INSURER:

ST. PAUL MEDICAL LIABILITY INSURANCE COMPANY

PHOENIX MEDICAL OFFICE - 02A

8900 N 22nd Avenue

Apt/ste 300

Phoenix, AZ 850216018

RECEIVED FEB - 4 222

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

\sim	aim	MI_	-
		MA	-

DM06628927-02A001/YY00152

Date:

January 31, 2002

Date of Loss:

November 8, 1996

Date of Claim:

November 3, 1998

Date Suit Filed:

January 17, 2002

September 30, 1998

Date Closed:

MLSP Complaint No:

L98-10-1574

Findings:

Address:

Reasonable probability of malpractice.

Other Dispositions:

Case settled prior to trial.

'NSURED:

Frank P. Silver, M.D. 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:

Patient:

Same as Claimant

DOB/Age:

53 years

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

If Summons & Complaint not attached,

Case No.:

A414074

old

Attached.

INSURER:

St. Paul Fire & Marine Insurance Company

P.O. Box 39600

PHOENIX, AZ 85069-9600

(602) 678-3400

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

DEC 2 2 1997

NEVADA STATE BOARD OF MEDICAL EXAMINERS

Claim No.: <u>DM08900582-02A001</u>	Date: <u>DECEMBER 17, 1997</u>
Date of Loss: 04/04/91 Date Suit Filed:	Date of Claim: 06/14/91 Date Closed: 10/29/97
MLSP Complaint No.: Findings: Other Dispositions:	
Insured: FRANK SILVER, MD Address: 2031 McDaniel St., Suite 210	, North Las Vegas, NV 89030
Loss Description: Suit alleges insured neglig hysterectomy procedure. Las Vegas, NV	ently injured bowel of 44-year old woman during
CLAIMANT: Same as Claimant Same as Claimant	DOB/Age:44
	Paradise Ln., #181, Las Vegas, NV 89109
	Claim Representative Phoenix, AZ 85069-9600
☐ Summons & Complaint Attached. If Summo	ns & 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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DEC 13 1996

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.: <u>DM06610233-02A003</u>
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 Substitution 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.
and the state of t
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:
PATIENT'S NAME: Birth Date:
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:mki

Nevada State Board of Medical Examiners P.O. Box 7238 Reno, Nevada 89510 RECEIVED
JUNUS 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: S Award: \$99,090.93 Date: 5/17/93
Other Dispositions:
TWOMBER OF THE PARTY OF THE PAR
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
Addless. 2025 E. Danald Ave., pas vegas, hv 21p code. 09100
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
Pay 5/89 ik

JUN 23 2003

Nevada Medical Professional Liability Closed Claim Report

1. Name of Insurer ST. PAUL MEDICAL LIABILITY INSURANCE COMPANY S						
6. Policy Type (choose a, b, or c) a) ☐ Occurrence b) ☑ Claims made c) ☐ 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) ☑ Initial Report b) ☐ Updated Report ### Updated R						
9. 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) ☑ Initial Report b) ☐ Updated Report ### Updated Report ### Updated Report ### Injured & Co-Defendants 1. Defendant & Co-Defendants 1. Defendant's Name						
9. Type of Report (choose a or b) a) Initial Report Dipdated Report II. Defendant & Co-Defendants I. Defendant's Name Last SILVER First M.I. Credentials (e.g. MD, DO, DMD, DDS) I. License Number 2641 Description OB/GYN ISO Code 4. Co-Defendant(s)? I. Shumber of Co-Defendant(s):						
I. Defendant & Co-Defendants Last First FRANK P Credentials (e.g. MD, DO, DMD, DDS)						
1. Defendant's Name						
SILVER FRANK P M.D. 2. License Number 2641 3. Specialty Description _OB/GYN						
Description OB/GYN						
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						
6. Name, License Number and Insurer of Each Co-Defendant, if known: N/A III. Injured & Injury 1. Injured & Injury 1. Injured Party's Name Last First M.I. 2. Sex: Male Female 1. Injured Party's Name Last First M.I. 2. Sex: Male Female 1. Injured Party's Name Last First M.I. 2. Sex: Male Female 1. Injured Party's Name Last First M.I. 2. Sex: Male Female 1. Injury Ocde (per appendix 2): ORG ORG						
III. Injured & Injury 1. Injured & Injury 1. Injured Party's Name						
III. Injured & Injury 1. Injured Party's Name Last First M.I. 2. Sex: Male Female 1. Injured Party's Name Last First M.I. 2. Sex: Male Female 1. Injury Party						
1. Injured Party's Name Last First M.I. 2. Sex: Male Female 3. Age 4. Date of Birth (MM/DD/YY) 5. Malpractice code (per Appendix 1): 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						
3. Age 4. Date of Birth (MM/DD/YY) 5. Malpractice code (per Appendix 1): 6. Injury Code (per appendix 2): 62 PO 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						
PO ORG						
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						
alleges lack of post-op care and other significant post-op complications as well. 8. City Where Injury Occurred						
8. City Where Injury Occurred Las Vegas IV. Medical/Dental Screening Panel (Hereafter, Panel) 1. Case Filed with Panel? Yes, No, Unknown (IF YES, ANSWER QUESTIONS 2 AND 3) 2. Panel Case Number L99-06-1706 3. Panel Decision: Is there Reasonable Probability of Malpractice? Other [case settled/withdrawn before panel met] 4. Court Case Filed After Panel Decision Yes No Unknown V. Court Case Filed? Yes, No, Unknown (IF YES, ANSWER QUESTIONS 2 - 7) 2. Court Case Number 3. Court Name 4. Court Department Number A423093 Dist. Court, Clark County, Nevada 21						
IV. Medical/Dental Screening Panel (Hereafter, Panel) 1. Case Filed with Panel? ☑Yes, ☐No, ☐Unknown (IF YES, ANSWER QUESTIONS 2 AND 3) 2. Panel Case Number						
1. Case Filed with Panel?						
2. Panel Case Number L99-06-1706 3. Panel Decision: Is there Reasonable Probability of Malpractice? a) ⊠Yes b) ☐No c) ☐Unable to Decide d) ☐Case Dismissed e) ☐Other [case settled/withdrawn before panel met] 4. Court Case Filed After Panel Decision ☒Yes ☐No ☐Unknown V. Court Case 1. Court Case Filed? ☒Yes, ☐No, ☐Unknown (IF YES, ANSWER QUESTIONS 2 - 7) 2. Court Case Number A423093 3. Court Name A423093 4. Court Department Number Dist. Court, Clark County, Nevada 21						
L99-06-1706 3. Panel Decision: Is there Reasonable Probability of Malpractice? a) ⊠Yes b) ☐No c) ☐Unable to Decide d) ☐Case Dismissed e) ☐Other [case settled/withdrawn before panel met] 4. Court Case Filed After Panel Decision ☑Yes ☐No ☐Unknown V. Court Case 1. Court Case Filed? ☑Yes, ☐No, ☐Unknown (IF YES, ANSWER QUESTIONS 2 - 7) 2. Court Case Number ☐ 3. Court Name ☐ 4. Court Department Number ☐ A423093 ☐ Dist. Court, Clark County, Nevada ☐ 21						
a) Syes b) No c) Unable to Decide d) Case Dismissed e) Other [case settled/withdrawn before panel met] 4. Court Case Filed After Panel Decision Yes No Unknown V. Court Case 1. Court Case Filed? Yes, No, 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						
V. Court Case 1. Court Case Filed? ☑Yes, ☐No, ☐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						
1. Court Case Filed? ☑Yes, ☐No, ☐Unknown (IF YES, ANSWER QUESTIONS 2 - 7) 2. Court Case Number 3. Court Name 4. Court Department Number Dist. Court, Clark County, Nevada 21						
2. Court Case Number 3. Court Name 4. Court Department Number Dist. Court, Clark County, Nevada 21						
A423093 Dist. Court, Clark County, Nevada 21						
A423093 Dist. Court, Clark County, Nevada 21						
5. Date Court Case Was Filed 08/16/2000 6. Date Verdict Was Filed, if Applicable 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						
VII. Claim Disposition (Attributed to this Defendant Only)						
VII. Glaim Disposition (Attributed to triis Defendant ONIY)						
1. Claim Disposition (Attributed to this Derendant Only) 1. Claim Disposition a) Decided By Trial a) Decided By Trial b) Decided by c) Decided by						
1. Claim Disposition a) Decided By Trial a) Decided By Trial b) Decided by c) Decided by (check one) in Favor of Plaintiff in Favor of Defendant Arbitrator in Favor of Arbitrator in Favor of						

Form NDOI-1102

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

VIII. Verdict Information (Attributed to All Defendants in Case) or N/A 1. Verdict Awarded \$ IX. Claim Information (Amounts Attributed to this Defendant Only, If Multiple Defendants) 1. Verdict or Settlement Awarded \$550,000 or ☐ N/A 2. Verdict or Settlement Paid \$550,000 or ☐ N/A 3. Reasons for Amount Awarded (1) Not Being Equal to Amount Paid (2), if Applicable (Check More than One, if Applicable) Post Verdict Settlement b) _____ Award Reduced to Present Value c) ____ Interest Awarded d) ____ Costs Awarded Non-economic damages limited by Judge to \$350,000 f) _____ Award Capped by Judge at Policy Limit _ Other (Explain) 4. How Will/Did Plaintiff Receive a) 🛛 Lump Sum b) Periodic Payments c) 🔲 N/A Payments? 5. If Periodic Payments, What is the Present Value (as of Date of Award) of the Payments? \$ N/A 6. Sources of Award a) Company \$550,000 b) Defendant \$ c) Other (describe) \$ **Payments** 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 M.I. Credentials (e.g. M.D., D.O) Last First 4. Verdict Awarded 2. License Number 3. Specialty ISO Code a) 🗌 Yes b) 🔲 No c) 🔲 Unknown Description 6. Verdict or Settlement Awarded \$ or N/A Settlement Made a) Tes b) No c) Unknown 1. Co-Defendant's Name First Credentials (e.g. M.D., D.O) 4. Verdict Awarded 2. License Number 3. Specialty a) Yes b) No c) Unknown Description ISO Code 5. Settlement Made 6. Verdict or Settlement Awarded \$ or N/A a) Yes b) No c) Unknown M.I. 1. Co-Defendant's Name First Credentials (e.g. M.D., D.O) Last 2. License Number 3. Specialty 4. Verdict Awarded Description ISO Code a) Yes b) No c) Unknown 5. Settlement Made 6. Verdict or Settlement Awarded \$ or N/A a) Tes b) No c) Unknown First 1. Co-Defendant's Name M.I. Credentials (e.g. M.D., D.O) Last 2. License Number 4. Verdict Awarded 3. Specialty a) Yes b) No c) Unknown Description ISO Code 5. Settlement Made 6. Verdict or Settlement Awarded \$ or N/A a) Yes b) No c) Unknown (Attach Additional Sheet(s) if Necessary.) XI. Closed Claim Report Information Name of Person Responsible for Report (Last, First) 1. Contact Person's Name (Last, First) Heinsohn, Connie Todd, Theodore Signature of Person Responsible for Report 2. Contact Person's Phone Number {(999) 999-9999} (602) 678-3424 3. Contact Person's Address 8900 N. 22nd Avenue, #300 ST. PAUL DOES NOT UTILIZE ISO CODES Phoenix, AZ 85021-6018

Form NDOI-1102



Hudson Insurance Company Hudson Specialty Insurance Company

851 Napa Valley Corporate Way Suite N Napa, CA 94558

T 707 225.3300 F 707 225.3333 www.hudsoninsgroup.com

An OdysseyRe |

Fairfax Company

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JUN 1 3 2011

June 10, 2011

NEVADA STATE BOARD OF MEDICAL EXAMINERS

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

RE: Park 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
\boxtimes	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 Speicalist

