the complaint, civil or otherwise to 775-688-2551.

Explanation 5: 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.

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. **N**

05/05/2009

Explanation 6: 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.

Have you been arrested, investigated for, charged with, convicted of, or pled guilty or nolo contendere to any criminal offense other than a criminal offense listed in Question #6? Please note that you **MUST** disclose ANY investigation or arrest, including those where the final disposition was dismissal, sealing of a record, or expungement.

N

05/05/2009

Explanation 7: 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.

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

05/05/2009

Explanation 8: 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.

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

05/05/2009

Explanation 9: 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.

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

05/05/2009

Explanation 10: 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.

Have you been denied membership, been asked to resign or expelled from a medical society or other professional medical organization (including the ABMS)?

N

05/05/2009

Explanation 11: 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.

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: N

05/05/2009

- 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?

Explanation 12: 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.

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

N

05/05/2009

Explanation 13: 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.

Have you had hospital staff privileges denied, suspended, limited, revoked or not renewed by the hospital, including any and all resignations from any medical staff in lieu of disciplinary or administrative action? N
If the answer is " Yes," type the name of the hospital, the hospital's mailing address, the type of action taken, and the date or dates of the actions taken in the textbox directly below this question.

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

Explanation 14: 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.

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

N

05/05/2009

If "Yes" during the time period July 1, 2007- June 30, 2009 type an explanation in the textbox directly below this question.

Explanation 15: 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.

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

N

05/05/2009

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.

Explanation 16: For the above question, if your answer is "Yes" and you want to change to inactive status for the next biennial July 1, 2009 – June 30, 2011, please provide a brief explanation in this text box.

Do you want to change your scope of practice or specialty?
If you answer "Yes" type your current scope of practice or specialty in the textbox directly below this question.

N

05/05/2009

Explanation 17: For the above question if your answer is "YES" , please type your new scope of practice or specialty in this text box.

ISBME Renewal Responses Report

10/1/2015

have completed the required amount of AMA Category 1 CME within the current biennial.
Review CME information online at www.medboard.nv.gov)
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.
renewing to an Inactive status, CME is not required and "No" can be selected.

Y

05/05/2009

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

05/05/2009

Nevada State Board of Medical Examiners

Renewal Responses Report

Thursday, October 01, 2015



License Number	Licensee	License Type
2641	Frank Paul SILVER	Medical Doctor

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

N

06/07/2011

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

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.

NSBME Renewal Responses Report

10/1/2015

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

06/07/2011

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

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.

If you use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety? N

06/07/2011

If you do not use chemical substances, select No.

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.

NSBME Renewal Responses Report

10/1/2015

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

N

06/07/2011

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 type your explanation in this text box.

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

06/07/2011

If "Yes" during the time period July 1, 2009 - June 30, 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 type your explanation in this text box. Please fax a copy of the complaint, civil or otherwise to 775-688-2551.

NSBME Renewal Responses Report

10/1/2015

Have you been arrested, investigated for, charged with, convicted of, or pled guilty or nolo contendere to any offense or violation of any federal (including the Uniform Code of Military Justice), state or local law, or the laws of any foreign country, which is a misdemeanor, gross misdemeanor, felony, violation of the Uniform Code of Military Justice, or synonymous thereto in a foreign jurisdiction, excluding any minor traffic offense (driving or being in control of a motor vehicle while under the influence of a chemical substance, including alcohol, is not considered a minor traffic offense), or for any offense which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? **Please note that you MUST disclose ANY investigation or arrest, including those where the final disposition was dismissal, or expungement.**

N

06/07/2011

Explanation 6: For the above question if your answer is "Yes" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box.

NSBME Renewal Responses Report

10/1/2015

Have you been denied a license, permission to practice medicine or any other healing art, or permission to take an examination to practice medicine or any other healing art in any state, country or U.S. territory? N

06/07/2011

Explanation 7: For the above question if your answer is "Yes" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box.

NSBME Renewal Responses Report

10/1/2015

Have you had a medical license or license to practice any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory? N

06/07/2011

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.

NSBME Renewal Responses Report

10/1/2015

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

N

06/07/2011

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.

Have you been denied membership, been asked to resign or expelled from a medical society or other professional medical organization (including the ABMS)? N

06/07/2011

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.

NSBME Renewal Responses Report

10/1/2015

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

06/07/2011

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.