Hudson Healthcare

851 Napa Valley Corporate Way, Suite N

Napa, CA 94558

SGish@Hudson in sgroup.com

(707) 225-3339

1. Name of Insurer: Hudson Insurance 2. Claim No.: £2551 3. Injury Date (Date of Loss): 0,5/23/07	I. Background							
6. Policy Type (choose a, b, or c): a)Occurrence b) _X Claims made c)Tail/Reporting Endorsement 7. Policy Limits (Per Claim/Aggregate): \$1MM \$23MM	1. Name of Insurer: Hu	dson Insu	ırance		2.	Claim I	No.: <u>67551</u>	
7. Policy Limits (Per Claim/Aggregate): \$1MM /\$2MM	3. Injury Date (Date of I	-oss): <u>05/2</u>			5.	Closure	Date: 06/02/1	1
9. Type of Report (choose a or b): a)_XInitial Report b)_Updated Report II. Defendant & Co-Defendants 1. Defendant & Co-Defendants 1. Defendant & Same: Last: Silver First: Frank M.I.: P. Credentials (e.g. Mo, DO, DMD, DDS): MC 2641. NV Description: major surgery 2641. NV Description of Alleged Majoractice and Injures Injured Party's Last: First: Majoractice code (per descriptions) Injured Party's Last: First: Majoractice code (per descriptions) Age: 24 4. Date of Birth (MMOD/NY): 2031/4/365 Appendix 1): MP 7. Description of Alleged Majoractice and Injuries (Altach Additional Sheet(s) if Necessary.): The claimant incurred septic should be to retained fragments of a laminaria placed in her cervix by the Insured. 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? Yes X No or Unknown (IF YES, ANSWER QUESTIONS 2 AND 3) 2. Panel Case Number: 3. Panel Decision: Is there Reasonable Probability of Majoractice? 3. Panel Decision: Is there Reasonable Probability of Majoractice? 3. Panel Decision: Streen Reasonable Probability of Majoractice? 4. Court Case Filed After Panel Decision: Yes No Unknown V. Court Case Filed After Panel Decision: Yes No Unknown V. Court Case Filed After Panel Decision: Yes No Unknown Intitate Sidual Sidu	6. Policy Type (choose	a, b, or c):	a) O ccu	rrence b) _)	X Claims	made	c) Tail/Rep	porting Endorsement
### ### ##############################					00	5/10/11		Report Submitted:
1. Defendant's Name: Last: Silver First: Frank M.I.: P. Credentials (e.g. MD, DO, DMO, DDS): ME 2. License Number: 3. Specialty: Gynecology — 2641. NY Specialty: Gynecology — 2641. NY Pescription: major surgery ISO Code: 80167 Yes Linknown St. Code: 80167 Yes Linknown Linkno	9. Type of Report (choo	se a or b):	a) <u>X</u> I nitial	Report b)_	_ U pdate	d Repor	t	
2. License Number: 2. License Number: 2. J. Specialty: Gynecology — Description: major surgery 1. So Code: 80167 5. Number of Co-Defendant(s): 2. No Unknown 6. Name, License Number and Insurer of Each Co-Defendant, if known: 2. Sex: Male or X Female Name: 3. Age: 24 4. Date of Birth (MM/DD/YY): 03/14/186 3. Age: 24 4. Date of Birth (MM/DD/YY): 03/14/186 3. Age: 24 4. Date of Birth (MM/DD/YY): 03/14/186 3. Age: 24 4. Date of Birth (MM/DD/YY): 03/14/186 3. Age: 24 4. Date of Birth (MM/DD/YY): 03/14/186 3. Age: 25 7. Description of Alleged Malpractice and Injuries (Attach Additional Sheet(s) if Necessary.): The claimant incurred septic sho due to retained fragments of a laminaria placed in her cervix by the insured. 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? Yes X No or Unknown (IF YES, ANSWER QUESTIONS 2 AND 3) 2. Panel Case Number: 3. Panel Decision: Is there Reasonable Probability of Malpractice? a) Yes b) No c) Unable to Decide d) Case Dismissed e) Other [case settled/withdrawn before panel me decision: Yes No Unknown (IF YES, ANSWER QUESTIONS 2-7) 2. Court Case Filed After Panel Decision: Yes No Unknown V. Court Case Filed? X Yes No Unknown (IF YES, ANSWER QUESTIONS 2-7) 3. Court Case Number: 3. Court Case Number: 3. Court Case Number: 3. Court Case Number: 4. Court Case Number: 5. Date Court Case Was Filed: 6. Date Verdict Was Filed, if Applicable: N/A 5. Date Settlement Offer Accepted, if Applicable: 1,172/04/10 4. Decided by Arbitrator in Favor of Plaintiff In Favor of Polefendant only) 1. Claim Disposition (Attributed to this Defendant only) 1. Claim Disposition (Attributed to this Defendant only) 1. Calim Disposition (Attributed to this Defendant only) 2. Settled W/O (1) Calim Denied (1) Calim Den		Co-Defe	ndants					
Description: major surgery Yes No Unknown	1. Defendant's Name:	Last: Si	lver	First: Frank	M	.I.: <u>P.</u>	Credentials (e.	3. MD, DO, DMD, DDS): <u>MD</u>
5. Number of Co-Defendant(s): N/A orUnknown 6. Name, Ličense Number and Insurer of Each Co-Defendant, if known: ### M.I.: 2. Sex:Male or _X_Female Note		Descript	tion: _major su				Y es	• •
Injured & Injury Last: First: M.I.: 2. Sex: Male or X. Female Name: S. Majpractice code (per Appendix 2): FnB Appendix 1): M. M. Male Appendix 2): FnB Appendix 1): M.	5. Number of Co-Defend			Unknown			_X NO	Unknown
1. Injured Party's Name: A. Date of Birth (MM/DD/YY): 03/14/86 Appendix 1): MP		 	rer or Each Co	-Derendant, II Kilo)WN: 			
(MM/DD/YY): 03/14/86 Appendix 1): MP 7. Description of Alleged Malpractice and Injuries (Attach Additional Sheet(s) if Necessary.): The claimant incurred septic sho due to retained fragments of a laminaria placed in her cervix by the insured. 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? Yes X No or _Unknown (IF YES, ANSWER QUESTIONS 2 AND 3) 2. Panel Case Number: 3. Panel Decision: Is there Reasonable Probability of Malpractice? 3. Panel Decision: Is there Reasonable Probability of Malpractice? 4. Court Case Filed After Panel Decision: Yes _ No _ Unknown V. Court Case Filed After Panel Decision: Yes _ No _ Unknown V. Court Case 1. Court Case Filed? X Yes _ No _Unknown (IF YES, ANSWER QUESTIONS 2-7) 2. Court Case Number: 3. Court Name: District Court Clark County, Nevada 5. Date Court Case Was Filed: 6. Date Verdict Was Filed, if Applicable: N/A 7. Date Settlement Offer Accepted, if Applicable: 12/20/10 V. Reserves (Amounts Attributed to this Defendant Only, If Multiple Defendants) 1. Claim Disposition (Attributed to this Defendant Only) 2. Claim Disposition (Attributed to this Defendant Only) 3. Claim Disposition (Attributed to this Defendant Only) 4. Court Orall Or	1. Injured Party's			First:	₽ M.	.I.:	2. Sex: M	ale or X Female
Section Sect	3. Age: <u>24</u>			•		-	6. Injury Code	(per Appendix 2): FnB
9. Name of Institution (If Injury Occurred in Institution): IV. Medical/Dental Screening Panel (Hereafter, Panel) 1. Case Filed with Panel?Yes _X_ No orUnknown (IF YES, ANSWER QUESTIONS 2 AND 3) 2. Panel Case Number: 3. Panel Decision: Is there Reasonable Probability of Malpractice? a)Yes _b)No _ c)Unable to Decide _d)Case Dismissede)Other [case settled/withdrawn before panel medically as							ssary.): <u>The cla</u>	imant incurred septic shock
IV. Medical/Dental Screening Panel (Hereafter, Panel) 1. Case Filed with Panel? _Yes _X_ No orUnknown (IF YES, ANSWER QUESTIONS 2 AND 3) 2. Panel Case Number: 3. Panel Decision: Is there Reasonable Probability of Malpractice? a) _Yes _b) _No _c) _Unable to Decide _d) _Case Dismissed _e) _Other [case settled/withdrawn before panel medical and the panel Decision: _Yes _No _Unknown V. Court Case Filed After Panel Decision: _Yes _No _Unknown V. Court Case Filed? _x_Yes _No _Unknown (IF YES, ANSWER QUESTIONS 2-7) 2. Court Case Number:3. Court Name: _District Court Clark County,4. Court Department Number:22	due to retained fragmen	ts of a lami	naria placed in					<u>.</u>
1. Case Filed with Panel?Yes _X_ No orUnknown (IF YES, ANSWER QUESTIONS 2 AND 3) 2. Panel Case Number: 3. Panel Decision: Is there Reasonable Probability of Malpractice? a)Yes _ b)No _ c)Unable to Decide _d)Case Dismissede)Other [case settled/withdrawn before panel me] 4. Court Case Filed After Panel Decision:YesNoUnknown V. Court Case 1. Court Case Filed?x_YesNoUnknown (IF YES, ANSWER QUESTIONS 2-7) 2. Court Case Number:	8. City Where Injury Occ	urred: <u>Las</u>	<u>Vegas</u>	9. Name of Ins	stitution (1	lf Injury	Occurred in Ins	titution):
1. Case Filed with Panel?Yes _X_ No orUnknown (IF YES, ANSWER QUESTIONS 2 AND 3) 2. Panel Case Number: 3. Panel Decision: Is there Reasonable Probability of Malpractice? a)Yes _ b)No _ c)Unable to Decide _d)Case Dismissede)Other [case settled/withdrawn before panel me] 4. Court Case Filed After Panel Decision:YesNoUnknown V. Court Case 1. Court Case Filed?x_YesNoUnknown (IF YES, ANSWER QUESTIONS 2-7) 2. Court Case Number:	IV. Medical/Dent	al Scree	ening Pane	l (Hereafter,	Panel			·
3. Panel Decision: Is there Reasonable Probability of Malpractice? a)Yesb)Noc)Unable to Decided)Case Dismissede)Other [case settled/withdrawn before panel me 4. Court Case Filed After Panel Decision:YesNoUnknown **V. Court Case** 1. Court Case Filed?x_YesNoUnknown (IF YES, ANSWER QUESTIONS 2-7) 2. Court Case Number:							ESTIONS 2 AND	3)
a) _ Yes _ b) _ No _ c) _ Unable to Decide _ d) _ Case Dismissed _ e) _ Other [case settled/withdrawn before panel me] 4. Court Case Filed After Panel Decision: _ Yes No Unknown	2. Panel Case Number:							
V. Court Case 1. Court Case Filed? _x_YesNoUnknown (IF YES, ANSWER QUESTIONS 2-7) 2. Court Case Number: _AS56577					missed	e) (Other [case settle	d/withdrawn before panel met]
1. Court Case Filed? _x_YesNoUnknown (IF YES, ANSWER QUESTIONS 2-7) 2. Court Case Number:	4. Court Case Filed After	Panel Deci	sion:Yes	No l	Unknown			
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(check one) in Favor of Plaintiff in Favor of Defendant Arbitrator in Favor of Plaintiff Defendant e) x_Settled w/o Court or Prior to Trial in Favor of Plaintiff Defendant D						c) D	ecided by	d) Decided by
Court or Prior to Trial	(check one)	in Favor of	Plaintiff	in Favor of Defend	dant	Arbitrate Plaintiff	or in Favor of	Arbitrator in Favor of Defendant
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Defendant's Name (Look Fi	wet AA T	\ Cilver Frank D	MD	Deta Thi	is Classel Claim Dance	+ C. h-: H-d. OC/10/11
Defendant's Name (Last, Fi	rst, M.I.): <u>Sliver, Frank P</u>	<u>., MU</u>	Date In	is Closed Claim Repor	t Submitted: <u>06/10/11</u>
VIII. Verdict Information 1. Verdict Awarded: \$ 0			to All Def	endants	in Case)	
IX. Claim Informat	ion (Al	mounts Attrib	uted to ti	his Defei	ndant Only, If Mu	ultiple Defendants)
1. Verdict or Settlement Av						
Reasons for Amount Awa Post Verdict Settlemer Court Costs Awarded Policy Limit	nt b) e)	Award Reduce	d to Present damages li	t Value	c)	ore than one if Applicable):Interest AwardedAward Capped by Judge at
4. How Will/Did Plaintiff Re	ceive	a) X Lump Sur	n	b) Pe	riodic Payments	c) N/A
Payments?: 5. If Periodic Payments, Wh	nat is the	Present Value (a	s of Date of	[f the Payments?: \$	1
6. Sources of Award Payme	nts:	a) Company: \$	240,000	b) Defen	dant: <u>\$</u>	c) Other (describe): §
7. Allocated Loss Adjustment Expenses:	nt	Total: \$82,140.	.04	Attorney	's Fees: \$63,214.50	Other: \$18,925.54
X. Claim Information	on (Am	ounts Attribu	ted to Ot	her Defe	endants)	
1.Co- Defendant's Name:	Last:		First:		M.I.:	Credentials (e.g. MD, DO):
2. License Number:	1	iption:			4. Verdict Awarded: a) Yes	
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(Attach Additional Sh XI. Closed Claim Re			,			
1. Contact Person's Name (I						nsible for Report (Last, First):
2. Contact Person's Phone N 3. Contact Person's Address Way, Suite N, Napa, CA S	: <u>851 N</u>		porate	7 [sh, Sandra gnature of Person Res	

Claim No.: <u>67551</u>

Name of Insurer: <u>Hudson Insurance</u>

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In The Matter of Charges and

Respondent.

Complaint Against

Frank Silver, M.D.,

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BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

* * * * *

NO. <u>Case No. 06-4041-1</u>

FILED 13 July

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

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

- 5. Patient A underwent the recommended surgical procedure on June 17, 2005, during which lysis of the adhesions was completed as well as drainage of the right ovarian cyst.
- 6. Patient A began experiencing abdominal pain and illness on June 18, 2005, and presented to the emergency room at North Vista Hospital on June 19, 2005, with these symptoms. Patient A's condition worsened and an exploratory laparotomy was to be performed, however, Patient A expired before undergoing surgery.
- 7. An autopsy was performed which stated the cause of death to be fibrinous peritoritis due to perforation of the sigmoid colon during the laparoscopic procedure and made the specific finding that the sigmoid colon showed an open defect with darkened, curled, and what appear to be, burnt edges.

Count I

- 8. All of the allegations in the above paragraphs are incorporated herein as if set forth in full.
- 9. Respondent was overly aggressive in his efforts to lyse Patient A's adhesions resulting in an injury to the sigmoid colon and thus his care of Patient A fell below the accepted standard of care.
- 10. Respondent's failure to provide Patient A with the accepted standard of care constitutes malpractice and thus violates Section 630.301(4) of the Nevada Revised Statues.
- 11. By reason of the foregoing, Respondent is subject to discipline by the Nevada State Board of Medical Examiners as provided in Section 630.352 of the Nevada Revised Statutes.

Count II

- 12. All of the allegations in the above paragraphs are incorporated herein as if set forth in full.
- 13. Respondent failed to recognize the injury to Patient A's sigmoid colon during the laparascopic procedure and take immediate action to repair the injury and thus his care fell below the standard of care.
- 14. Respondent's failure to provide Patient A with the accepted standard of care constitutes malpractice and thus violates Section 630.301(4) of the Nevada Revised Statues.

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

WHEREFORE, the Investigative Committee prays:

- 1. That the Nevada State Board of Medical Examiners fix a time and place for a formal hearing;
- 2. That the Nevada State Board of Medical Examiners give respondent notice of the charges herein against him, the time and place set for the hearing, and the possible sanctions against him;
- 3. That the Nevada State Board of Medical Examiners determine what sanctions it determines to impose for the violation or violations committed by Respondent;
- 4. That the Nevada State Board of Medical Examiners make, issue and serve on Respondent its findings of facts, conclusions of law and order, in writing, that includes the sanctions imposed; and
- 5. That the Nevada State Board of Medical Examiners take such other and further action as may be just and proper in these premises.

DATED this _____ day of July, 2006.

INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS

Lyn E. Beggs

Attorney for the Investigative Committee of the Nevada

State Board of Medical Examiners

1	VERIFICATION
2	STATE OF NEVADA)
3	COUNTY OF CLARK) : ss.
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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 12 m day of July , 2006.
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14	SOUHAIL U. ANJUM, M.D.
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ORIGINAL

BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

* * * * *

In The Matter of Charges and

Respondent.

Complaint Against

Frank Silver, M.D.,

FILED SE No. 06-4041-1 & DECOL

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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

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

- 5. Patient A underwent the recommended surgical procedure on June 17, 2005, during which lysis of the adhesions was completed as well as drainage of the right ovarian cyst.
- 6. Patient A began experiencing abdominal pain and illness on June 18, 2005, and presented to the emergency room at North Vista Hospital on June 19, 2005, with these symptoms. Patient A's condition worsened and an exploratory laparotomy was to be performed, however, Patient A expired before undergoing surgery.
- 7. An autopsy was performed which stated the cause of death to be fibrinous peritonitis due to perforation of the sigmoid colon during the laparoscopic procedure and made the specific finding that the sigmoid colon showed an open defect with darkened, curled, and what appear to be, burnt edges.

Count I

- 8. All of the allegations in the above paragraphs are incorporated herein as if set forth in full.
- 9. Respondent was overly aggressive in his efforts to lyse Patient A's adhesions resulting in an injury to the sigmoid colon and thus his care of Patient A fell below the accepted standard of care.
- 10. Respondent's failure to provide Patient A with the accepted standard of care constitutes malpractice and thus violates Section 630.301(4) of the Nevada Revised Statues.
- 11. By reason of the foregoing, Respondent is subject to discipline by the Nevada State Board of Medical Examiners as provided in Section 630.352 of the Nevada Revised Statutes.
- WHEREFORE, the Investigative Committee prays:
- 1. That the Nevada State Board of Medical Examiners fix a time and place for a formal hearing;
- 2. That the Nevada State Board of Medical Examiners give respondent notice of the charges herein against him, the time and place set for the hearing, and the possible sanctions against him;
- 3. That the Nevada State Board of Medical Examiners determine what sanctions it determines to impose for the violation or violations committed by Respondent;

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

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

day of December, 2006. DATED this _

> INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS

Attorney for the Investigative Committee of the Nevada State Board of Medical Examiners

1	VERIFICATION
2	STATE OF NEVADA)
3	COUNTY OF CLARK)
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 gray day of December, 2006.
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14	January Johnson
15	SOUHAIL U. ANJUM, M.D.
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BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

* * * * *

In The Matter of Charges and

Complaint Against

NO. Case No. 06-4041-1

PILED Home was

Respondent.

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

complaint in this matter, were excused from participating and took no part in the proceedings of the Board.

remaining members of the Board, being members of the Investigative Committee that issued the

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

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

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

Javaid Anwar, M.D., President Nevada State Board of Medical Examiners

APPLICATION FOR CERTIFICATE TO PRACTICE MEDICINE IN NEVADA

lo 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. atic copies are acceptable.) No certificate as to the possession of these credentials will be accepted in lieu thereof, plications 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 agrements with the State ofPennsylvania
That I am a citizen of
If not a citizen of the United States, have you applied for U. S. citizenship?
Aged37 years, and a resident of
County ofPhiladelphia, State ofPennsylvania, where
I have been engaged in the practice of medicine for a period ofyears preceding the date of
this application. That I received my medical education in
Thomas Jefferson Medical Collage - 1957 - 1961 (Give names of all medical schools and dates of attendance)
That I was granted a diploma as a graduate in Medicine byThomasJeffersonMedical
College, 11th and Walnut Streets (Give the name of your medical school of graduation)
located in Philadelphia State of Pennsylvania on the
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6th day of June , 19.61 ; That I was granted Certificate No028394 by the
Pennsylvania State Board of Medical Examiners
datedIuly 16, 1962_, upon Written Examination (Written examination or diplome)
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 19 72, 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:
71)
Signed, Applicant

AFFIDAVIT AS TO MORAL AND PROFESSIONAL CHARACTER

	hysicians in applicant's county), M.D., being duly sworn, deposes and says:
I reside at5030. Oxford Avenue	, in the County of Philadelphia ,
in the State ofPennsylvania	, and am personally acquainted with
Dr. Frank P. Silver	
named in the accompanying diploma, andhe	is of good moral and professional character.
Subscribed and sworn to before me this 28 4/2.	A A A A A A A A A A A A A A A A A A A
day of april , A.D. 1972	Address 5030 Oxford Avenue
miles a material	Philadelphia, Pa. 19124
Notery Publics President and Aprilable Co. 17. Commission Explication 1972	
	he 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, joint gomery,
in the State ofPennsylvania	and am personally acquainted with
Dr. Frank P. Silver	, and know h.im to be the identical person
named in the accompanying diploma, andhe	is of good moral and professional character.
Subscribed and sworn to before me this 28.24	Name Charles 2 Brifett 100.
day of	Address 1789 Washington Lane
MELET II. ZAVISZA Notery Public, Philadelphia, Miladelphia Co.	Meadowbrook, Pennsylvania
My Commission Explica Revember 18, 44-72	The state of the s
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Address 715 Martin Road Address 715 Martin Road Elkins Park, Pa. Elkins Park, Pa. Place of birth Rhiladelphia, Pennsylvania Name of college issuing medical diploma: Thomas Jefferson Medical Gollege 11th and Walnut Sts., Phila 19107	Date of graduation 1961. Internship Nazareth Hospital Located at 2601 Holme Avenue from July 1,51 to June 30 , 19.62 Total years of practice 7. years your specialty Oh-Gyn issued by Certificate No. 028394. issued by Pennsylvania State Board of Medical Examiners on July 16.
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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

Í, Alva R. Cockley	of Harrishurg, Penneylvania
Secretary of thePermsylvania	te Board of Medical Education & Licensure
hereby certify that Dr. Frank Silver	of
Philadelphia, Pennsylvania was grant	ed on the 20th day of July , 1962 ,
Certificate No. 28 394 by the	Pennsylvania
State Board of Medical Education & Lic	ensure upon examination by the said Board in
the following subjects: Anatomy & Bacteriology, 77 Anatomy rating percent Pathology, 83	Chemistry, Physiology & Pharmacology, 83 Pathelogy rating percent Obstetrios, Gynecology & Pediatrics, 85
Ghemistry rating percent Symptomatology & Therapeutics, 75 Materia Medica and Therapeutics rating percent	Physiology rating percent Surgery, 84 Theory and practice rating percent
Public Health, Sanitation & Medical Jur Obstatrics rating percent	isprudence, 79 Surgery rating percent Total
awarded a general average of809 percent t	re true and correct and that the said applicant was hereon. I further certify that no certificate issued by has ever been revoked or suspended,
of professional recognition, and recommend him fit and proper person to receive reciprocal recogn	e I believe him to be of good moral character and worthy to the Nevada State Board of Medical Examiners as a ition by the Nevada State Board of Medical Examiners.
In testimony thereof witness my hand and seal.	Qua Q Cockelley
	Secretary of the Pennsylvania State
[SEAL]	Board of Medical Education & Licensure
Post office address 279 Boas Street, Harr	isburg, Pennsylvania 17120
Dated at Harrisburg, Penns	
this 10th day of May , 19	72

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.

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STATE OF NEVADA (: :		
Philadelphia	County 5	.	. * :		· · .
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HISTORY OF YEARS OF PRACTIC			VI.		
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Philadelphia Obstetrics Society					
American College of Obstetrics-	Cynecolog	u			
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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

Date Received Nevada License No. APPLICATION FOR REGISTRATION File No. **NEVADA STATE BOARD OF MEDICAL EXAMINERS** Renewal 🗆 New 🗆 * Office Box 7238 Reno, Nevada 89510 Phone (702) 329-2559 section for BOARD USE ONLY I hereby apply for a 1985-87 certificate of biennial positration 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 PRACTICE: acheek one Only Direct Patient Care ☐ Resident 1401 E Lake Mead Blvd ☐ Administration ☐ Military NV □ Medical Teaching □ Refired N Las Vegas 89030 TYPE OR PRINT LEGIBLY Servial P. Frank Bilver NAME Business Phone POP 1401 S. Lake Mead No. Las Vegas, BUSINESS OR MAILING ADDRESS .. Street Address or E.O. Box 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.) AP DRESS WILL CHANGE ON: BUSINESS OR MAILING ADDRESS. Street Address or P.O. Box Suite No. State Cuv Zip Code If you have retired or moved your practice, please indicate the location BOARD CERTIFICATION: of former patient's records below: NAME Obstetrics & Gynecology ADDRESS PHONE # (Date of Certification or Recertification . Primary Specialty (List only one) OB/ CYN ____Sub-Specialties: _____ SINCE YOUR LAST REGISTRATION: 1. Have you been investigated, charged or convicted of improfessional 3. Have you surrendered your license to practice medicine in another conduct, professional incompetence or gross or repeated malprae-tice by any medical licensing board or other agency, hospital or jurisdiction? No 🛱 🗸 ff "yes" attach a detailed explanation medical society? 777 Yes Cl. NoTT if "yes" attach a detailed explanation 4. Have any malpractice settlements, awards or judgment been made against you in any jurisdiction? 2. Have you been investigated, charged or convicted for the possession, Yes LL No ZEX If "yes" attach a detailed explanation use of, or illegal sale or dispensing of controlled substances? Yes □ NoXX If "yes" attach a detailed explanation STAFF PRIVILEGES: List all Nevada Hospitals in which you have any staff privileges: (Name and Location) Southern Nevada Remorial ______ 2. Valley Hospital Community Hospital I certify that all the above statements are truck Make checks payable to: BOARD OF MEDICAL EXAMINERS (Foreign checks must indicate "U.S. FUNDS")

Signature____ No rubber stamps

APPLICATION FOR REGISTRATION NEVADA STATE BOARD OF MEDICAL EXAMINERS

NOV 13 1984

Post Office Box 7238 Reno, Nevada 89	······································		
Alinquent after March 2, 1985	Nevada License No.	2641	File No.
•	Date of License		New □ Renewal □
	This shaded section	for BOARD USE ON	LY
I hereby apply for a 1985 certificate of	aumal registration AND ENCLOS	SE the fee for \$100	.00
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Silver,	Frank P.	Charles of the same of the sam	Social Secur
NAME	First Middl	e	purs 205 m Rth S r 1403 I
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	Net represent to the S	tand 10. THY	State Zap Code
NEW ADDRESS: If your address will o	hange within the next two month to by letter just prior to changing locat	s, show new address	s below.
ADDRESS WILL CHANGE ON:	19	•	
OUSINESS OR MAILING ADDRESS.	Street Address or It O. Box S		State Zip Crair
if you have retired or moved your pra- of former patient's records below:			CATION:
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ADDRESS		AM, Bd. of	
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STAFF PRIVILEGES: List all Nevada I Southern Nevada o	dospitals in which you have any stremorial. Hosp. Las V	aff privileges: (Name egas, NV V	e and Location) Alley Hospital Las Vegas, NV
North Las Vegas	Community Hogas; NV	4	
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Poreign checks must indicate "U.S. FUNDS			. •
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APPLICATION FOR REGISTRATION

nevada state board of medical examiners

NOV 29 1983

Post Office Box 7238 Reno, Nevada 39510 Phone (702) 329-2559	
Delinquent after March 1, 1984 Nevada License No	o. 2641 Date of License \$18/72
File No This shaded see	New □ Renewal X
I hereby apply for a 1984 certificate of annual registration AND EN	NCLOSE the fee for \$75.00.
THE THE PROPERTY OF THE PROPER	
SILVER, FRANK P ME 1401 E LAKE MEAG BLVD	"T 1903C
	or print legibly
NAME Silver Frank	Social Security *
BUSINESS ADDRESS 1401 Z. Lake Mead Nort	Middle Paisiness Phone (702-642-4091
MAILING ADDRESS 1401 E. Lake Mead Nort	
NOTE: Business Address will be used as directory address unless	s requested otherwise IN WRITING!
NEW ADDRESS: If your address will change within the next two α (If longer than two months, notify this office by letter just prior to changing	months, show new address below. og location.)
ADDRESS WILL CHANGE ON:	19
BUSINESS ADDRESSCity	State Zip Code
MAILING ADDRESS	
City If you have retired or moved your practice, please indicate the local	State Zip Code cation BOARD CERTIFICATION:
of former patient's records below:	77
NAME	··· ··· ··· ··· ··· ··· ·· · · · · · ·
ADDRESS	AM. Bd. of
PFIONE # ()	
Primary Specialty (List only one) Obstetrics	Sub-Specialtics: <u>Gynecology</u>
Has any disciplinary action been taken	Yes No PRACTICE: (CheckOne Only)
against you in any jurisdiction	Direct Patient Care() "attach a detailed explanation
	Administration
Has any malpractice action been taken	Yes No Medical Teaching
against you in any jurisdiction since your last registration? If "yes"	" attach a detailed explanation
1/22-based Company of the Company of	
STAFF PRIVILEGES: List all Nevada Hospitals in which you have a	•
1. Southern Nevada memorial	2. variey nospital
3. North Las Yegas	
Make checks payable to: BOARD OF MEDICAL EXAPTINERS (Foreign checks must indicate "U.S. FUNDS")	I certify that at the above statements are true
	Signature

APPILICATION HOR DECISTRATION

Signature

License	No.:

5/28/87

NEVADA STATE BO REDICAL EXAMI Post Office Box 7238 Reno, Nevada 895.	ard of Ners	JUN 0 5 198 NEVADA STATE BOA MEDICALIS BY MANNE	the control of the co	Renewal D
why apply for a 1987-89 certificate of t	CANADA CANADA MARIA MARIA CANADA CANA			NOS PERIODOS ESPECIOS ESPECIAS
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Silver Frank	\mathcal{P}_{\bullet}	The Walter Committee of the Committee of	Social Security #	SHEAD CONTRACTOR OF THE SHEAD O
NAME 13st	First	Middle	Business Phone (702	1 642-4091
	1401 E. Lake Me	ead Blvd. No. Las	vegas,Nevada 89	030
BUŞINESS OR MAILING ADDRESS	Street Address or P.O. Box	Sutte No. City	State	Zip Cede
of former patient's records below: NAME Frank P. Silver, M. ADDRESS 1401 E. Lake Mead PHONE # (702) 642-4091	D. Blvd. N. LV,NV 89	Yes X O30 AM. Bd. of CB/ Date of Certification	GYN	・マーS64 1/12/67
Primary Specialty (List only one)	THE RESERVE THE RESERVE THE STREET STREET, SHOWING AND THE STREET		TATALITY AND	
I certify that since July 1, 1985, I have of files documentation of such I understant	ompleted a minimum of 40 ad that the CME requiremen	hours of Continuing Medi it is mandated by NRS 630.	cal Education, AMA-Catego 253 and NAC 630.153.	ry I and that I have in my
Signed:	!No rubber stamps ple:	354	Date5/28/87	
SINCE YOUR LAST REGISTRATION: (T	Principal management of the Company
i. Have you been investigated, charged a conduct, professional incompetence or by any medical licensing board or othe society?	or convicted of unprofession gross or repeated malpractic	4. Have you beer to practice in an suspended or lin	i I denied a medical license o other jurisdiction or had you nited in unother jurisdiction	ur medical license revoked
2. Have you been arrested, fined (over \$1 of a crime, indicted, imprisoned or place	d on probation? Yes 🗀 No	revoked or not re of disciplinary of	staff privileges in a hospital onewed, or have you resigned radministrative action?	
3. Have you been investigated, arrested, possession, use of, or illegal sale or disper-	charged or convicted for the sing of controlled substances Yes 🗆 No	s? ممر 6. Have any malj	oractice settlements, award: by jurisdiction?	s or judgments been made Yes lif No∷
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² Valley Hospital, LV	,NV			
3. Community Hospital				
certify that all the above statements are	e true and that I have actively	NAME OF THE OWNER OF THE OWNER, WHEN THE OWNER,	Destruction of the section of the se	
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(No rubber sumps 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)

330.257 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

APR 24 1989 MEDICAL EXAMINERS

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License No. 2641 File No. ∴ New □ Renewal

MANAGEMENT REPORTED TO THE PROPERTY OF THE PRO	New □
1. Office Box 7238 Reno, Nevada 89510 Phone (702) 329-2559	NEVADA STATE BOARD OF for BOARD USE ONLY
ATTENTION TO A PROTECT OF THE PROTEC	www.weenserver.com.com.com.com.com.com.com.com.com.com
negative apply for certificate of hierardal castistration and evoluge the a	unpropriate fee as tridicated below:

ACTIVE STATUS \$300.00	priate ice as indicated below:		
	O GRACE PERIOD LICENSES NOT RENEWED BY JULY 1 E AUTOMATICALLY SUSPENDED FOR NON PAYMENT.		
CI RETIRED STATUS \$ 50.00	RS630 explanation of status on reverse side		
Frank P. SILVER MD	Make checks payable to: BOARD OF MEDICAL EXAMINERS		
1401 E Lake Mead Blvd L N Las Vegas NV 890	(Foreign checks must indicate "U.S. FUNDS")		
TYPE OR PR	ITT LEGIBLY		
NAME Silver Frank P.	Social Security "		
	Business Phone (702 642-4091		
BUSINESS OR MAILING ADDRESS	d Blvd, C-1 N 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		
:ME	YesNo		
ADDRESS.	AM. Bd. of		
PHONE # ()	Date of Certification or Recertification		
	Sub-Specialties:		
I certify that within the past 24 months, I have completed a minimum of in my files documentation of such. Lunderstand that the CME requirem	40 hours of Continuing Medical Education, AMA-Category 1 and that I have ent is mandated by NRS 630.253 and NAC 630.153.		
Signed: (No rubber stamps)			
SINCE YOUR LAST REGISTRATION: (If any question is answered "yes," atta 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 D No ix	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 11 No Al		
2. Have you been arrested, fined (over \$100), charged with or convicted of a crime, indicted, imprisoned or placed on probation? Yes \(\Boxed{\text{ Ves}}\) No \(\Delta\)	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 complex.		
3. Have you been investigated, arrested, charged or convicted for the possession, use of, or illegal sale or dispensing of controlled substances Y Yes \(\Boxed{Y}\) No \(\Delta\)	medical records? Yes \(\text{No } \text{L} \) 6. Have any malpractice settlements, awards or judgments been made		
STAFF PRIVILEGES: List all Nevada Hospitals in which you have any sta			
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2 Community	5		
·	6.		
ertily that all the above statements are true and that I have actively pro-			

Signature _____

(No rupner 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.

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(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)

KARKINISTONO OTO GOVERNO DO SERVICIO

APPLICATION FOR REGISTRATION

NEVADA STATE BOARD OF MEDICAL EXAMINERS

Signature

HOTE: Have you signed both "signature" lines.

APR 12 1991

Elçênse No. Elle No. (1986) New (1986) Renewal Cl.

Date 4/4/91

st Office Box 7238 Reno, Nevada 89510 Phone (702) 329-2559 This staded section for BOARD USE ONLY I hereby apply for certificate of biennial registration and enclose the appropriate fee as indicated below: MACTIVE STATUS \$400.00 } NOTE: NO GRACE PERIOD - LICENSES NOT RENEWED BY JULY 1 (1) INACTIVE STATUS \$150.00 ARE AUTOMATICALLY SUSPENDED FOR NON PAYMENT. CI RETIRED STATUS \$ 50.00 NRS630 explanation of status on reverse side Make checks payable to: Frank P. SILVER, MD 0904041 BOARD OF MEDICAL EXAMINERS 1401 E Lake Mead Blvd C1 (Foreign checks must indicate "U.S. FUNDS") N Las Vegas NV 89030--0000 TYPE OR PRINT LEGIBLY Social Security # Business Phone (642 4091 BUSINESS OR MAILING ADDRESS 1401 E. Lake Mead Blvd. N. Las Vegas, NV 89030 Street Address or F.O. Box Softe No. 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 JAME ADDRESS. AM. Ed. of The American Board of OB GYN Date of Certification or Recertification 1967 Sub-Specialties:. Primary Specialty (List only one)_ I certify that within the past 24 months, I have completed a minimum of 40 hours of Continuing Medical Education, AMA-Category 1 and that I have in my files documentation of such. I understand that the CME requirement is mandated by NRS 630.253 and NAC 630.153. Signature (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 4. Have you been denied a medical ticense or surrendered your ticense conduct, professional incompetence or gross or repeated malpractice to practice in another jurisdiction or had your medical license or right to by any medical licensing board or other agency, hospital or medical, practice medicine revoked, suspended or limited in another jurisdiction. society? 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 2. Have you been arrested, fined (over \$100), charged with or convicted, of a crime, indicted, imprisoned or placed on probation? Yes I No Z of disciplinary or administrative action, excluding failure to complete, 3. Have you been investigated, arrested, charged or convicted for the possession, use of, or illegal sale or dispensing of controlled substances? medical records? 6. Have any maipractice settlements, awards or judgments been made against you in any jurisdiction? Yes [] No fa STAFF PRIVILEGES: List all Nevada Hospitals in which you have any staff privileges: (Name and Location) Community Hospital N.Las Vegas, NV 89,030 2 Valley Hospital Las Vegas, NV 89102 University Medical Center Las Vegas, NV 89102 I certify that all my statements in this application are true. I have whave not [2] actively practiced in Nevada within the past 12 months. (Check one)

(No rubber sumps)

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

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- (b) File an affidavit with the board describing his activities during the period of his inactive status;
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TO THE BOARD <u>PRIOR</u> 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

H Las Vegas

Date Received: by State Board

APR 5 1993

License No. 264

File No.

(Foreign checks must indicate 'U.S. FUNDS')

Renewal

This shaded section for BOARD USE ONLY

© ACTIVE STATUS O INACTIVE STATUS O RETIRED STATUS	\$3:20.00 \$150.00 \$ 50.00	NOTE: NO GRACE PERIOD - LICENSED NOT RENEWED BY JULY 1 ARE AUTOMATICALLY SUSPENDED FOR NON PAYMENT.	
Frank P. Silver, 2031 McDaniel St	₩D ₩210	9994841 Make checks payable to: BOARD OF MEDICAL EXAMINERS	

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

NV 89938-8000

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

_____ 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 curren	itly active in me	edicIne?				
	a. () y ES.	in training.					
	b. (YES,	working full-tir	ne.				
	e. () YES,	working part-ti	me.				
	d. () NO, re						
	e. () NO, o	ther (specify)	•	
	• ,						
2.	Please indicate codes:	your primary.	secondary and tertlary spec	ialties ar	nd percent of time spen	it in each, using the following	
			SPECIALT	Y CODE	:	•	
	1 ADOLESCENT 2 AEROSPACE M 3 ALLERGY/IMM 4 ANESTHESIOL 5 ELOODBAIKIN 6 BRONCO-ESO 7 CARDIOVASC 8 CATSCAN/ULI 9 CHILD NEURO 10 CHILD PSYCH 11 CLINICAL FHA 12 CRITICAL CAR 13 DERMATOLOC 14 EMERGENCY 15 ENDOCRINOL 17 GASTROENTE 18 GERIATRICS 20 GYNECOLOGY 21 HEMATOLOC 22 HYPNOSIS 23 IMMUNOLOGY 24 INPECTIOUS I	AEDICINE AUNOLOGY JOGY NG PHAGOLOGY DISEASES PRASOUND FLOGY HATRY RMACOL JE SY MEDICINE OGY FICE ROLOGY ACTICE	26 INFERTILITY 26 INTERNAL MEDICINE 27 LARYNOOLOGY 28 LEGAL MEDICINE 29 MATERIAL/FETAL MED 30 NEO/PERINATAL MED 31 NEOPLISTIC DISEASES 32 NEPHROLOGY 33 NEUROLOGY 34 NEUROPATHOLOGY 35 NEURORATHOLOGY 36 NEURORAPHOLOGY 36 NEURORAPHOLOGY 37 NUTRITION 38 OBSTETRICS 40 OCCUPATIONAL MED 41 ONCOLOGY 42 ONCOLOGY, GYNECOLOGIC 43 ONCOLOGY, HEMATOLOGY 44 ONCOLOGY, SURGICAL 46 OPHTHALMOLOGY 47 OTOLARYNGOLOGY 48 OTOLOGY 49 OTOLOGY 41 OTOLOGY 41 OTOLOGY 42 ONCOLOGY 43 OTOLOGY 44 ONCOLOGY 45 ONCOLOGY 46 OPHTHALMOLOGY 47 OTOLARYNGOLOGY 47 OTOLARYNGOLOGY 48 OTOLOGY 48 OTOLOGY	49 50 51 52 53 54 55 56 57 53 59 60 61 62 63 64 65 66 67 71	PAIN MANAGEMENT PATHOLOGY PATHOLOGY, ANATOMIC PATHOLOGY, CUINICAL PATHOLOGY, FOREMSIC PED, ALLERGY PED, CARDIOLOGY PED, ENDOCRINOLOGY PED, HEMAT/ONCOLOGY PED, INFECTIOUS DIS PED, INFECTIOUS DIS PED, INTENSIVIST PED, NEPHROLOGY PED, SURGERY PED, SURGERY PED, UROLOGY PED, UROLOGY PED, HANGLOGY PED, HANGLOGY PED, SURGERY PED, UROLOGY PED, SURGERY PED, UROLOGY PEDIATRICS PHYSICAL MED/REHAB PREVENTATIVE MED PSYCHOANALYSIS PSYCH	72 PULMONARY DISEASES 73 RADIOLOGY 74 RADIOLOGY, DIAGNOSTIC 75 RADIOLOGY, NUCLEAR 76 RADIOLOGY, THERAPEUT 77 RHEUMATOLOGY 78 RIHINOLOGY 79 SLEEP DISORDERS 50 SURGERY, ADDOMINAL 81 SURGERY, CARDIOVASC 82 SURGERY, COLON, RECTAL 83 SURGERY, COLON, RECTAL 84 SURGERY, HEAD/NECK 86 SURGERY, HEAD/NECK 86 SURGERY, MAXILLOFAC 87 SURGERY, NEUROLOGICAL 88 SURGERY, NEUROLOGICAL 98 SURGERY, PLASTIC 90 SURGERY, THORACIC 91 SURGERY, THORACIC 91 SURGERY, UROLOGIC 93 SURGERY, UROLOGIC 93 SURGERY, VASCULAR 94 UROLOGY	
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	Primary		1.1.1.		- 8		
	Secondary						
	Tertiary						
	Board	CATE AMERICA	N BOARD OF MEDICAL SPA	ecialtii	ES BOARD CERTIFICA	TION:	
	Subboard						
3.	How many hou	irs per week do	you spend in each of the fo	ollowing	activities?		
	40 hours	Patient care of	services				
	hours						
	hours	Teaching med	ical courses				
	hours	Research					
	hours	Other (specify)	
		_					
4.	Form of emplo	yment is [04]	. (Use the following codes.))			
	Self-Emp	LOYED				2170	
		p or Group Fracillions	rs	1008 1009	Federal Government (civilian State Government	F.H. S., etc.)	
	SALARIED.	EMPLOYED BY Practitioner		1010 1011	County Government Local Government		
	1004 Partnership	p or Group of Practition Ith Plan Facility (such		i012	Other (specify)	
	1006 Other Non-	Government Employe vernment (armed serv	r (hospital, school, etc.)				