NSBME Renewal Responses Report

10/1/2015

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

N

06/07/2011

Explanation 12: For the above question if your answer is "Yes" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box.

Have you had hospital staff privileges denied, suspended, limited, revoked or not renewed by the hospital, including any and all resignations from any medical staff in lieu of disciplinary or administrative action? N
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.

06/07/2011

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

Explanation 13: For the above question if your answer is "Yes" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box.

NSBME Renewal Responses Report

10/1/2015

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

N

06/07/2011

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

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

NSBME Renewal Responses Report

10/1/2015

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

N

06/07/2011

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.

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.

NSBME Renewal Responses Report

10/1/2015

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

06/07/2011

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

NSBME Renewal Responses Report

10/1/2015

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

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

N

06/07/2011

Explanation 17: For the above question if your answer is "Yes" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box.

NSBME Renewal Responses Report

10/1/2015

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

Y

06/07/2011

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

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

I SWEAR OR AFFIRM UNDER THE PENALTY OF PERJURY THAT I PERSONALLY ANSWERED ALL
OF THE QUESTIONS IN THIS APPLICATION AND THAT THE ANSWERS I HAVE PROVIDED ARE
TRUE AND CORRECT.

Y

06/07/2011

PHYSICIAN
APPLICATION FOR REGISTRATION RENEWAL
FOR THE BIENNIAL REGISTRATION PERIOD 2013 - 2015
NEVADA STATE BOARD OF MEDICAL EXAMINERS
Post Office Box 7238 Reno, Nevada 89510 Phone (775) 688-2559
Physical Address: 1105 Terminal Way, Suite 301 Reno, Nevada 89502

RECEIVED
Date Received by Board
JUN - 5 2013
NEVADA STATE BOARD OF
MEDICAL EXAMINERS

License No. 2641
File No. _____

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

- ACTIVE STATUS ----- \$850.00
 INACTIVE STATUS ----- \$450.00

SAVE \$35 by renewing online at www.medboard.nv.gov

Make checks payable to:
NEVADA STATE BOARD OF MEDICAL EXAMINERS
(Foreign checks must indicate "U.S. Funds")
Credit card authorization may also be utilized.

PLEASE NOTE THE FOLLOWING IMPORTANT INSTRUCTIONS REGARDING YOUR APPLICATION:

- Your current physician's license expires on **JUNE 30, 2013**. If this form is not received by the Nevada State Board of Medical Examiners' (Board) office by July 1, 2013 at 5:00 p.m., your license will be automatically expired and you will not be able to practice medicine until you reinstate your license. **NEVADA HAS NO GRACE PERIOD.**
- Your license will not be renewed unless you answer **ALL** questions on this application and provide written explanation(s) for any/all question(s) answered "yes".
- Your license will not be renewed unless it is accompanied with a check for the proper fee or credit card authorization.
- You may have been selected in a random continuing medical education (CME) audit of all licensees. If you were randomly selected, you will be contacted by the Board for proof of your CME. Your license will not be renewed if you do not have proof of the required CME. Refer to page 4 for a review of your CME requirement. Please retain proof of your CME as the Board does not retain copies.
- All information provided on this application is **PUBLIC** information.
- If you select "INACTIVE STATUS," you are prohibited from practicing medicine and prohibited from writing prescriptions in the state of Nevada. Inactive licensees are not required to submit to the Board for a random audit.
- PLEASE TYPE OR PRINT LEGIBLY.**

RENEWED
7/1/13 - 6/30/15
BIENNIAL

Please print your name and address clearly in the space provided below. Be advised that the address you indicate below is viewable on the Board website and is listed as the public address. Also, please indicate your current public telephone and fax numbers. [Note: If your name has changed, a copy of the document authorizing your legal name change (marriage license, divorce decree, etc.) must be included.]

Name Frank Silver MD
Street 1900 E DESERT INN RD
City LV County CLARK State NV
Zip 89169
Phone Number 702-735-1960 Cell Phone Number _____
Fax Number 702-735-3431 E-mail address _____

In the event that you were selected in the random audit, providing an email address will greatly assist the Board to expedite communication for your renewal.

RECEIVED
JUN - 5 2013
NEVADA STATE BOARD OF
MEDICAL EXAMINERS

Please indicate any American Board of Medical Specialties Board Certification or Recertification:

Date of Initial Certification (Mo./Yr.)