5. Have you been denied a license to practice medicine? Have you been denied a license to practice medicine? Have you been denied staff membership with any licensed hospital, nursing home or other hospital care facility with an organized medical staff? Have you been denied staff membership with any licensed hospital, nursing home or other hospital care facility with an organized medical staff? Have you been denied reprimanded, disciplined, land 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, lawe been a staff member, have been a partner, or have held hospital privileges? Have you beat American Board certification because of disciplinary action against you? Have you beat metical staff member, have been a partner, or have held hospital privileges? Have you been obliged of a provided a license you have held or taken any other disciplinary action against you? Have you voluntarily surrentlered a license issued to you by any state and/or Canadian provincial licensing of disciplinary action was pending? Have you obeen denied a new remarked to you by any state and/or Canadian provincial licensing or disciplinary agence? Have you been denied and any provincial licensing or disciplinary agences in with any any state and/or Canadian provincial licensing or disciplinary agences with any organized and you with any state and/or Canadian provincial licensing or disciplinary agencies limited, respectively on water any of canadian provincial licensing or disciplinary agencies limited, respectively or particle medicine? Have you been delided provider participation in mental lilness? Yes \(\) No \(\) No \(\) Yes \(\) No \(\		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.					
Have you been deuted staff membership with any Iteensed hospital, nursing home or other hospital care facility with an organized medical staff? 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? 9. Have you lost American Board certification because of disciplinary action? 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? 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? 12. Have you been totilled of any current/pending charges or complaints filed against you with any state and/or Canadian provincial licensing or disciplinary agency? 13. Have you been diagnosed or treated for any physical illness that would serve to hinder your ability to practice medicine? Yes \(\) No \(\) Yes \	5.	Have you been rejected for membership by any medical society?	Yes C	No 🖼			
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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 'edical 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.

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. Thave earned a minimum of 40 hours approved A July 1, 1991, through June 30, 1993.	MA Category I continuing medical educa	tion (CME) for the period
2. I am exempt because I have completed a full year registration immediately preceding the submis-	of residency or fellowship training during of this application.	ng the period for biennial
3. I am exempt as I am applying for INACTIVE or	RETIRED status.	
Signature (SIGNATURESTAMP UNACCEPTABLE	.)	
IMPORTANT: ATTACH COPIES OF CE PROOF OF CME CREDIT	ERTIFICATES OF DECLARED CME CR IS WILL NOT BE RETURNED.	EDITS
Date of Birth: 8 23 34 Social Secunonth/day/year DEA Number	rity Number:	
Medical School: Thomas Jeljus	m-Um- Phila	Pa
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Residency: Spiscopal H88p	ilila Phila	State
	City	State
	City	State
AC NG	City	State
Fellowship: 1500.	City	State
I hereby certify that I am the person named in this applic Nevada; that all statements I have made herein are true; t in the various documents and credentials furnished to th	hat I am the original and lawful possess	or of and person named
HAVE WHAVE NOT G ACTIVELY PRACTICED IN	NEVADA WITHIN THE PAST 12 MON	THS. (CHECK ONE)
642-4091 4/193 x	Signature (SIGNATURE STAMP I	INACCEPTARY E)

APPLICATION FOR REGISTRATION RENEWAL MEVADA STATE BOARD OF

Date Received by State Board

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	MEDICAL EXAMINERS Post Office Box 7238 Reno, Nevada 89510 Phone (702) 688-2559	AY U4 1995 This shaded a	rection for BOAKO USE ONLY
	creby apply for renewal of biennial registration and end	rico-energenet unavivario transverstera en miore elemente inclusiva.	
	ACTIVE STATUS \$420 INACTIVE STATUS \$150 (see attached NRS 630.2 RETIRED STATUS \$ 50 (see attached NRS 630.2 P.A. SUPERVISING PHYSICIAN \$200	PLEASE NOTE: 255 & 630.257) [SHIFT NOTE: 256 & 630.257] [THE TRANSPORTED LEASE STATE]	NEVADA HAS NO GRACE PERIOD. LICENSES NOT RENEWED BY JULY 1, 1995 ARE AUTOMATICALLY SUS- PENDED FOR NON-PAYMENT.
	Frank P. Silvem. MD 2000 hoBaniel St 5218 3 Los Vegas - JV 99030-0980	3004041	Make ubecke payablu to: NEVADA STATE BOARD OF MEDICAL EXAMINERA (Foreign checks must indicate "US FINDS")
	INSTRUCTIONS - TY	YPE OR PRINT LEG	HBLY
	YOUR CURRENT M.D. LICENSE EXPIRES ON JUIL LICENSE. To be eligible to act as a supervising physician of the tion for Approval as Supervising Physician form ACTIVE STATUS REGISTRATION RENEWAL REGISTR	for a physician assistant. QUIRES THE SUBMISSION completed during Ju Application for Registra g, please complete and val as Supervising Physicorrect fee(s) PRIOR TO ed form(s) and fee(s). lat printed on this form,	ot, complete the enclosed Applica- ON OF PROOF OF 40 HOURS AMA ly 1, 1993 through June 30, 1995. Ition Renewal form. Teturn your Application for Regis- tician form (if applicable) with your O JULY 1, 1995. Use the enclosed clearly indicate that change in the
	StreetCounty		
3.	IF YOU HAVE RETIRED OR MOVED YOUR PRAPATIENT 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 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, seconds codes.	ary and ter	tiary	specialti	es and percent o	of time spent in e	ach, using the following
			BPEC:	LALTY C	ODE:		
i	ADOLESCENT MEDICINE	35	NEUF	RORADIOL	OGY	64	FED, UROLOGY
2	AEROSPACE MEDICINE	36	NUCL	EAR MED		65	PEDIATRICS
3	Allergy / Immunology Anesthesiology	37 38	OBST		YNECOLOGY	56 68	Physical med / rehab Physician assistant
5	BLCODBANKING	39		ETRICS	MIZCOLOGI		PREVENTIVE MED
- 6 - 7	Bronco-Esophagology Candiovasc diseases			IPATIONAI	. MED	83	PSYCHIATRY
8	CATSCAN / ULTRASOUND	41 45		XLOGY XLOGY, GY	NECOLOGIC	69 70	PSYCHOANALYSIS PSYCHOMATIC MEDICINE
9	CHILD NEUROLOGY	42	ONCO	DLOGY, HE	MATOLOGY	71	Public Health
10	CHILD PSYCHIATRY CLINICAL PHARMACOL	43 4 4		Dlogy, Ra Dlogy, Su		72 73	
12	CRITICAL CARE			HALMOLO			RADIOLOGY, DIAGNOSTIC
13 14	DERMATOLOGY EMERGENCY MEDICINE			ARYNGOL OCY	OGY		RADIOLOGY, NUCLEAR
15	ENDOCRINOLOGY	48 49	OTOL PAIN	managen	ent	77	Radiology, Therapeut Rheumatology
10	FAMILY PRACTICE	50	PATH	OLOGY		78	RHINOLOGY
17	GASTROENTEROLOGY GENERAL PRACTICE	51 52		OLOGY, AI OLOGY, CI		79 100	
19	GERIATRICS	53	PATH	OLOGY, FO		80	SURGERY, ABDOMINAL
20 31	GYNBCOLOGY HEMATOLOGY	54 55		ALLERGY CARDIOLO	vc.v	81	SURGERY, CARDIOVASC SURGERY, COLON/RECTAL
22	HYPNOSIS	99		CRITICAL		82	
23 24	MMUNOLOGY INFECTIOUS DISEASES	9 7 56		emergen Endochi		83 84	
25	INFERTILITY	5 7			NCOLOGY	92	
26	INTERNAL MEDICINE			INFECTIO		93	SURGERY, NEUROLOGICAL
27 28	Laryngology Legal medicine	6 0		intensivi Nephrol		85 86	
29	MATERNAL / FETAL MED		PED.	NEUROLO	GY	9 7	SURGERY, THORACIC
30 31	MEO / PERINATAL MED MEOPLASTIC DISEASES	101 61		ophthal Physiatr		. 39 . 39	
32	HEPHROLOGY	95	PED,	PULMONA	RY	90	SURGERY, VASCULAR
33 34	MEUROLOGY MEUROPATHOLOGY	62 63		radiolo(Surgery	Υ	94	UROLOGY
		Code		Per	rcent of Time	Board Cer	tified (Indicate Yes/No)
Pul	mary	20			100		YES:
Sec	condary						
Ter	rilary						
	PLEASE INDICATE AMERICAN and $OB/Gy/$	BOARD			Do		n Date of Last Recertification
						(MoJYr.)	(Mo/Yr.)
Su	bboard					(Mo/Yr.)	(Mo./Yr.)
						, ,	, ,
3.	How many hours per week do you sp	end in eac	h of t	he follow	ving activities?		
Ĺ	D hours Patient care or services						
	hours Administration (schools,	agencies,	asso	ciations,	etc.)		
	hours Teaching medical course				•		
	hours Research	••					
	Thomas Research	201					,
0-7	hours Other (specify Sung)	-24					
4.	Form of employment is 1001 . (Jse the fol	lowin	g codes.)		
	SELF-EMPLOYED			1000	O15		. ت د د د
	1001 Solo Practice	lanova		1006			er (hospital, school, etc
	1002 Partnership or Group Practiti	OHCIS		1007 1008		iment (armed sei iment (civillan, P	rvices personnel only)
	SALARIED, EMPLOYED BY			1003	State Governm		exercity Citiej
	1003 Individual Practitioner			1010	County Govern		
	1004 Parinership or Group of Prac			1011	Local Governm		
	1005 Group Health Plan Facility (s	uch as H.A	(LO.)	1019	Other (enerify		Y

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 ienses 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 scierosis, 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.

"Megal 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.

18.		or federal controlled substance registr		n anv wav?	Q Yes	9 No
17.	• "	harged with, or convicted of any violation ground, hospital, medical society, government.		erning the practice of	C) Yes	· i No
•					···	
	Hospital	Mailing Address	Type of Action	Dates of A From (Mo./Yr.)	Action To (Mo./	řc)
		l staff in lieu of disciplinary or adminis e hospital medical records, attend hosp	•	•	tice insur	succ.)
16.	• •	had staff privileges denied, suspended	-	•		
	•	ip or expelled from a medical society o			C) Yes	@No
	•	l a license to practice in the healing ar	•	•	O Yes	No
13.	Have you had a medical license r	evoked, suspended, limited, or restrict	ed in any state, country or U.S. territe	ory?	🔾 Yes	€ No
	examination to practice medicine	or any other healing arts in any state,	country or U.S. territory?		() Yes	Privo
12.	Have you been denied a license,	ermission to practice medicine or any	other heating arts, or permission to	take an		
	medical education?	· · · · · · · · · · · · · · · · · · ·	g	, , , , , , , , , , , , , , , , , , , ,) Yes	₹ No
3.4.	-	elving a loan or scholarship from the fo	•	•		
. 1.		formance of public service within one		la regulard to begin to	₩ Ies	:J :NO
	· · · · · · · · · · · · · · · · · · ·	ates, or a foreign country? nedical licensure in Nevada (including :	t residency trade m)?			S No
9.	felony in any state, the United St	ited for, charged with or convicted of, o	r pied unto contendere to any offens	e, misdemeanor or	EV Maria	The state of
		distribution, prescribing, or dispensing			Q Yes	No.
8.		harged with or convicted of, or pled no		ieral, state or local		_
	your behalf or paid such a claim	yourself?			Yes	O No
7.	Have you been a defendant in a le	egal action involving professional liabil	lty (malpractice) or had a professions	l Hability claim paid in		
6.	-	illegal use of controlled dangerous su	•			SI No
5.		ng, or have you been treated for pedop	nilla, exhibitionism, or voveurism?			To No
₩.	setting, or the manner in which		mired or amedorated because in the	neid of practice, the	() Vec	TNo
3.		ance(s) in any way impair or limit your to caused by your medical condition re			2 Yes	53/No
2.		which in any way impairs or limits you				≅ No
		overnment which you received to financ	• • •			3 No
1.	Have you failed to repay, in accor	dance with the terms of the loan, any	licect loan or loan which is insured o	r guaranteed by the Feder	ત્રો	

CONTINUING MEDICAL EDUCATION

530.153 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 blennial registration, submit to the board by the final date set by the board for submitting applications for blennial registration evidence, in such form as the board requires, with the has completed 40 full hours of continuing medical education during the preceding 2 years in one or more educational programs. Each educational fram 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 aponsored in whole or in part by an organization accredited or deemed to be an equivalent organization to offer such programs by the American Medical Association or the Lisison Committee on Continuing Medical Education.
 - 2. Any holder of a license who has completed a full year of residency or fellowship any time during the period for identifial registration immediately

preceding the submission of the application for blennial 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; 11-21-68; 9-12-91)

FLEASE CHECK ONE OF THE FOLLOWING:

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

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.

642-4091 4/25/75 X
Signature (SIGNATURE STAMP UNACCEPTABLE)

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

- 1. Each holder of a license to practice medicine must pay to the secretary-treasurer of the board on or before July 1 of each alternate year the applicable tee for blennial registration. This fee must be collected for the period for which a physician is licensed.
- 2. When a holder of a license fails to pay the fee for biennial registration after it becomes due, his license to practice medicine in this state is automatically suspended. The holder may, within 2 years after the date his license is suspended, upon payment of twice the amount of the current fee for biennial registration to the secretary-treasurer, and after he is found to be in good standing and qualified under the provisions of this chapter, be reinstated to practice.
 - 3. The board shall notify a licensee:
 - (a) At least once that his fee for bienuial registration is due; and
- (b) That his license is suspended for nonpayment of the fee. A copy of this notice must be sent to the Drug Enforcement Administration o. ... United States Department of Justice or its successor agency.

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

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

- 1. Any licensee who changes the location of his practice of medicine from this state to another state or country, has never engaged in the practice of medicine in this state after licensure or has ceased to engage in the practice of medicine in this state for 12 consecutive months must be placed on inactive status.
 - 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
 - (c) Satisfy the board of his competence to practice medicine.
- 3. If the board determines that the conduct or competence of the registrant during the period of inactive status would have warranted denial of an application for a license to practice medicine in this state, the board may refuse to place the registrant on active status,

(Added to NRS by 1985, 2222; A 1987, 195; 1993, 2299) 630.256 Retired licensees: Duties; requirements for reinstatement.

- 1. If a licensee retires from the practice of medicine, he shall notify the board in writing of his intention to retire, and the board shall record the fact of retirement. Alicensee 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 hoard 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.

-- XIDD has LÓDE โดยอง. X TOND ยอดด

APPLICATION FOR RENEWAL REGISTRA	ATIONUM 2	 Date received by 	Board License No
APPLICATION FOR RENEWAL REGISTRA NEVADA STATE BOARD OF MEDICAL EXAMINERS Post Office Box 7238 Reno, Nevada 89510 Phone (7	ී ් ్ර (02) 688-2559	/99> JUN 1 5 (Board Use Only)	1 110
hereby apply for renewal of biennial registra ACTIVE STATUSINACTIVE STATUSRETIRED STATUSP.A. SUPERVISING PHYSICIAN	ation and enclo \$600.00 \$150.00 \$ 50.00 \$200.00	se the appropriate for PLEASE NOTE:	es as indicated below: 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		DA STA	Make checks payable to: ATE BOARD OF MEDICAL EXAMINERS
N Las Vegas, NV	89030		n checks must indicate "U.S. FUNDS")
• • • • • • • • • • • • • • • • • • • •	NEWAL REQU DUCATION co ted Application ssing, please of Physician form 97. Use the en from that printe authorizing you authorizing you	IRES THE SUBMISS mpleted during the properties of Registration Rencomplete and return you (if applicable) with you closed self-addressed on this form, clearly in name change (main state). State PLEASE INDICAT	SION OF PROOF OF 40 HOURS OF AMA period July 1, 1995 through June 30, 1997, ewal form. Our Application for Registration Renewal form your proof of 40 hours AMA Category I CME denvelope to return your completed form(s) y indicate the change in the space provided, riage license, divorce decree, etc.) must be
Street			
CityCounty		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

a. [] YES, in training. c. [] YES, working part-ti e. [] NO, other (specify_	b. [YES, working full- ime d. [] NO, retired.	time	
Please indicate your primary, second	ary and tertiary specialties and percen	t of time spent in each, using the	following codes.
	SPECIALTY CODE:		
6 BLOCCBANKING B BRONCO-ESCIPIAGOLOGY 7 CARCIOVASC DISEASES 8 CATSCANULTRASOUND 10 CHELD PSYCHATRY 11 CLINICAL PHARMACOL 12 ORTICAL CARE 12 DERMATOLOGY 14 EMERGINCY MEDICINE 15 ENDOCRINOLOGY 16 FAMILY PRACTICE 17 GASTROENTEROLOGY 18 GENERAL FRACTICE 19 GERIATRICS 20 GYNECOLOGY 11 HEMATOLOGY 12 HYPNOSIG 13 INFLUENCE TOUR STEASES 14 INFLUENCE TOUR STEASES 15 INFLUENCE TOUR STEASES 16 INFLUENCE TOUR STEASES 17 INFLUENCE TOUR STEASES 18 INFLUENCE TOUR STEASES 18 INFLUENCE TOUR STEASES 19 INFLUENCE TOUR STEASES 19 INFLUENCE TOUR STEASES 19 INFLUENCE TOUR STEASES 10 INFLUENCE TOUR STEASES	15 HEURORADIOLOGY 18 HUCLEAR MEDICINE 17 NUTRITION 19 OBSTETRICGYNECOLOGY 19 OBSTETRICG 19 OCCUPATIONAL MED 10 OCCUPATIONAL MED 11 ONCOLOGY, GYNECOLOGIC 12 ONCOLOGY, RADIATION 14 ONCOLOGY, RADIATION 15 ONCOLOGY, RADIATION 16 OPHTHALMOLOGY 17 OTOLARYNGOLOGY 18 PATHOLOGY 19 PATHOLOGY, DATATOMIC 19 PATHOLOGY, ANATOMIC 19 PATHOLOGY, CHINICAL 19 PATHOLOGY, CHINICAL 19 PED, CRITICAL CARE 19 PED, ENDOCRINICLOGY 19 PED, CRITICAL CARE 19 PED, EMERGENCY MED 19 PED, CRITICAL CARE 19 PED, EMERGENCY MED 19 PED, CRITICAL CARE 19 PED, EMERGENCY MED 19 PED, CRITICAL CARE 19 PED, HEMATIONCOLOGY 10 PED, MERCETIOUS DIS 10 PED, HEMATIONCOLOGY 10 PED, NEPHROLOGY 11 PED, OPHTHALMOLOGY 11 PED, PHYSIATRY 12 PED, SURGERY 15 ONCOLOGY 16 PED, PULMONARY 17 PED, SURGERY	PED. UROLOGY PEDIATRICS PHYSICAL MED/REHAB PHYSICAN ASSISTANT FREVENTIVE MED PSYCHIATRY PSYCHOAMILYSIS PSYCHOAMILYSIS PSYCHOAMIC MEDICINE PUBLIC HEALTH PUBLIC HEALTH PADIOLOGY, DIAGNOSTIC RADIOLOGY, NUCLEAR RADIOLOGY, THERAPEUT RHINOLOGY, THERAPEUT RHINOLOGY, THERAPEUT RHINOLOGY, THERAPEUT RHINOLOGY, THERAPEUT RHINOLOGY, THERAPEUT RHINOLOGY, THERAPEUT SURGERY, ABDOMINAL SURGERY, ABDOMINAL SURGERY, COLON/RECTAL SURGERY, COLON/RECTAL SURGERY, HEAD/NECK SURGERY, HEAD/NECK SURGERY, HEAD/NECK SURGERY, NEUROLOGICAL SURGERY, NEUROLOGICAL SURGERY, PLASTIC SURGERY, PLASTIC SURGERY, TRAUMATIC SURGERY, TRAUMATIC SURGERY, TRAUMATIC SURGERY, UROLOGICAL SURGERY, TRAUMATIC SURGERY, UROLOGIC	
Primary Secondary Tertiary	Code Percent of Time	Board Certified (Indi	cate Yes/No)
PLEASE INDICATE AMERICAN BOARD OF MEI BOARD He Green Board	DICAL SPECIALTIES BOARD CERTI	Date of Initial Certification	Date of Last Certification
Subboard		/ (Mo//Yr.)	(Mo./Yr.)
3. Form of employment is SELF-EMPLOYED 1001 Solo Practice 1002 Partnership or Group Practitioners SALARIED, EMPLOYED BY: 1003 Individual Practitioner 1004 Partnership or Group of Practitioners 1005 Group Health Plan Facility (such as H.N. 1012 Of	1007 Federal Government 1008 Federal Government 1009 State Government 1010 County Government	(Mo.Yr.) (ED BY (continued) ent Employer (hospital, school, e (armed services personnel only) (civilian, P.H.S., etc.)	

All of the following questions refer to the time period July 1, 1995, through the present date only.

FOR ALL YES RESPONSES, PLEASE EXPLAIN ON A SEPARATE SHEET AND

RETURN WITH THIS REGISTRATION APPLICATION

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

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

1. Are you currently active in medicine?

- 1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments; and
- 2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
- 3. The physician capability to perform medical tasks such as physician examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.
- "Medical condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to, orthopedic, vision, speech, and hearing, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, emotional or mental illness, HIV disease, tuberculosis, drug addiction, and alcoholism.
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- "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.

<i>,</i>
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
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? YesNo
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? YesNo
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?YesNo
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? YesNo
6. Have you ever been investigated for, charged with, convicted of, or plead guilty or noto 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?
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?
8. Have you ever had a medical license revoked, suspended, limited, or restricted in any state, country or U.S. territory?Yes
9. Have you ever voluntarily surrendered a license to practice a healing art in any state, country or U.S. territory? Yes Vo
10. Have you ever been denied membership or expelled from a medical society or other professional medical organization?Yes
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 Yes
12. Have you ever surrendered your state or federal controlled substance registration or had it revoked or restricted in any way?Yesi/_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). Mailing Type of Dates of Action Hospital Address Action From (Mo./Yr.) To (Mo./Yr.)
If more space is needed, attach separate sheet.
If more space is needed, attach separate sheet. PLEASE CHECK ONE OF THE FOLLOWING:
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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 Olymature stamp unacceptable
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PHYSICIAN Date Received by Board License No. 264 APPLICATION FOR RENEWAL REGISTRATION **NEVADA STATE BOARD OF** MAY 1 4 1999 MAY 2 0 1999 File No. **MEDICAL EXAMINERS** Post Office Box 7238 Reno, Nevada 89510 Phone (775) 688-2559 (Board Use Only) hereby apply for renewal of biennial registration and enclose the appropriate fee(s) as indicated below; \$600.00 ACTIVE STATUS . **INACTIVE STATUS** \$200.00 **RETIRED STATUS** \$ 50.00 SUPERVISING/COLLABORATING PHYSICIAN \$200.00 Frank P. Silver, MD Make checks payable to: 2031 McDaniel St #210 **NEVADA STATE BOARD OF MEDICAL EXAMINERS** N Las Vegas NV 89030 (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. 3. IF YOU HAVE RETIRED OR MOVED YOUR PRACTICE. INDICATE THE LOCATION OF PATIENT RECORDS BELOW:

7. Are you currently active in m				·	
a. [] YES, in trainir c. [] YES, working	part-time	b. [V] YES, wo d. [] NO, retir	orking full-time red.		`
e.[] NO, other (sp	ecity				_)
 Please indicate your prima following codes: 	ry, secondar	y and tertiary specialtie SCOPE OF PRAC' SPECIALTY COD	TICE	practice time spent	in each, using the
ADDICTION MEDICINE ADOLESCENT MEDICINE ALLERGY/IMMUNOLOGY ALTERNATIVE MEDICINE ANESTHESIOLOGY BLOODBANKING BRONCO-ESOPHAGOLOGY CARDIOVASCULAR DISEASES CATSCAN/ULTRASOUND CHILD NEUROLOGY CHILD PSYCHIATRY CLINICAL PHARMACOLOGY CRITICAL CARE DERMATOLOGY EMERGENCY MEDICINE FAMILY PRACTICE GASTROENTEROLOGY BGENERAL PRACTICE GERIATRICS GYNECOLOGY HEMATOLOGY HEMATOLOGY HEMATOLOGY INFECTIOUS DISEASES IMMUNOLOGY INFECTIOUS DISEASES INFERTILITY INTERNAL MEDICINE ALERGAL MEDICINE THE CONTROLOGY AND CONTROLO	32 33 34 35 36 37 38 39 40 41 45 42 43 44 46 47 48 49 50 51 52 53 54 57 58	NEOPLASTIC DISEASES NEPHROLOGY NEUROLOGY NEUROPATHOLOGY NEURORADIOLOGY NUCLEAR MEDICINE NUTRITION OBSTETRICS/GYNECOLO OBSTETRICS OCCUPATIONAL MEDICIN ONCOLOGY, GYNECOLO ONCOLOGY, GYNECOLO ONCOLOGY, RADIATION ONCOLOGY, RADIATION ONCOLOGY, SURGICAL OPHTHALMOLOGY OTOLOGY PAIN MANAGEMENT PATHOLOGY PATHOLOGY, ANATOMIC PATHOLOGY, FORENSIC PEDIATRIC, CARDIOLOGY PEDIATRIC, CRITICAL CA PEDIATRIC, EMERGENCY PEDIATRIC, EMERGENCY PEDIATRIC, HEMATOLOG PEDIATRIC, INFECTIOUS PEDIATRIC, INFECTIOUS PEDIATRIC, INTENSIVIST	63 64 65 66 67 68 0GY 69 70 8E 71 72 GICAL 73 GY 74 75 76 77 78 79 100 80 103 81 91 91 92 Y 83 RE 84 (MEDICINE 92 LOGY 93 BY/ONCOLOGY 85	SURGERY, HEAD/NEC SURGERY, MAXILLOF SURGERY, NEUROLC SURGERY, ORTHOPE	REHABILITATION NE CINE ES STIC R PEUTIC AL HORACIC ASCULAR ECTAL CK ACIAL GGICAL GGICAL
29 MATERNAL/FETAL MEDICINE 106 MEDICAL ACUPUNCTURE 107 MEDICAL ETHICS 30 NEO/PERINATAL MEDICINE	60 98 101 61	PEDIATRIC, NEPHROLOGY PEDIATRIC, NEUROLOGY PEDIATRIC, OPHTHALMO PEDIATRIC, PHYSIATRY PEDIATRIC, PULMONARY	9Y 88 Y 89 LOGY 90	SURGERY, TRAUMAT SURGERY, UROLOGI SURGERY, VASCULA UROLOGY	ic C
	Code	Percent of Time	B	oard Certified (Indica	te Yes/No)
Primary	20	60		ريعه	The F
Secondary Tertiary	40	90		Aso U.	IME
PLEASE INDICATE ALL AME		RD OF MEDICAL SPE	Ī	D OR SUBBOARD (Date of Certification	DERTIFICATIONS: Date of Last Certification
Dogld 1311 (411 4011 10	410000		ń)	no./Yr.)	(Mo./Yr.)
Subboard			(1)	Mo.Mr.)	, (Mo/Yr.)
Board AMERICAN BO	BRD I	MOESENDENT		E XAM· Mo./Yr.)	(Mo./Yr.)
Subboard			`` <u>``</u>		
9. Form of employment is	ED BY: er p of Practition	1006 C s 1007 F 1008 F 1009 S ners 1010 C	he following code ALARIED, EMPLO Other Non-Govern rederal Governme	DYED BY: (continue nment Employer (hos ent (armed services p ent (civilian, P.H.S., el nt	spital, school, etc.) ersonnel oniy)

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

Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? YesNo
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? YesNoV_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? YesNo/_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? YesNoN/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? YesNo
6. Have you ever been investigated for, charged with, convicted of, or plead guilty or noto 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 of dispensing of controlled substances? YesNo
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
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?
Have you ever voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. erritory? YesNo
10. Have you ever been denied membership or expelled from a medical society or other professional medical organization? Yes

	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
	12. Have you ever surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? YesINo
	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).
	Mailing Type of Dates of Action Hospital Address Action From (Mo./Yr.) To (Mo./Yr.)
	4///
	(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) HAVE NOT ACTIVELY PRACTICED IN NEVADA WITHIN THE PAST 12 MONTHS. (CHECK ONE) THEREBY 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.
1	102-228-4004 4-27-99 Business Telephone # Date Signature (SIGNATURE STAMP UNACCEPTABLE)

LCENTER COMMENT REPORTED BY JUNE AND ADMICE THE PROPERTY OF TH	\$	ECSTRUCTURE INSPIRATOREMENTAL INSPIRATION PROPERTY OF THE STREET, STRE
PHYSICIAN APPLICATION FOR REGISTRATION RENEWAL	Date Received by Board	License No. 2641
FOR THE BIENNIAL REGISTRATION PERIOD 2001-2003	MAY 2 2 2001	Clock Too.
NEVADA STATE BOARD OF MEDICAL EXAMINERS	/F P (14 O-14)	File No.
Post Office Box 7238 Reno, Nevada 89510 Phone (775) 688-2559 I hereby apply for renewal of biennial registration and enclose	(For Board Use Only) the appropriate fee(s) as indicate	d below:
ACTIVE STATUS	\$600.00	a motorn
INACTIVE STATUS	•	IS REQUIRES THAT THE
RETIRED STATUS SUPERVISING/COLLABORATING PHYSICIAN	\$ 50.00 APPLICANT NOT \$200.00: ANYWHERE)	T PRACTICE MEDICINE
	V200.00: /////////////////////////////////	
nie nov. capoidais no 546	MD	
		ks payable to: D OF MEDICAL EXAMINERS
341 N Buffalo #B		st Indicate "U.S. FUNDS")
Las Vegas, NV 89145		
DI EACE NOTE:		
PLEASE NOTE: YOUR CURRENT M.D. LICENSE EXPIRES ON JUNE 30	2001 COMPLETED APPLICA	TION FOR REGISTRATION
RENEWAL FORMS NOT RECEIVED AT THE BOARD O		
SUSPENDED FOR NON-PAYMENT. EXTENSIONS OF		
HAS <u>NO GRACE PERIOD</u> . (USE THE ENCLOSED ENV REGISTRATION RENEWAL FORM.)	ELOPE TO MAIL YOUR COMPL	ETED APPLICATION FOR
YOUR LICENSE WILL NOT BE RENEWED UNLESS YO	OU ANSWER ALL QUESTIONS O	N THIS APPLICATION FOR
REGISTRATION RENEWAL FORM. YOU MUST PROV	IDE WRITTEN EXPLANATIONS	FOR ALL QUESTIONS
ANSWERED "YES." ALL INFORMATION YOU PROVIDE ON THIS APPLICA	TION EOD DEGISTRATION DEM	CIMAL EODM IS BUILD IC
INFORMATION.	HOW FOR REGISTRATION REN	EVAL FORWIS FORLIO
	R PRINT LEGIBLY	
	Comments and the Comment of the Comm	,
1. To be eligible to act as a SUPERVISING PHYSICIAN FO		
PHYSICIAN FOR AN ADVANCED PRACTITIONER OF NURS you must complete the enclosed Application for Approval a		
payment in the amount of \$200.00 in the enclosed envelope.	a capervishing contact during , n	yororan and rotarn it man your
		(AB40
2. Active status registration renewal requires the submission of medical education (CME), which includes 2 hours of CME in re-	· · · · · · · · · · · · · · · · · · ·	
specialty completed during the period July 1, 1999 through		
your completed Application for Registration Renewal form. (S		
3. If your name and/or address has changed from that printed	on the label on this form clearly in	dicate the change in the space
provided below. Also, please indicate your current telephone a		
document authorizing your name change (marriage license, d	livorce decree, etc.) must be inclu	ded.]
Name FRANK P. SILVER I	n.D.	
Name FRANK P. SILVER, I's Street 341 N. Buffalo Suite City Las Vegas County Clar Phone Number (702) 228-4004 Fax Nu	B	
SHEEL SIT W. BUTTHE SUITE	1. 21. 4/15	- 09166-
City LAS VEGAS County CIAR	State 7/1.	Zip 3 // 7.5
Phone Number (702) 228-4009 Fax Nu	imber (101) 228-5	<u>635</u>
4. IF YOU HAVE RETIRED OR MOVED YOUR PRACTICE, I	indicate the location of patient rec	ords below:
Namo		
Name		
Street		
CityCounty	State	Zip
Phone Number		
5. indicate below the EXACT NAME AND LOCATION of the M	ledical School from which you grad	fuated and your EXACT DATE
of graduation:		and the second section of second section of the second
JEFFERSON MEdiCAL COLLEGE	- 10,	4.1
JETIENSON TIBUICHT CETTESTE	<u> </u>	