Date of Last Recertification (Mo./Yr.)

Board:

Subboard:

7/16/11
Independent Medical Examiner 10 yrs ago

If any of the ABMS Certifications or Recertifications were received after your last application with the Board, please attach copies of documents evidencing your Certifications or Recertifications.

QUESTIONS

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

"Medical condition" includes physiological, mental or psychological condition or disorder.

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

Please answer all of the following questions for the time period
July 1, 2011 – June 30, 2013, or since your last renewal.

For all YES responses to the following questions, you must submit your written explanation(s) on a separate sheet attached to this form.

1. Do you currently have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? _____ Yes No
2. If you currently have a medical condition which in any way impairs or limits your ability to practice medicine, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? _____ Yes _____ No N/A
3. If you currently use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety? _____ Yes _____ No N/A
4. Have you been named as a defendant, or been requested to respond as a defendant, to a legal action involving professional liability, or malpractice, including any military tort claims if applicable? _____ Yes No
5. 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? Yes _____ No
6. 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. _____ Yes No
7. 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? _____ Yes No
8. 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? _____ Yes No

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JUN - 5 2013

NEVADA STATE BOARD OF MEDICAL EXAMINERS

- 9. Have you voluntarily surrendered a license to practice medicine or any other health profession in any state, country or U.S. territory in lieu of any disciplinary action? Yes No
- 10. Have you failed to initiate the performance of public service within one year after the date the public service is required to begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local government for your medical education? Yes No
- 11. 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? Yes No
- 12. Have you surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? Yes No
- 13. Have you had 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," on a separate sheet list the name of the hospital, the hospital's mailing address, the type of action taken, and the date or dates of the actions taken. (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.)* Yes No
- 14. Have you actively practiced medicine in Nevada within the past 12 months? Yes No

If your answer is "yes", please indicate the approximate percentage of time allotted to the following medical activities.

Clinical practice 100 % Administrative _____ % Teaching _____ % Other _____ %

ATTESTATIONS

SAFE INJECTION PRACTICE ATTESTATION

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

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/hicpac/2007IP/2007isolationPrecautions.html>

I hereby attest that I have knowledge of my duties and responsibilities under the guidelines of the Centers for Disease Control and Prevention and of safe and appropriate injection practices.

Yes No

CONSCIOUS SEDATION DEEP SEDATION OR GENERAL ANESTHESIA ATTESTATION

Nevada Revised Statutes (NRS) require the Nevada State Board of Medical Examiners to obtain from each applicant who seeks renewal of his or her license to practice medicine, a report stating the number and type of surgeries requiring conscious sedation, deep sedation or general anesthesia performed by the holder of the license at his or her office or any other facility, excluding any surgical care performed at a medical facility as defined in NRS 449.0151, or outside the state of Nevada.

I hereby attest that I am in compliance with the reporting requirements of NRS 630.30665, and am aware that failure to submit a report or filing false information in a report is grounds for disciplinary action under Nevada's Medical Practice Act.

Yes No

RECEIVED
JUN - 5 2013
NEVADA STATE BOARD OF
MEDICAL EXAMINERS

CHILD SUPPORT

PLEASE PLACE AN "X" NEXT TO THE STATEMENT THAT APPLIES TO YOU:

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


CONTINUING EDUCATION

ALL CONTINUING MEDICAL EDUCATION MUST HAVE BEEN COMPLETED DURING THE PERIOD OF JULY 1, 2011 THROUGH JUNE 30, 2013. Please place a check mark next to the statement that applies to you.

- I was initially licensed in Nevada prior to July 1, 2011 or during the first 6 months of the biennial period of registration (July 1, 2011 through December 31, 2011) and have completed a minimum of forty (40) hours of AMA Category 1 continuing medical education (CME), two (2) hours of which were in medical ethics and twenty (20) hours of which were in my scope of practice or specialty.
- I was initially licensed in Nevada during the second 6 months of the biennial period of registration (January 1, 2012 through June 30, 2012) and have completed a minimum of thirty (30) hours of AMA Category 1 CME, two (2) hours of which were in medical ethics and twenty (20) hours of which were in my scope of practice or specialty.
- I was initially licensed in Nevada during the third 6 months of the biennial period of registration (July 1, 2012 through December 31, 2012) and have completed a minimum of twenty (20) hours of AMA Category 1 CME, two (2) hours of which were in medical ethics and eighteen (18) hours of which were in my scope of practice or specialty.
- I was initially licensed in Nevada during the fourth 6 months of the biennial period of registration (January 1, 2013 through June 30, 2013) and completed a minimum of ten (10) hours of AMA Category 1 CME, two (2) hours of which were in medical ethics and eight (8) hours of which were in my scope of practice or specialty.
- I am exempt from submitting proof of completion of CME because I have completed a full year of residency or fellowship training during the biennial period of July 1, 2011 through June 30, 2013. If you checked this statement, please attach a copy of proof of completion of your training.

AFFIRMATION

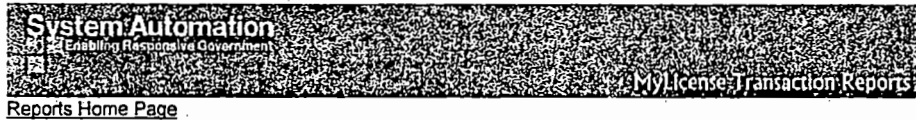
BY SIGNING BELOW, I SWEAR OR AFFIRM UNDER PENALTY OF PERJURY THAT I PERSONALLY ANSWERED ALL OF THE QUESTIONS IN THIS APPLICATION AND THAT THE ANSWERS I HAVE PROVIDED ARE TRUE AND CORRECT.



Signature (Stamp Unacceptable)

5/30/13

Date



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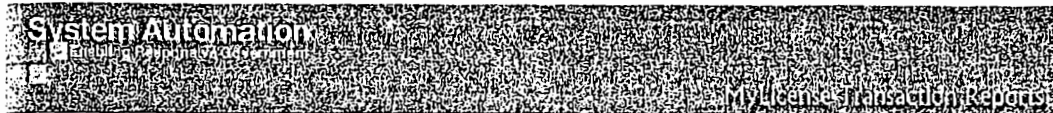
Renewal Questions for License Number 2641



Licensee	Question	Answer	Date
SILVER, Frank Paul	Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? If you do not have a medical condition, select No.	N	6/3/2015
SILVER, Frank Paul	If you have a medical condition which in any way impairs or limits your ability to practice medicine, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, the manner in which you have chosen to practice, or by any other reasonable accommodation? If you do not have a medical condition, select No.	N	6/3/2015
SILVER, Frank Paul	If you use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety? If you do not use chemical substances, select No.	N	6/3/2015
SILVER, Frank Paul	Have you been named as a defendant, or been requested to respond as a defendant, to a legal action involving professional liability, malpractice, including any military tort claims if applicable? Please include: who, what, where (provide state), and when in the textbox directly below this question.	N	6/3/2015
SILVER, Frank Paul	Have you had a professional liability, malpractice, claim paid on your behalf or paid such a claim yourself including any military tort claims if applicable? If "Yes" during the time period July 1, 2013 - June 30, 2015 type an explanation in the textbox directly below this question.	N	6/3/2015
SILVER, Frank Paul	Have you been arrested, investigated for, charged with, convicted of, or pled guilty or nolo contendere to any offense or violation of any federal (including the Uniform Code of Military Justice), state or local law, or the laws of any foreign country, which is a misdemeanor, gross misdemeanor, felony, violation of the Uniform Code of Military Justice, or synonymous thereto in a foreign jurisdiction, excluding any minor traffic offense (driving or being in control of a motor vehicle while under the influence of a chemical substance, including alcohol, is not considered a minor traffic offense), or for any offense which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? Please note that you MUST disclose ANY investigation or arrest, including those where the final disposition was dismissal, or expungement.	N	6/3/2015
SILVER, Frank Paul	Have you been denied a license, permission to practice medicine or any other healing art, or permission to take an examination to practice medicine or any other healing art in any state, country or U.S. territory?	N	6/3/2015
SILVER, Frank Paul	Have you had a medical license or license to practice any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory?	N	6/3/2015
SILVER, Frank Paul	Have you voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory in lieu of any disciplinary action?	N	6/3/2015
		N	6/3/2015