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

SCOPE OF PRACTICE SPECIALTY CODES

3 9 1	<u>Code</u>		Code		<u>Code</u>
39 1					
39 1	NEPHROLOGY	78	PEDIATRIC, SURGERY		
	NEOPLASTIC DISEASES	77	PEDIATRIC, RADIOLOGY		
	NEO/PERINATAL MEDICINE	76	PEDIATRIC, PULMONARY	115	UROLOGY
	MEDICAL GENETICS	75	PEDIATRIC, PHYSIATRY		URGENT CARE
	MEDICAL ETHICS		PEDIATRIC, OPHTHALMOLOGY		SURGERY, VASCULAR
	MEDICAL ACUPUNCTURE	73	PEDIATRIC, NEUROLOGY		SURGERY, UROLOGIC
	MATERNAL/FETAL MEDICINE		PEDIATRIC, NEPHROLOGY	111	SURGERY, TRAUMATIC
	LEGAL MEDICINE		PEDIATRIC, INTENSIVIST		SURGERY, TRANSPLANT
	LARYNGOLOGY		PEDIATRIC, INFECTIOUS DISEASES		SURGERY, THORACIC
	INTERNAL MEDICINE	69	PEDIATRIC, HEMATOLOGY/ONCOLOGY	108	SURGERY, PLASTIC
	INFERTILITY		PEDIATRIC, GASTROENTEROLOGY		SURGERY, ORTHOPEDIC
	INFECTIOUS DISEASES	67		106	SURGERY, NEUROLOGICAL
	IMMUNOLOGY		PEDIATRIC, EMERGENCY MEDICINE	105	SURGERY, MAXILLOFACIAL
	HYPNOSIS	65		104	SURGERY, HEAD/NECK
	HOMEOPATHY		PEDIATRIC, CARDIOLOGY	103	SURGERY, HAND
	HEMATOLOGY	63	PEDIATRIC, ALLERGY		SURGERY, GENERAL
	GYNECOLOGY		PATHOLOGY, FORENSIC		SURGERY, COLON/RECTAL
	GERIATRICS		PATHOLOGY, CLINICAL	100	SURGERY, CARDIOVASCULAR
	GENERAL PRACTICE	60	PATHOLOGY, ANATOMIC	99	SURGERY, CARDIOTHORACIC
	GASTROENTEROLOGY	59		98	SURGERY, ABDOMINAL
	FAMILY PRACTICE		PAIN MANAGEMENT	97	SPORTS MEDICINE
	ENDOCRINOLOGY	57	OTOLOGY	96	SLEEP DISORDERS
	EMERGENCY MEDICINE	56 57	OTOLARYNGOLOGY	95	RHINOLOGY
	DERMATOPATHOLOGY	55 56	OPHTHALMOLOGY	94	RHEUMATOLOGY
	DERMATOLOGY	54	ONCOLOGY, SURGICAL	93	RADIOLOGY, VASCULAR
	CRITICAL CARE	53	ONCOLOGY, RADIATION	92	RADIOLOGY, THERAPEUTIC
	CLINICAL PHARMACOLOGY	52	ONCOLOGY, HEMATOLOGY	91	RADIOLOGY, NUCLEAR
	CHILD PSYCHIATRY	51	ONCOLOGY, GYNECOLOGICAL	90	RADIOLOGY, INTERVENTIONAL
	CHILD NEUROLOGY	50	ONCOLOGY	89	RADIOLOGY, DIAGNOSTIC
	CATSCAN/ULTRASOUND	49	OCCUPATIONAL MEDICINE	88	RADIOLOGY
	CARDIOVASCULAR DISEASES	48	OBSTETRICS/GYNECOLOGY	87	PULMONARY DISEASES
	BRONCO-ESOPHAGOLOGY	47	OBSTETRICS	86	PUBLIC HEALTH
	BLOODBANKING	46	NUTRITION	85	PSYCHOMATIC MEDICINE
	ANESTHESIOLOGY	45	NUCLEAR MEDICINE		PSYCHOANALYSIS
	ALLERGY/IMMUNOLOGY	44	NON-CONVENTIONAL MEDICINE	83	PSYCHIATRY
	ALLERGY	43	NEURORADIOLOGY	82	PREVENTIVE MEDICINE
	AEROSPACE MEDICINE		NEUROPATHOLOGY		PHYSICAL MEDICINE/REHABILITATION
	ADOLESCENT MEDICINE	41	NEURO-OPHTHALMOLOGY	80	PEDIATRICS
	ADDICTION MEDICINE	40	NEUROLOGY	79	PEDIATRIC, UROLOGY

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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;
- 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.

[&]quot;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.

 Do you have a medica safety? 	al condition which	in any way impairs or limits yo	our ability to practice medicine w	ith reasonable skill and YesNo
			your ability to practice medicine e setting, or the manner in which	
If you use chemical su and safety?	ıbstances, does y	our use in any way impair or l	imit your ability to practice medic	ine with reasonable skillsN/A
	ment of your rece		one year after the date the publom the federal government or a s Yes	
5. Have you been a defe paid in your behalf or pa			iability (malpractice) or had a pro —	ofessional liability claim YesNo
of any federal, state or excluding any minor traff	local law, includic ic offense (driving	ling any foreign country, whi g or in control of a motor vehic	plead guilty or nolo contendere to ch is a misdemeanor, gross m cle while under the influence of an manufacture, distribution, presco	any offense or violation isdemeanor, or felony, ny chemical substance is
7. Have you ever been examination to practice i	denied a license medicine or any	, permission to practice med other healing art in any state,	icine or any other healing art, or country or U.S. territory?	permission to take an YesNo
8. Have you ever had a pany state, country or U.S		r license to practice any other	r healing art revoked, suspended —	I, limited, or restricted in YesNo
9. Have you ever volunt territory?	tarily surrendered	d a license to practice medici	ne or any other healing art in an	y state, country or U.S. YesNo
10. Have you ever beer	denied membe	rship or expelled from a medi	ical society or other professiona	medical organization?YesNo
any violation of a statute	e, rule or regulati	on governing your practice a	or; b) investigated for; c) charged s a physician by any medical lic levada State Board of Medical E	ensing board, hospital,
12. Have you ever surre	ndered your state	e or federal controlled substa	nce registration or had it revoked —	or restricted in any way? No
any and all resignations	from any medio ons for failure to	cal staff in lieu of disciplinary complete hospital medical re	nded, limited, revoked or not rene or administrative action. (<u>Pleas</u> cords, attend hospital departme	<u>se Note</u> : Do not include
	Mailing	Type of	Dates of	
Hospital	Address	Action	From (Mo./Yr.)	To (Mo./Yr.)
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	/ 1			
•				

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

CHILD SUPPORT STATEMENT

"YES" ANSWER(S).

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 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 plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuate 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 we in medical ethics and 20 hours of which were in my scope of practice or specialty, during the past biennial period of July 1, 199 through June 30, 2001;
(b) I was initially licensed in Nevada during the time period January 1, 2000 through June 30, 2000, the second smonths 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 mont of the past biennial period, and completed a minimum of 20 hours of AMA Category I continuing medical education (CME), 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 month of the past biennial period, and completed a minimum of 10 hours of AMA Category I continuing medical education (CME), 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 complete 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 PERIO 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.
HAVE VALUE HAVE NOT (CHECK ONE) ACTIVELY PRACTICED MEDICINE IN NEVADA WITHIN THE PAST OF MONTHS.
BY SIGNING ON THE SIGNATURE LINE BELOW:
 THEREBY REPRESENT THAT I AM THE PERSON NAMED IN THIS APPLICATION FOR REGISTRATION RENEWAL C LICENSE TO PRACTICE MEDICINE IN THE STATE OF NEVADA AND THAT ALL STATEMENTS THAVE MADE HERE 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 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

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PHYSICIAN APPLICATION FOR REGISTRATION RENEWAL	Date Received by Board License No. 2691
FOR THE BIENNIAL REGISTRATION PERIOD 2003-2005	FEB 2 4 2003
NEVADA STATE BOARD OF MEDICAL EXAMINERS	File No
Post Office Box 7238 Reno, Nevada 89510 Phone (775) 688-2559 Physical Address: 1105 Terminal Way, Suite 301 Reno, Nevada 89502	(Fur Board Use Only)
I hereby apply for renewal of biennial registration and enclose t	
	00.00 , 00.00 (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 P SILVER M.C	
341 N Buffalo #B Las Vegas, NV 89145	NEVADA STATE BOARD OF MEDICAL EXAMINERS (Foreign checks must indicate "U.S. FUNDS")
Request for NON-RENEWAL of Lice	nse to Practice Medicine In Nevada
I hereby represent that I am the person named in this AP	PLICATION FOR REGISTRATION RENEWAL of license to
practice medicine in the state of Nevada.	15 W 400 mm
	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 STA	MP UNACCEPTABLE)
PLEASE NOTE:	
BENEWAL FORMS NOT RECEIVED AT THE BOARD OF SUSPENDED FOR NON-PAYMENT. EXTENSIONS OF THAS NO GRACE PERIOD. (USE THE ENCLOSED ENVIRED STRATION RENEWAL FORM.) YOUR LICENSE WILL NOT BE RENEWED UNLESS YOU REGISTRATION RENEWAL FORM. YOU MUST PROVIDE ANSWERED "YES." ALL INFORMATION YOU PROVIDE ON THIS APPLICATED.	2003. COMPLETED APPLICATION FOR REGISTRATION FICE-BY JULY 1, 2003 AT 5:00 P.M. ARE AUTOMATICALLY FIME ARE NOT ALLOWED FOR ANY REASON, AS NEVADA ELOPE TO MAIL YOUR COMPLETED APPLICATION FOR I ANSWER ALL QUESTIONS ON THIS APPLICATION FOR IDE WRITTEN EXPLANATIONS FOR ALL QUESTIONS FION FOR REGISTRATION RENEWAL FORM IS PUBLIC
INFORMATION.	
PLEASE TYPE OF	r print legibly
1. Active status registration renewal requires the submission of medical education (CME), which includes 2 hours of CME in me specialty completed during the period July 1, 2001 through your completed Application for Registration Renewal form. (See Manage of Section 2015)	edical ethics and 20 hours of CME in your scope of practice or June 30, 2003. Submit your proof of completion of CME with ee last page of this form for CME statement.)
 If your name and/or address has changed from that printer space provided below. Also, please indicate your current telep copy of the document authorizing your name change (marriage 	hone and fax numbers. [Please note: a notarized or certified
Name	
Street	
CityCounty	State Zip
City County Phone Number (702) 228-7004 Fax Nur	nber (702) 228-5653
3. IF YOU HAVE RETIRED OR MOVED YOUR PRACTICE, I	
Name	
StreetN	
Street County	StateZip
Phone Number	
THORN THERESE	

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

SCOPES OF PRACTICE CODES

			•		
1	ADDICTION MEDICINE	41	NEOPLASTIC DISEASES	31	PEDIATRIC, RHEUMATGLOGY
2	ADOLESCENT MEDICINE	42	NEPHROLOGY	82	PEDIATRIC, SURGERY
3	AEROSPACE MEDICINE	43	NEUROLOGY	33	PEDIATRIC, UROLOGY
4	ALLERGY	44	NEURO-OPHTHALMOLOGY	84	
5	ALLERGY/IMMUNOLOGY	45		85	PHYSICAL MEDICINE/REHABILITATION
õ	AMBULATORY MEDICINE	46	NEURORADIOLOGY	86	PREVENTIVE MEDICINE
7	ANESTHESIOLOGY	47	NON-CONVENTIONAL MEDICINE	37	PSYCHIATRY
3	BLOODBANKING	48	NUCLEAR MEDICINE	88	PSYCHOANALYSIS
9	BRONCO-ESOPHAGOLOGY	49	NUTRITION	89	PUBLIC HEALTH
10	CARDIOVASCULAR DISEASES	50	OBSTETRICS	90	PSYCHOMATIC MEDICINE
11	CATSCAN/ULTRASOUND	51	OBSTETRICS/GYNECOLOGY	91	PULMONARY DISEASES
12	CHILD NEUROLOGY	52	OCCUPATIONAL MEDICINE	92	RADIOLOGY
13	CHILD PSYCHIATRY	53	ONCOLOGY	93	RADIOLOGY, DIAGNOSTIC
14	CLINICAL PHARMACOLOGY	54		94	
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		93	FIHEUMATOLOGY
19	ENDOCRINOLOGY	59		99	HHINOLOGY
20	FAMILY PRACTICE	60			SLEEP DISORDERS
(1)	GASTROENTEROLOGY	61	PAIN MANAGEMENT	101	SPORTS MEDICINE
:1:2	GENERAL PRACTICE		PATHOLOGY		SURGERY, ABDOMINAL
23	GERIATRIC PSYCHIATRY		PATHOLOGY, ANATOMIC	103	
24	GERIATRICS		PATHOLOGY, CLINICAL		SURGERY, CARDIOVASCULAR
25	GYNECOLOGY	65	PATHOLOGY, FORENSIC	105	
26	HAIR TRANSPLANTATION	66	PEDIATRIC, ALLERGY	106	SURGERY, GENERAL
27	HEMATOLOGY		PEDIATRIC, CARDIOLOGY		SURGERY, HAND
28	HOMEOPATHY	68	PEDIATRIC, CRITICAL CARE	108	SURGERY, HEAD/NECK
29	HYPNOSIS	69	PEDIATRIC, EMERGENCY MEDICINE		SURGERY, MAXILLOFACIAL
30	IMMUNOLOGY	70	PEDIATRIC, ENDOCRINOLOGY		SURGERY, NEUROLOGICAL
31	INFECTIOUS DISEASES	71	PEDIATRIC, GASTROENTEROLOGY	111	SURGERY, ORTHOPEDIC
32	INFERTILITY		PEDIATRIC, HEMATOLOGY/ONCOLOGY		SURGERY, PLASTIC
33	INTERNAL MEDICINE	73			SURGERY, THORACIC
34	LARYNGOLOGY	74			SURGERY, TRANSPLANT
35	LEGAL MEDICINE	75		115	
36	MATERNAL/FETAL MEDICINE		PEDIATRIC, NEUROLOGY		SURGERY, UROLOGIC
37	MEDICAL ACUPUNCTURE		PEDIATRIC, OPHTHALMOLOGY		SURGERY, VASCULAR
38	MEDICAL ETHICS		PEDIATRIC, PHYSIATRY		TOXICOLOGY
39	MEDICAL GENETICS	79	PEDIATRIC, PULMONARY	119	
40	NEO/PERINATAL MEDICINE	80	PEDIATRIC, RADIOLOGY	120	UROLOGY

<u>Code</u> <u>Code</u>

Primary Scope of Practice 3 5 Secondary Scope of Practice

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

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

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

- 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.

 Do you have a medical cor safety? 	ndition which in any	way impairs or limits your a	ability to practice medicine with reasonable skill an YesN
			ability to practice medicine, is that impairment of ting, or the manner in which you have chosen toNoN/
If you use chemical substa skill and safety?	ances, does your u	se in any way impair or limi	it your ability to practice medicine with reasonabl
	ent of your receiving		year after the date the public service is required to from the federal government or a state or location
5. Have you been a defendar paid in your behalf or paid su			ty (malpractice) or had a professional liability clair
violation of any federal, state felony, excluding any minor t	or local law, inclu raffic offense (drivi l a minor traffic o	ding any foreign country, v	olead guilty or nolo contendere to any offense of which is a misdemeanor, gross misdemeanor, of vehicle while under the influence of any chemical to the manufacture, distribution, prescribing, of the manufacture.
			or any other healing art, or permission to take a ntry or U.S. territory?YesN
8. Have you ever had a mediany state, country or U.S. ter		se to practice any other hea	uling art revoked, suspended, limited, or restricted
9. Have you ever voluntarily territory?	surrendered a licer	nse to practice medicine or	any other healing art in any state, country or U.S
10. Have you ever been den	ied membership or	expelled from a medical so	oclety or other professional medical organizationYesN
any violation of a statute, rule	e or regulation gove	erning your practice as a pl) investigated for; c) charged with; or d) convicted only investigated for; c) charged with; or d) convicted only investigated for; c) charged with; or d) convicted only investigated for the charged with; or d) convicted only investigated for the charged with; or d) convicted only investigated for; c) charged with; or d) convicted only investigated for; c) charged with; or d) convicted only investigated for; c) charged with; or d) convicted only investigated for; c) charged with; or d) convicted only investigated for; c) charged with; or d) convicted only investigated for; c) charged with; or d) convicted only investigated for; c) charged with; or d) convicted only investigated for; c) charged with; or d) convicted only investigated for; c) charged with; or d) convicted only investigated for; c) charged with; or d) convicted only investigated for; c) charged with; or d) convicted only investigated for; c) charged for convicted only investigated for; c) charged for convicted for con
12. Have you ever surrende way?	red your state or fe	ederal controlled substance	e registration or had it revoked or restricted in ar
List any and all resignations f	rom any medical st or failure to comple	aff in lieu of disciplinary or a	ed, limited, revoked or not renewed by the hospital administrative action. (<u>Please Note</u> : Do not includes, attend hospital department or staff meetings, or
•	Mailing Address	Type of Action	Dates of Action From (Mo./Yr.) To (Mo./Yr.
Hospital	Address	/\text{\tin}\text{\tinc{\tinc{\tint{\text{\tin}\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\texi}\text{\text{\text{\tex{\text{\texit{\text{\text{\text{\texi}\text{\texi}\text{\text{\text{\text{\text{\text{\text{\texi}\text{\texit{\text{\text{	110H (WO.11.) 10 (WO.11.
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(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 of 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 Navada during the time period January 1, 2003 through June 30, 2003, the fourth signorths 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.
HAVE V HAVE NOT (CHECK ONE) ACTIVELY PRACTICED MEDICINE IN NEVADA WITHIN THE PAST 12 MONTHS.
BY SIGNING ON THE SIGNATURE LINE BELOW:
) THEREBY 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).