SILVER, Frank Paul	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?		
SILVER, Frank Paul	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	6/3/2015
SILVER, Frank Paul	Have you surrendered your state or federal controlled substance registration or had it revoked or restricted in any way?	N	6/3/2015
SILVER, Frank Paul	Have you had hospital staff privileges denied, suspended, limited, revoked or not renewed by the hospital; including any and all resignations from any medical staff in lieu of disciplinary or administrative action? If the answer is "Yes," type the name of the hospital, the hospital's mailing address, the type of action taken, and the date or dates of the actions taken in the textbox directly below this question. (Please Note: Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance.)	N	6/3/2015
SILVER, Frank Paul	Have you actively practiced medicine in Nevada within the past 12 months?	Y	6/3/2015
SILVER, Frank Paul	OPTION TO CHANGE LICENSE STATUS FROM ACTIVE TO INACTIVE: NOTE: If you choose to drop to Inactive status during this renewal, your status will be changed to "Inactive" as of the date of your renewal. If you do NOT wish to change your status to "Inactive" as of today, DO NOT COMPLETE YOUR RENEWAL UNTIL SUCH TIME AS YOU ARE PREPARED TO HAVE YOUR STATUS CHANGED (prior to JULY 1ST). For your information, your answers to the questions that you've already completed will remain, but you should not complete the renewal and pay until such time as you are prepared to change your status to "Inactive." I hereby request my license to be placed on Inactive status, which means I will <u>not</u> physically practice in the state of Nevada. If you choose to place your license on Inactive status, make certain to select "Yes" to this question AND choose the Inactive status in the dropdown box located at the end of the questions:	N	6/3/2015
SILVER, Frank Paul	If you believe that you are in compliance with the Centers for Disease Control safe injection practices, your answer should be "YES". I hereby attest to knowledge of and compliance with the guidelines of the Centers for Disease Control and Prevention concerning the prevention of transmission of infectious agents through safe and appropriate injection practices. I also attest that any person who is currently, or will be under my control as their supervising physician in the future, and who is not licensed pursuant to chapter 630 of the Nevada Revised Statutes and whose duties involve injection practices, has knowledge of and is in compliance with the guidelines of the Centers for Disease Control and Prevention concerning the prevention of transmission of infectious agents through safe and appropriate injection practices. http://www.cdc.gov/injectionsafety/IP07_standardPrecaution.html	Y	6/3/2015
SILVER, Frank Paul	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	Y	6/3/2015

	<p>Medical Practice Act.</p> <p>I HAVE SUBMITTED A "FORM A" OR "FORM B" REPORT TO THE BOARD.</p> <p>Instructions and Forms A and B for in-office surgery/procedure reporting can be located on the Board's website by clicking the red "In-Office Surgery Reporting" link on the home page of the Board's website: www.medboard.nv.gov.</p> <p>If you have submitted your in-office surgery/procedure reporting forms (A/B Forms) to the Board and are in compliance with NRS 630.30665, your answer should be "YES."</p>		
SILVER, Frank Paul	<p>Are you out of compliance with court ordered child support? If this does not apply to you, please answer "no".</p> <p>If "Yes" during the time period July 1, 2013 - June 30, 2015 type an explanation in the textbox directly below this question.</p>	N	6/3/2015
SILVER, Frank Paul	<p>Once you have read the statute regarding the reporting of the abuse or neglect of a child, your answer to this question will be "YES".</p> <p>I attest and affirm that I am aware of and understand the reporting requirements found in Nevada Revised Statute 432B.220 regarding the abuse or neglect of a child.</p> <p>www.leg.state.nv.us/NRS/NRS-432B.html#NRS432BSec220</p>	Y	6/3/2015
SILVER, Frank Paul	<p>Have you ever served in the United States Military (to include National Guard or Reserves)?</p>	Y	6/3/2015
SILVER, Frank Paul	<p>Explanation 17: If your answer is "No", you do not have to provide information in the text box for the remaining questions regarding the Military Service Attestation.</p> <p>1. If yes, in which branch of service did you serve? 2. What was your Military occupation specialty or specialties? 3. Provide your dates of service in the Military.</p>		6/3/2015
SILVER, Frank Paul	<p>Do you hold a Nevada state business license issued <u>in your individual name</u>?</p>	N	6/3/2015
SILVER, Frank Paul	<p>Explanation 18: If yes, provide the business license number:</p>		6/3/2015
SILVER, Frank Paul	<p>I have completed the required amount of AMA Category 1 CME within the current biennial. I understand that I may be included in a random audit. I agree to retain CME's taken between July 1, 2013 and June 30, 2015. (Review CME information online at www.medboard.nv.gov)</p> <p>If renewing to an <u>Inactive</u> status, CME is not required and "No" can be selected.</p>	Y	6/3/2015
SILVER, Frank Paul	<p>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.</p>	Y	6/3/2015