Samalo (SIGNATURE STAMP UNACCEPTABLE)

Frank Paul SILVER M.D. NEVADA STATE BO	THE PROPERTY OF THE PROPERTY O	A THE REAL PROPERTY OF THE PARTY OF THE PART
FOR THE BIENNIAL REGISTRATION PERIOD 2005 - 2007 NEVADA STATE BOARD OF MEDICAL EXAMINERS **pot Office box 7238 Reno, Nevada 9510 Phone (775) 689-2593 **physical Address*** 1105 Terminal Way, Suite 301 Reno, Nevada 9502 **Physical Address**** 1105 Terminal Way, Suite 301 Reno, Nevada 9502 **NACTIVE STATUS **\$000.00	License No.	2641
Page Office Box 7233 Reno, Nevada 89510 Prone (775) 688-2559 (For Board Use Only) Physical Address: 1105 Terminal Way, Suite 201 Reno, Nevada 89502 (For Board Use Only) Physical Address: 1105 Terminal Way, Suite 201 Reno, Nevada 89502 (For Board Use Only) Physical Address: 1105 Terminal Way, Suite 201 Reno, Nevada 89502 (For Board Use Only) Physical Address: 1105 Terminal Way, Suite 201 Reno, Nevada 89502 (For Board Use Only) Physical Address: 1105 Terminal Way, Suite 201 Reno, Nevada 89502 (For Board Use Only) Physical Address: 1105 Terminal Physical Address: 1105 Terminal Physical Physical 800,000 (For Board Use Only) Physical Address: 1105 Terminal Physical Physical 800,000 (For Board Use Only) Physical Physical 800,000 (For Board Use Only) Physical Physical Physical Physical 800,000 (For Board Use Only) Physical Physical Physical Renoval Physical Phys		
Personal Address: 1105 Terminal Way, Sulle 301 Reno, Nevada 89502 hereby apply for renewal of biennial registration and enclose the appropriate fee(s) as ind ACTIVE STATUS \$600.00. INACTIVE STATUS \$300.00(INACTIVE STATUS \$300.00(INACTIVE STATUS \$300.00(INACTIVE STATUS \$1 REQUEST NON-RENEWAL OF MY LICENSE* THE PRACTICES ("IF YOU ARE REQUESTING NON-RENEWAL SEE BELOW) THE WRITING OF THE WRIT	File No	· -
nereby apply for renewal of biennial registration and enclose the appropriate fee(s) as ind ACTIVE STATUS INACTIVE STATUS INACTIVE STATUS IREQUEST NON-RENEWAL OF MY LICENSE* THE PRACTICE OF THE WRITING OF THE WRI		
ACTIVE STATUS \$300.00(INACTIVE STATUS \$300.00(INACTIVE STATUS \$300.00(INACTIVE STATUS \$300.00(INACTIVE STATUS INACTIVE STATUS \$300.00(INACTIVE STATUS INACTIVE STATUS INACTIVE STATUS STATUS INACTIVE STATUS INACTIVE STATUS INACTIVE STATUS INACTIVE STATUS INACTIVE STATUS STATUS INACTIVE STATUS STAT	icated below:	
THE PRACTICE OF THE WRITING OF THE W		
THE WRITING OF File No. License No. 2641 Frank Paul SILVER 341 N Buffalo #B Las Vegas NV 89145- Request for NON-RENEWAL of License to Practice Meteoretic medicine in the state of Nevada. By signing on the signature line below, I am requesting that my 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 by the Nevada State Board of Medical Examiners. I will return this signed for Renewed by the Nevada State Board of Medical Examiners. I will return this signed for Renewal Forms NOT RECEIVED AT THE BOARD OFFICE BY JULY 1, 2005 AT 5:00 P. M. SUSPENDED FOR NON-PAYMENT. EXTENSIONS OF TIME ARE NOT ALLOWED FOR AN HAS NO GRACE PERIOD. (USE THE ENCLOSED ENVELOPE TO MAIL YOUR COMPLETE REGISTRATION RENEWAL FORM.) YOUR LICENSE WILL NOT BE RENEWED UNLESS YOU ANSWER ALL QUESTIONS ON THE REGISTRATION RENEWAL FORM. YOU MUST PROVIDE WRITTEN EXPLANATIONS FOR ANSWERED "YES." ALL INFORMATION YOU PROVIDE ON THIS APPLICATION FOR REGISTRATION RENEWAL INFORMATION. PLEASE TYPE OR PRINT LEGIBLY 1. Active status registration renewal requires the submission of proof of completion of 44 hor medical education (CME), which includes 2 hours of CME in medical education renewal required for acts of terrorism that involves the use of a weapon of mass destruction. "The course must prote that includes instruction in the following subjects: (1) An overview of acts of terrorism and we personal protective equipment required for acts of terrorism; (3) Common symptoms and method to the course must provide the use of, the Health Alert Network." Submit your proof of completion of CME with Registration Renewal form. (See last page of this form for CME statement.) PLEASE TYPE OR PRINT LEGIBLY 1. Active status registration in the following subjects: (1) An overview of acts of terrorism and we personal protective equipment required for acts of terrorism; (3) Common symptoms and method to the course must provide below. Also, please indicate your current te		
Frank Paul SILVER 341 N Buffalo #B Las Vegas NV 89145- Request for NON-RENEWAL of License to Practice Medical Examiners. I will return this signed for the Nevada State Board of Medical Examiners. I will return this signed for Renewed by the Nevada State Board of Medical Examiners. I will return this signed for Hongrey (ISGNATURE STAMP UNACCEPTABLE) PLEASE NOTE: YOUR CURRENT M.D. LICENSE EXPIRES ON JUNE 30, 2005. COMPLETED APPLICATION RENEWAL FORMS NOT RECEIVED AT THE BOARD OFFICE BY JULY 1, 2005 AT 5:00 P. M. SUSPENDED FOR NON-PAYMENT. EXTENSIONS OF TIME ARE NOT ALLOWED FOR AN HAS NO GRACE PERIOD. (USE THE ENCLOSED ENVELOPE TO MAIL YOUR COMPLETE REGISTRATION RENEWAL FORM.) YOUR LICENSE WILL NOT BE RENEWED UNLESS YOU ANSWER ALL QUESTIONS ON THE REGISTRATION RENEWAL FORM. YOU MUST PROVIDE WRITTEN EXPLANATIONS FOR ANSWERED "YES." ALL INFORMATION TOU PROVIDE ON THIS APPLICATION FOR REGISTRATION RENEWAL INFORMATION. PLEASE TYPE OR PRINT LEGIBLY 1. Active status registration renewal requires the submission of proof of completion of 44 hours and the period July 1, 2003 through June 30, 2005. Additiona Statutes (NRS) 630, 253(2)(b), an applicant must complete a course of instruction relating to that includes instruction in the following subjects: (1) An overview of acts of terrorism and versposure to, or injuries caused by, chemical, biological, radioactive and nuclear agents; eporting procedures for acts of terrorism that involves the use of a weapon of mass destruction. "The course must protent includes instruction in the following subjects: (1) An overview of acts of terrorism and versposure to, or injuries caused by, chemical, biological, radioactive and nuclear agents; eporting procedures for acts of terrorism that involves the use of, the Health Alert Network." Submit your proof of completion of CME with Registration Renewal form. (See last page of this form for CME statement.) PLEASE TYPE OR PRINT LEGIBLY 1. If your name and/or address has changed from that printed on the label on this form, of space p		
Frank Paul SILVER 341 N Buffalo #B Las Vegas NV 89145- Request for NON-RENEWAL of License to Practice Met Thereby represent that I am the person named in this APPLICATION FOR REGISTRATION and the state of Nevada. By signing on the signature line below, I am requesting that my license to practice renewed by the Nevada State Board of Medical Examiners. I will return this signed for Medical Examiners. I will return this signed for RENEWAL FORMS NOT RECEIVED AT THE BOARD OFFICE BY JULY 1, 2005 AT 5:00 P.M. SUSPENDED FOR NON-PAYMENT. EXTENSIONS OF TIME ARE NOT ALLOWED FOR AN HAS NO GRACE PERIOD. (USE THE ENCLOSED ENVELOPE TO MAIL YOUR COMPLETE REGISTRATION RENEWAL FORM.) YOUR LICENSE WILL NOT BE RENEWED UNLESS YOU ANSWER ALL QUESTIONS ON THE REGISTRATION RENEWAL FORM. YOU MUST PROVIDE WRITTEN EXPLANATIONS FOR ANSWERED "YES." ALL INFORMATION YOU PROVIDE ON THIS APPLICATION FOR REGISTRATION RENEWAL FORM. YOU MUST PROVIDE WRITTEN EXPLANATION FOR MEDICAL Education (CME), which includes 2 hours of CME in medical ethics and 20 hours of specialty completed during the period July 1, 2003 through June 30, 2005. Additional statutes (NRS) 630.253(2)(b), an applicant must complete a course of instruction relating to act of terrorism that involves the use of a weapon of mass destruction. "The course must prohat includes instruction in the following subjects: (1) An overview of acts of terrorism and we exposure to, or injuries caused by, chemical, biological, radioactive and nuclear agents; eporting procedures for acts of terrorism that involves has changed from that printed on the label on this form, capacity provided below. Also, please indicate your current telephone and fax numbers. [Pleawarm Park Park Park Park Park Park Park Park	PRESCRIPTIO	MO IN MENADI
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space provided below. Also, please indicate your current telephone and fax numbers. [Plecopy of the document authorizing your name change (marriage license, divorce decree, etc.) Name FRANK Paul Silver, MD	CME in your sco lly, pursuant to it the medical consovide at least 4 ho veapons of mass hods of treatmen (4) Syndromic so wof the informati	ope of practice of Nevada Revise sequences of a ours of instructions destruction; (2 at associated with surveillance and tion available or
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and I come	00	
City LAS VEGAS County Clark State NV	Zip_87/	145

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City_		County	11	State	Zip
Phor	ne Number			-	
4. lr	dicate below your primar	y and second	lary so	copes of practice using the f	ollowing codes:
		s	COPE	S OF PRACTICE CODES	
1	ADDICTION MEDICINE	43	NEPH	ROLOGY	85 PEDIATRIC, SURGERY
2	ADOLESCENT MEDICINE	44	NEUF	ROLOGY	86 PEDIATRIC, UROLOGY
3	AEROSPACE MEDICINE			RO-OPHTHALMOLOGY	87 PEDIATRICS
4 5	ALLERGY ALLERGY/IMMUNOLOGY			ROPATHOLOGY RORADIOLOGY	88 PHYSICAL MEDICINE/REHABILITATION 89 PREVENTIVE MEDICINE
6	AMBULATORY MEDICINE			ROTOLOGY	90 PSYCHIATRY
7	ANESTHESIOLOGY			CONVENTIONAL MEDICINE	91 PSYCHOANALYSIS
8	BLOODBANKING	50		EAR MEDICINE	92 PSYCHOMATIC MEDICINE
9	BRONCO-ESOPHAGOLOGY		NUTF		93 PUBLIC HEALTH
10	CARDIOVASCULAR DISEASES			ETRICS ETRICS/GYNECOLOGY	94 PULMONARY DISEASES 95 OCCUPATIONAL MEDICINE
11 12	CATSCAN/ULTRASOUND CHILD NEUROLOGY			JPATIONAL MEDICINE	96 RADIOLOGY
13	CHILD PSYCHIATRY	55	ONC	DLOGY	97 RADIOLOGY, DIAGNOSTIC
14	CLINICAL PHARMACOLOGY			DLOGY, GYNECOLOGICAL	98 RADIOLOGY, INTERVENTIONAL
15		57	ONCO	DLOGY, HEMATOLOGY DLOGY, RADIATION	99 RADIOLOGY, NUCLEAR
17	DERMATOLOGY DERMATOPATHOLOGY			DLOGY, RADIATION DLOGY, SURGICAL	100 RADIOLOGY, THERAPEUTIC 101 RADIOLOGY, VASCULAR
18	EMERGENCY MEDICINE			THALMOLOGY	102 RHEUMATOLOGY
19		61		ARYNGOŁOGY	103 RHINOLOGY
20			OTOL		104 SLEEP DISORDERS
21 22	FORENSIC MEDICINE			MANAGEMENT IOLOGY	105 SPORTS MEDICINE
22 23	GASTROENTEROLOGY GENERAL PRACTICE			OLOGY OLOGY, ANATOMIC	106 SURGERY, ABDOMINAL 107 SURGERY, CARDIOTHORACIC
24	GERIATRIC PSYCHIATRY			OLOGY, CLINICAL	108 SURGERY, CARDIOVASCULAR
25	GERIATRICS	67	PATH	IOLOGY, FORENSIC	109 SURGERY, COLON/RECTAL
26	GYNECOLOGY	68	PEDI	ATRIC, ALLERGY	110 SURGERY, CRANIOFACIAL
27 28	HAIR TRANSPLANTATION			ATRIC, ANESTHESIOLOGY	111 SURGERY, GENERAL
29	HEMATOLOGY HOMEOPATHY	70 71	PEDIA	ATRIC, CARDIOLOGY ATRIC, CRITICAL CARE	112 SURGERY, HAND 113 SURGERY, HEAD/NECK
30	HYPNOSIS			ATRIC, EMERGENCY MEDICINE	114 SURGERY, MAXILLOFACIAL
31	IMMUNOLOGY			ATRIC, ENDOCRINOLOGY	115 SURGERY, NEUROLOGICAL
32	INFECTIOUS DISEASES			ATRIC, GASTROENTEROLOGY	116 SURGERY, ORTHOPEDIC
33	INFERTILITY			ATRIC, HEMATOLOGY/ONCOLOGY	117 SURGERY, PLASTIC
34 35	INTERNAL MEDICINE LARYNGOLOGY	70 77	PEDI	ATRIC, INFECTIOUS DISEASES ATRIC, INTENSIVIST	118 SURGERY, THORACIC 119 SURGERT, TRANSPLANT
36	LEGAL MEDICINE			ATRIC, NEPHROLOGY	120 SURGERY, TRAUMATIC
37	MATERNAL/FETAL MEDICINE			ATRIC, NEUROLOGY	121 SURGERY, UROLOGIC
38	MEDICAL ACUPUNCTURE			ATRIC, OPHTHALMOLOGY	122 SURGERY, VASCULAR
39				ATRIC, PHYSIATRY	123 TOXICOLOGY
	MEDICAL GENETICS			ATRIC, PULMONARY	124 TRANSPLANTATION
41	NEO/PERINATAL MEDICINE NEOPLASTIC DISEASES	83 84		ATRIC, RADIOLOGY ATRIC, RHEUMATOLOGY	125 URGENT CARE 126 UROLOGY
		Code	,		Code
Pr	imary Scope of Practice _	26		Secondary Sco	pe of Practice <u>33</u>
911	EASE INDICATE AMERICA	N BOARD O	MED	ICAL SPECIALTIES BOARD	CERTIFICATION & RECERTIFICATION
	4			Date of Initial Cortifi	
Boa	d AMERICAN BU	apd (.)	15 G	YN 1962	NOEXDIRATION
				(Mo./Yr.)	(Mo./Yr.)
Sub	board				
				(Mo./Yr.)	(Mo./Yr.)

July 1, 2003, through the present date only.

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

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

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

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

3. The physical 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.

			
11/1			
Hospital	Address	Action	From (Mo./Yr.) To (Mo./Yr.)
List any and all resignation suspensions or restriction maintain required malprac	ns from any medical staf s for failure to complete ctice insurance.) (If mon Mailing	f in lieu of disciplinary or a hospital medical records e space is needed, attacl Type of	Dates of Action
way?			YesiNo
	idered your state or fed	eral controlled substance	e registration or had it revoked or restricted in any
any violation of a statute,	rule or regulation gover	ning your practice as a p) investigated for; c) charged with; or d) convicted of onlysician by any medical licensing board, hospital, da State Board of Medical Examiners? YesNo
10. Have you ever been o	lenied membership or e	expelled from a medical s	ociety or other professional medical organization?
Have you ever voluntar territory?	rily surrendered a licens	se to practice medicine or	r any other healing art in any state, country or U.S. Yes No
8. Have you ever had a m any state, country or U.S.		to practice any other hea	aling art revoked, suspended, limited, or restricted inYesNo
			or any other healing art, or permission to take an ntry or U.S. territory? Yes Ves No
violation of any federal, s felony, excluding any min-	tate or local law, includ or traffic offense (driving ared a minor traffic off	ing any foreign country, g or in control of a motor	plead guilty or nolo contendere to any offense or which is a misdemeanor, gross misdemeanor, or vehicle while under the influence of any chemical d to the manufacture, distribution, prescribing, or
5. Have you been a defen paid in your behalf or paid			ity (malpractice) or had a professional liability claim YesNo
	ement of your receiving		year after the date the public service is required to from the federal government or a state or local YesNoN/A
If you use chemical suits skill and safety?	bstances, does your us	e in any way impair or lim	nit your ability to practice medicine with reasonable YesNoN/A
			r ability to practice medicine, is that impairment or tting, or the manner in which you have chosen toNoN/A
Do you have a medical safety?	condition which in any v	vay impairs or limits your	ability to practice medicine with reasonable skill and YesNo

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.
HAVE NOT (CHECK ONE) ACTIVELY PRACTICED MEDICINE IN NEVADA WITHIN THE PAST 12 MONTHS.
BY SIGNING ON THE SIGNATURE LINE BELOW: 1) I HEREBY REPRESENT THAT I AM THE PERSON NAMED IN THIS APPLICATION FOR REGISTRATION RENEWAL OF LICENSE TO PRACTICE MEDICINE IN THE STATE OF NEVADA AND THAT ALL STATEMENTS I HAVE MADE HEREIN ARE TRUE;
2) I UNDERSTAND THAT THIS APPLICATION FOR REGISTRATION RENEWAL WILL BE DENIED IF I HAVE NOT PLACED A CHECK MARK NEXT TO (a), (b), OR (c) UNDER THE CHILD SUPPORT STATEMENT SECTION; AND
3) I UNDERSTAND THAT THIS APPLICATION FOR REGISTRATION RENEWAL WILL BE DENIED IF I HAVE NOT ANSWERED ALL QUESTIONS THEREON AND/OR ATTACHED THERETO: (a) THE APPROPRIATE COPIES OF PROOF OF CONTINUING MEDICAL EDUCATION (CME), OR RESIDENCY OR FELLOWSHIP TRAINING COMPLETION; (b) PAYMENT OF THE APPROPRIATE REGISTRATION RENEWAL FEE; AND (c) WRITTEN EXPLANATION(S) TO ANY "YES" ANSWER(S).