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Renewal Questions for License Number 2641



Licensee	Question	Answer	Date
SILVER, Frank Paul	Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? If you do not have a medical condition, select No.	N	4/28/2017
SILVER, Frank Paul	Explanation 1: For the above question if your answer is "Yes" for the time period July 1, 2015 – June 30, 2017, 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>emailed to elicensensbme@medboard.nv.gov.</u>		
SILVER, Frank Paul	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	4/28/2017
SILVER, Frank Paul	Explanation 2: For the above question if your answer is "Yes" for the time period July 1, 2015 - June 30, 2017, 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>emailed to elicensensbme@medboard.nv.gov.</u>		
SILVER, Frank Paul	If you use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety? If you do not use chemical substances, select No.	N	4/28/2017
SILVER, Frank Paul	Explanation 3: For the above question if your answer is "Yes" for the time period July 1, 2015 - June 30, 2017, 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>emailed to elicensensbme@medboard.nv.gov.</u>		
SILVER, Frank Paul	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 text box directly below this question.	Y	4/28/2017
SILVER, Frank Paul	Explanation 4: For the above question if your answer is "Yes" for the time period July 1, 2015 - June 30, 2017, or since your last renewal, please type your explanation in this text box. Please fax a copy of the Complaint, Settlement and/or Dismissal, civil or otherwise to 775-688-2551 or scan and <u>email to elicensensbme@medboard.nv.gov.</u>		4/28/2017

SILVER, Frank Paul	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, 2015 - June 30, 2017 type an explanation in the text box directly below this question.	N	4/28/2017
SILVER, Frank Paul	Explanation 5: For the above question if your answer is "Yes" for the time period July 1, 2015 - June 30, 2017, or since your last renewal, please type your explanation in this text box. Please fax a copy of the Complaint, Settlement and/or Dismissal, civil or otherwise to 775-688-2551 or scan and email to elicensensbme@medboard.nv.gov .		
SILVER, Frank Paul	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 during this time period.	N	4/28/2017
SILVER, Frank Paul	Explanation 6: For the above question if your answer is "Yes" for the time period July 1, 2015 - June 30, 2017, or since your last renewal, please type your brief explanation in this text box (Fields are space limited to 256 characters). Lengthy explanations or additional information may be faxed to 775-688-2551 or scanned and emailed to elicensensbme@medboard.nv.gov.		
SILVER, Frank Paul	Have you been denied a license, permission to practice medicine or any other healing art, or permission to take an examination to practice medicine or any other healing art in any state, country or U.S. territory?	N	4/28/2017
SILVER, Frank Paul	Explanation 7: For the above question if your answer is "Yes" for the time period July 1, 2015 - June 30, 2017, or since your last renewal, please type your brief explanation in this text box (Fields are space limited to 256 characters). Lengthy explanations or additional information may be faxed to 775-688-2551 or scanned and emailed to elicensensbme@medboard.nv.gov.		
SILVER, Frank Paul	Have you had a medical license or license to practice any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory?	N	4/28/2017
SILVER, Frank	Explanation 8: For the above question if your answer is "Yes" for the time period July 1, 2015 - June 30, 2017, or since your last renewal,		

Paul	please type your brief explanation in this text box (Fields are space limited to 256 characters). Lengthy explanations or additional information may be faxed to 775-688-2551 or scanned and emailed to elicensensbme@medboard.nv.gov.		
SILVER, Frank Paul	Have you voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory in lieu of any disciplinary action?	N	4/28/2017
SILVER, Frank Paul	Explanation 9: For the above question if your answer is "Yes" for the time period July 1, 2015 - June 30, 2017, or since your last renewal, please type your brief explanation in this text box (Fields are space limited to 256 characters). Lengthy explanations or additional information may be faxed to 775-688-2551 or scanned and emailed to elicensensbme@medboard.nv.gov.		
SILVER, Frank Paul	Have you failed to initiate the performance of public service within one year after the date the public service was 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	4/28/2017
SILVER, Frank Paul	Explanation 10: For the above question if your answer is "Yes" for the time period July 1, 2015 - June 30, 2017, or since your last renewal, please type your brief explanation in this text box (Fields are space limited to 256 characters). Lengthy explanations or additional information may be faxed to 775-688-2551 or scanned and emailed to elicensensbme@medboard.nv.gov.		
SILVER, Frank Paul	Have you been: a) asked to respond to an investigation; b) notified that you were under investigation for; c) investigated for; d) charged with; or e) convicted of any violation of a statute, rule or regulation governing your practice as a physician by any medical licensing board, hospital, medical society, governmental entity or agency <u>other than the Nevada State Board of Medical Examiners</u> ?	N	4/28/2017
SILVER, Frank Paul	Explanation 11: For the above question if your answer is "Yes" for the time period July 1, 2015 - June 30, 2017, or since your last renewal, please type your brief explanation in this text box (Fields are space limited to 256 characters). Lengthy explanations or additional information may be faxed to 775-688-2551 or scanned and emailed to elicensensbme@medboard.nv.gov.		
SILVER, Frank Paul	Have you surrendered your state or federal controlled substance registration or had it revoked or restricted in any way?	N	4/28/2017
SILVER, Frank Paul	Explanation 12: For the above question if your answer is "Yes" for the time period July 1, 2015 - June 30, 2017, or since your last renewal, please type your brief explanation in this text box (Fields are space limited to 256 characters). Lengthy explanations or additional information may be faxed to 775-688-2551 or scanned and emailed to elicensensbme@medboard.nv.gov.		
SILVER, Frank Paul	Have you had hospital staff privileges denied, suspended, limited, revoked or not renewed by a 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(s) of the actions taken in the text box directly below this question. (Please Note: Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or	N	4/28/2017

	staff meetings, or maintain required malpractice insurance.)		
SILVER, Frank Paul	Explanation 13: For the above question if your answer is "Yes" for the time period July 1, 2015 – June 30, 2017, 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>emailed to elicensensbme@medboard.nv.gov.</u>		
SILVER, Frank Paul	Have you been denied membership, been asked to resign or expelled from a medical society or other professional medical organization?	N	4/28/2017
SILVER, Frank Paul	Explanation 14: For the above question if your answer is "Yes" for the time period July 1, 2015 – June 30, 2017, 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>emailed to elicensensbme@medboard.nv.gov.</u>		
SILVER, Frank Paul	Have you actively practiced medicine in Nevada within the past 24 months?	Y	4/28/2017
SILVER, Frank Paul	Explanation 15: For the above question if your answer is "No" for the time period July 1, 2015 – June 30, 2017, 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>emailed to elicensensbme@medboard.nv.gov.</u>		
SILVER, Frank Paul	<p>OPTION TO CHANGE LICENSE STATUS FROM ACTIVE TO INACTIVE:</p> <p>NOTE: If you choose to drop to Inactive status during this renewal, your status will be changed to "Inactive" as of the date of submission of your renewal (today). 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."</p> <p>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.</p> <p>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.</p>	N	4/28/2017
SILVER, Frank Paul	<p>If you believe that you are in compliance with the Centers for Disease Control safe injection practices, your answer should be "YES".</p> <p>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 his/her 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.</p>	Y	4/28/2017

	http://www.cdc.gov/injectionsafety/IP07_standardPrecaution.html		
SILVER, Frank Paul	<p>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.</p> <p>I HAVE SUBMITTED A "FORM A" OR "FORM B" REPORT TO THE BOARD.</p> <p>Instructions and Forms A and B for in-office surgery/procedure reporting can be located on the Board's website by clicking the red "In-Office Surgery Reporting" link on the home page of the Board's website: medboard.nv.gov/forms/in-office_surgery.</p> <p>If you have submitted your in-office surgery/procedure reporting form ("A" OR "B" FORM) to the Board and are in compliance with NRS 630.30665, your answer should be "YES."</p>	Y	4/28/2017
SILVER, Frank Paul	<p>Are you out of compliance with court ordered child support? If this does not apply to you, please answer "no."</p> <p>If "Yes" during the time period July 1, 2015 - June 30, 2017 type an explanation in the text box directly below this question.</p>	N	4/28/2017
SILVER, Frank Paul	<p>Explanation 16: For the above question, if your answer is "Yes" for the biennial July 1, 2015 - June 30, 2017, please type your brief explanation in this text box (Fields are space limited to 256 characters). Lengthy explanations or additional information may be faxed to 775-688-2551 or scanned and emailed to elicensensbme@medboard.nv.gov.</p>		
SILVER, Frank Paul	<p>I attest and affirm that I am aware of and understand the reporting requirements found in Nevada Revised Statute 432B.220 regarding the abuse or neglect of a child.</p> <p>http://www.leg.state.nv.us/NRS/NRS-432B.html#NRS432BSec220</p> <p>Once you have read the statute regarding the reporting of the abuse or neglect of a child, your answer to this question will be "YES."</p>	Y	4/28/2017
SILVER, Frank Paul	<p>Explanation 17: For the above question if your answer is "No" for the time period July 1, 2015 - June 30, 2017, or since your last renewal, please type your explanation in this text box.</p>		
SILVER, Frank Paul	<p>I have completed the required amount of AMA Category 1 CME within the current biennial. I understand that I may be included in a random audit. I agree to retain CME's taken between July 1, 2015 and June 30, 2017. (Review CME information online at http://medboard.nv.gov/licensees/ce/)</p> <p>If renewing to an <u>Inactive</u> status, CME is not required and "No" can be selected.</p>	Y	4/28/2017
SILVER, Frank Paul	<p>I am a medical doctor whose specialty is psychiatry and I am in compliance with NRS 630.253, as I have completed a minimum of 2 hours of continuing medical education in the area of suicide prevention and awareness. Note: If you are not a psychiatrist or you hold Inactive-status licensure (or choose to change to Inactive status during your renewal), your answer should be "No."</p>	N	4/28/2017
SILVER, Frank	I SWEAR OR AFFIRM UNDER THE PENALTY OF PERJURY THAT I PERSONALLY ANSWERED ALL OF THE QUESTIONS IN THIS APPLICATION AND THAT THE	Y	4/28/2017

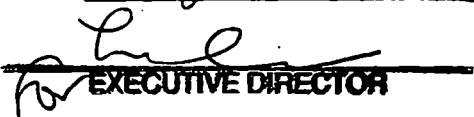
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ANSWERS I HAVE PROVIDED ARE TRUE AND CORRECT.

1 **BEFORE THE BOARD OF MEDICAL EXAMINERS**
2 **OF THE STATE OF NEVADA**

3 * * * * *

4)
5 **In The Matter of Charges and**)
6 **Complaint Against**)
7 **FRANK SILVER, M.D.,**)
8 **Respondent.**)
9 _____)

NO. Case No. 06-4041-1
FILED 24 June 2008

EXECUTIVE DIRECTOR

10 **ORDER OF DISMISSAL**

11 The above-entitled matter came on regularly for decision before the Nevada State Board of
12 Medical Examiners, hereinafter "Board," on June 13, 2008, at the Board's Offices located at 1105
13 Terminal Way, Reno, Nevada, on the complaint filed herein pursuant to Nevada's Open Meeting Laws,
14 NRS and NAC chapters 630, and NRS Chapter 233B. Neither Frank Silver, M.D. ("Respondent") nor
15 his attorney, John Cotton, Esq., were present for the proceedings.

16 The members of the Board participating in the decision were Jean Stoess, M.A., Cindy
17 Lamerson, M.D., Benjamin Rodriguez, M.D., Charles Held, M.D. and Javaid Anwar, M.D.
18 Rene West was absent and thus did not participate in the adjudication of the matter. All other
19 remaining members of the Board, being members of the Investigative Committee that issued the
20 complaint in this matter, were excused from participating and took no part in the proceedings of the
21 Board.

22 The Board having received and read the Synopsis of the Hearing Officer of the hearing
23 conducted in this matter, having received and read a copy of the hearing transcript, and having been
24 provided with the complaint and exhibits in this matter, and having reviewed and read all the above,
25 proceeded to make a decision pursuant to the provisions of NRS 630.352.

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1 The Board, after due consideration of the record, evidence and law, and being fully advised in
2 the premises, hereby finds Respondent not guilty of the count alleged against him in the above
3 identified matter.

4 **IT IS HEREBY ORDERED** that the complaint against Frank Silver, M.D., is hereby
5 dismissed.

6 Done in open session this 13th day of June, 2008.

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9 _____
10 Javaid Anwar, M.D., President
11 Nevada State Board of Medical Examiners
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