Signature (SIGNATURE STAMP UNACCEPTABLE)

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
easonable skill and s	safety? luring the time period July 1, 200	pairs or limits your ability to practice med 5 - June 30, 2007 email to	icine with N	05/04/2007

elicensensbme@medboard.nv.gov

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?

If you answer "Yes" during the time period July 1, 2005 - June 30, 2007 email to elicensensbme@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?

If you answer "Yes" during the time period July 1, 2005 - June 30, 2007 email to

10/1/2015

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?

Ν

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?

Υ

10/1/2015

Ν

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

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 elicensensbme@medboard.nv.gov.

10/1/2015

Ν

Ν

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

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

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?

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

10/1/2015

Ν

Ν

Have you been denied membership or expelled from a medical society or other professional medical organization?

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

05/04/2007

Have you been:

- a) notified that you were under investigation for;
- o) 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 icensing board, hospital, medical society, governmental entity or agency other than the Nevada State 3oard of Medical Examiners?

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

Ν

Ν

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

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

05/04/2007

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

f you have answered "Yes" you will be required to submit a list of any and all resignations from any nedical staff in lieu of disciplinary or administrative action via email to elicensensbme@medboard.nv.gov Please Note: Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance.) f "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov.

10/1/2015

s your license <u>currently</u> contingent upon compliance with the Diversion program also known as the Nevada Health Professionals Assistance Foundation?

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

Ν

05/04/2007

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

Ν

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?

f "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".

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

Ν

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

Ν

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

CME's taken between July 1, 2005 and June 30, 2007.

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)
I understand that I may be included in a random audit following July 1st 2007 renewal. I agree to retain

05/04/2007

I have <u>actively</u> practiced medicine in Nevada within the past 24 months.

Υ

Υ

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

Ν

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.

Υ

Ν

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

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

05/05/2009

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.

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

f 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, 2007 - lune 30, 2009, or since your last renewal, please type your explanation in this text box.

05/05/2009

, aces your use in any way impair or limit your ability to practice medicine N and safety?

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.

lave you been named as a defendant, or been requested to respond as a defendant or potential defendant, to a legal action involving professional liability (malpractice)? Please include: who, what, where (provide state), and when in the textbox directly below this question.

Ν

05/05/2009

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.

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

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

05/05/2009

05/05/2009

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.

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.

05/05/2009

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 lisclose ANY investigation or arrest, including those where the final disposition was dismissal, sealing of a record, or expungement.

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.

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

05/05/2009

explanation 8: For the above question if your answer is "Yes" for the time period July 1, 2007 - lune 30, 2009, or since your last renewal, please type your explanation in this text box.

lave 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?

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.

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

Ν

05/05/2009

explanation 10: For the above question if your answer is "Yes" for the time period July 1, 2007 - une 30, 2009, or since your last renewal, please type your explanation in this text box.

N

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

05/05/2009

Explanation 11: For the above question if your answer is "Yes" for the time period July 1, 2007 - lune 30, 2009, or since your last renewal, please type your explanation in this text box.

ISBME Renewal Responses Report

10/1/2015

Ν

Regarding any medical licensing board, hospital medical society, or other governmental entity or agency other than the Nevada State Board of Medical Examiners), have you been:

- a) Asked to respond to an investigation;
- b) Notified that you were under investigation for;
- c) Investigated for;
- d) Charged with; or
- e) Convicted of

any violation of a statute, rule or regulation governing your practice as a physician?

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.

05/05/2009

10/1/2015

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

Ν

05/05/2009

explanation 13: For the above question if your answer is "Yes" for the time period July 1, 2007 - une 30, 2009, or since your last renewal, please type your explanation in this text box.

lave you had hospital staff privileges denied, suspended, limited, revoked or not renewed by the hospital, nocluding any and all resignations from any medical staff in lieu of disciplinary or administrative action? The answer is "Yes," type the name of the hospital, the hospital's mailing address, the type of action aken, 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 ecords, 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 inswer "no".

05/05/2009

f "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 - lune 30, 2009, or since your last renewal, please type your explanation in this text box.

ISBME Renewal Responses Report

10/1/2015

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

N

05/05/2009

you choose to place your license on Inactive status, make certain to select "Yes" to this question AND hoose 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 nactive status for the next biennial July 1, 2009 – June 30, 2011, please provide a brief explanation in this text box.

N

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

05/05/2009

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

ISBME Renewal Responses Report

10/1/2015

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Υ

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 stain 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.

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 RUE AND CORRECT.

05/05/2009

Nevada State Board of Medical Examiners

Renewal Responses Report

Thursday, October 01, 2015



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License Numbe	er Licensee	 License Type		Subject of the second second	
2641	Frank Paul SILVER	 Medical Doctor			
		to a large and the second		The second secon	
Question		 	Answer	. ::4	 Date
Question	, mi	 	Allswer	,0	 A1586

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

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.

06/07/2011

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.

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

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

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.

06/07/2011

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.

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.

N

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

06/07/2011

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.

NSBME Renewal Responses Report

10/1/2015

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

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.

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.

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.

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?

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.

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?

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.

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.

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.

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?

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.

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

N

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? If the answer is "Yes," type the name of the hospital, the hospital's mailing address, the type of action taken, and the date or dates of the actions taken in the textbox directly below this question.

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

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

06/07/2011

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

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

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.

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

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

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.

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?

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

06/07/2011

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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.

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.

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I have completed the required amount of AMA Category 1 CME within the current biennial. (Review CME information online at www.medboard.nv.gov)
I understand that I may be included in a random audit following the July 1st, 2011 renewal. I agree to retain CME's taken between July 1, 2009 and June 30, 2011.
If renewing to an Inactive status, CME is not required and "No" can be selected.

06/07/2011

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.

PHYSICIAN APPLICATION FOR REGISTRATION RENEWAL FOR THE BIENNIAL REGISTRATION PERIOD 2013 – 2015 NEVADA STATE BOARD OF MEDICAL EXAMINERS

Dra	
Date Received by Boald	1641
JUN - 5 2013	License No.
NEVADA STATE BOARD OF MEDICAL EXAMINERS	File No.

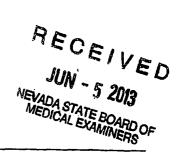
NEVADA STATE BOARD OF MEDICAL EXAMIN Post Office Box 7238 Reno, Nevada 89510 Phone (775) 688-255 Physical Address: 1105 Terminal Way, Suite 301 Reno, Nevada 89	9 MEDIEA BOOKENSEUNOF
I hereby apply for renewal of blennial registration and er	nclose the appropriáte fee(s) as indicated below:
EI ACTIVE STATUS \$850.00	Make checks payable to:
☐ INACTIVE STATUS \$450.00 SAVE \$35 by renewing online at www.medboard.nv.gov	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 IN	STRUCTIONS REGARDING YOUR APPLICATION:
State Board of Medical Examiners' (Board) off	IE 30, 2013. If this form is not received by the Nevada ice by July 1, 2013 at 5:00 p.m., your license will be to practice medicine until you reinstate your license.
 Your license will not be renewed unless you answered "yesplanation(s) for any/all question(s) answered "yesplanation(s) 	ver <u>ALL</u> questions on this application and provide written es"
 Your license will not be renewed unless it is accauthorization. 	companied with a check for the proper fee or credit card
you were randomly selected, you will be contact	nuing medical education (CME) audit of all licensees. If ed by the Board for proof of your CME. Your license will equired CME. Refer to page 4 for a review of your CME the Board does not retain copies.
All information provided on this application is <u>PUE</u>	BLIC information.
 If you select "INACTIVE STATUS," you are prohil prescriptions in the state of Nevada. Inactive lice 	nited from practicing medicine and prohibited from writing nsees are not required to sale man and prohibited from writing
PLEASE TYPE OR PRINT LEGIBLY.	7/1/13 - 6/30/15 BIENNIAL
below is viewable on the Board website and is listed	e provided below. Be advised that the address you indicate as the <u>public</u> address. Also, please indicate your current has changed, a copy of the document authorizing your legal
Name Prunk Silver	$\mathcal{M}_{\mathcal{D}}$
Street 1900 & DESENT	ino Ba
City LV . County C	LAUL State W
Zip 90160	
	Gell Phone Number
Fax Number 02.135-3431	E-mail address



Ple	ease indicate any American Board of Medical Specialties Board Certification or Recertification:
	Date of Initial Certification (Mo./Yr.) Date of Last Recertification (Mo./Yr.)
Воа	ard:
Sub	oboard: Independent MéDical examiner 10415 aso
If a	iny of the ABMS Certifications or Recertifications were received after your last application with the Board, please attach pies of documents evidencing your Certifications or Recertifications.
	. QUESTIONS .
F	or the purposes of the following questions, these phrases or words have these meanings:
"Me	edical condition" includes physiological, mental or psychological condition or disorder.
"Cl legit	nemical substances" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for imate 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.
	r all <u>YES</u> responses to the following questions, <u>you must submit your written explanation(s) on a parate sheet</u> 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? YesYes
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? YesNoN/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? YesNoNA
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? YesNo
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?
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?

RECEIVED JUN - 5 2013

9.	Have you voluntarily surrendered a license to practice medicine or an incomplete 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
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
14.	Have you actively practiced medicine in Nevada within the past 12 months? YesNo
	If your answer is "yes", please indicate the approximate percentage of time allotted to the following medical activities. Clinical practice Machine
	ATTESTATIONS
	SAFE INJECTION PRACTICE ATTESTATION
	ATTESTATION TO KNOWLEDGE OF AND COMPLIANCE WITH THE GUIDELINES OF THE CENTERS FOR DISEASE CONTROL AND PREVENTION
con any pura in c	ereby attest to knowledge of and compliance with the guidelines of the Centers for Disease Control and Prevention cerning the prevention of transmission of infectious agents through safe and appropriate injection practices. I also attest that person who is currently, or will be under my control as their supervising physician in the future, and who is not licensed suant to chapter 630 of the Nevada Revised Statutes and whose duties involve injection practices, has knowledge of and is compliance with the guidelines of the Centers for Disease Control and Prevention concerning the prevention of transmission affectious agents through safe and appropriate injection practices.
	http://www.cdc.gov/hicpac/2007IP/2007isolationPrecautions.html
	ereby attest that I have knowledge of my duties and responsibilities under the guidelines of the Centers for Disease Control Prevention and of safe and appropriate injection practices. YesNo
	CONSCIOUS SEDATION DEEP SEDATION OR GENERAL ANESTHESIA ATTESTATION
rene sed	rada Revised Statutes (NRS) require the Nevada State Board of Medical Examiners to obtain from each applicant who seeks ewal of his or her license to practice medicine, a report stating the number and type of surgeries requiring conscious ation, deep sedation or general anesthesia performed by the holder of the license at his or her office or any other facility, luding any surgical care performed at a medical facility as defined in NRS 449.0151, or outside the state of Nevada.
	, , , , , , , , , , , , , , , , , , , ,
l he	reby attest that I am in compliance with the reporting requirements of NRS 630.30665, and am aware that failure to submit a ort or filing false information in a report is grounds for disciplinary action under Nevada's Medical Practice Act.



CHILD SUPPORT

PLEASE	PLACE AN "X" NEXT TO THE STATEMENT THAT APPLIES TO YOU:
$\overline{\chi}$	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 .
	NTINUING MEDICAL EDUCATION MUST HAVE BEEN COMPLETED DURING THE PERIOD (1, 2011 THROUGH JUNE 30, 2013. Please place a check mark next to the statement that by you.
registration Category 1	I was initially licensed in Nevada prior to July 1, 2011 or during the first 6 months of the biennial period of a (July 1, 2011 through December 31, 2011) and have completed a minimum of forty (40) hours of AMA continuing medical education (CME), two (2) hours of which were in medical ethics and twenty (20) hours of a in my scope of practice or specialty.
2012 throu	was initially licensed in Nevada during the second 6 months of the biennial period of registration (January 1, 194 June 30, 2012) and have completed a minimum of thirty (30) hours of AMA Category 1 CME, two (2) hours ere in medical ethics and twenty (20) hours of which were in my scope of practice or specialty.
through De	was initially licensed in Nevada during the third 6 months of the biennial period of registration (July 1, 2012 ecember 31, 2012) and have completed a minimum of twenty (20) hours of AMA Category 1 CME, two (2) hich were in medical ethics and eighteen (18) hours of which were in my scope of practice or specialty.
2013 throu	was initially licensed in Nevada during the fourth 6 months of the biennial period of registration (January 1, 1996) gh June 30, 2013) and completed a minimum of ten (10) hours of AMA Category 1 CME, two (2) hours of a medical ethics and eight (8) hours of which were in my scope of practice or specialty.
fellowship	m exempt from submitting proof of completion of CME because I have completed a full year of residency or training during the biennial period of July 1, 2011 through June 30, 2013. If you checked this statement, ach a copy of proof of completion of your training.
	AFFIRMATION
PERSON	NING BELOW, I SWEAR OR AFFIRM UNDER PENALTY OF PERJURY THAT I ALLY ANSWERED ALL OF THE QUESTIONS IN THIS APPLICATION AND THAT THE RS I HAVE PROVIDED ARE TRUE AND CORRECT.
A	501,3
Signature	(Stamp Unacceptable) Date



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

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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?	Ň	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
	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?		
SILVER, Frank Paul	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.	N	6/3/2015
	(<u>Please Note</u> : Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance.)		
SILVER, Frank Paul	Have you actively practiced medicine in Nevada within the past 12 months?	Υ	6/3/2015
in and the second	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,		
SILVER, Frank Paul	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."	N	6/3/2015
	I hereby request my license to be placed on Inactive status, which means I will not physically practice in the state of Nevada.		
	If you choose to place your license on Inactive status, make certain to select "Yes" to this question <u>AND</u> choose the Inactive status in the dropdown box located at the end of the questions.		
	If you believe that you are in compliance with the Centers for Disease Control safe injection practices, your answer should be "YES".		
CILVED	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		
SILVER, Frank Paul	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	Y	6/3/2015
	guidelines of the Centers for Disease Control and Prevention concerning the prevention of transmission of infectious agents through safe and appropriate injection practices.		
. <u>.</u>	http://www.cdc.gov/injectionsafety/IP07 standardPrecaution.html		
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

	Medical Practice Act.		[
	I HAVE SUBMITTED A "FORM A" OR "FORM B" REPORT TO THE BOARD.		
	Instructions and Forms A and B for in-office surgery/procedure reporting can be located on the Board's website by clicking the red "In-Office Surgery Reporting" link on the home page of the Board's website: www.medboard.nv.gov.		
	If you have submitted your in-office surgery/procedure reporting forms (A/B Forms) to the Board and are in compliance with NRS 630.30665, your answer should be "YES."		
SILVER,	Are you out of compliance with court ordered child support? If this does not apply to you, please answer "no".		
Frank Paul	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
	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".		
SILVER, Frank Paul	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.	Υ	6/3/2015
	www.leg.state.nv.us/NRS/NRS-432B.html#NRS432BSec220		
SILVER, Frank Paul	Have you ever served in the United States Military (to include National Guard or Reserves)?	Υ	6/3/2015
	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.		
SILVER, Frank Paul	 If yes, in which branch of service did you serve? What was your Military occupation specialty or specialties? Provide your dates of service in the Military. 		6/3/2015
SILVER, Frank Paul	Do you hold a Nevada state business license issued in your individual name?	N	6/3/2015
SILVER, Frank Paul	Explanation 18: If yes, provide the business license number:		6/3/2015
SILVER, Frank Paul	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) If renewing to an Inactive status, CME is not required and "No" can be	Υ	6/3/2015
	selected.		
SILVER, Frank Paul	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.	Υ	6/3/2015



Reports Home Page Back

Renewal	Questions	for l	.icense	Number 2641

	Renewal Questions for License Number 2641		POWERED BY MYLICONSO*
Licensee	າງູ້ານອະຊຸເຄື່ອນ	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</u> to elicensensbme@medboard.nv.gov.		
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</u> to elicensensbme@medboard.nv.gov.		
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</u> to <u>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.	Υ	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 emailto:emsensbme@medboard.nv.gov .		4/28/2017

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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	N	4/28/2017
SILVER, Frank Paul	Explanation in the text box directly below this question. 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 <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</u> 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 <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</u> 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,		

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•		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</u> 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 <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</u> 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 other than the Nevada State Board of Medical Examiners?	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 <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 surrendered your state or federal controlled substance registration or had it revoked or restricted in any way?	n. 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?	N	4/28/2017
		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.	e	
		(<u>Please Note</u> : Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or		

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	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?		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?	Υ	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> .		
	OPTION TO CHANGE LICENSE STATUS FROM ACTIVE TO INACTIVE:		
SILVER, Frank Paul	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."	N	4/28/201 7
	I hereby request my license to be placed on Inactive status, which means I will not physically practice in the state of Nevada.		
	If you choose to place your license on Inactive status, make certain to select "Yes" to this question <u>AND</u> choose the Inactive status in the dropdown box located at the end of the questions.		
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".	Υ	4/28/2017
	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.		

10/30/2018	https://nsbme.mylicense.com/Reports/ren_questions.aspx?person=2641&year=2017	/&pror=2	
	http://www.cdc.gov/injectionsafety/IP07 standardPrecaution.html		
	I hereby attest that I am in compliance with the reporting requirements of NRS 630.30665, and am aware that failure to submit a report or filing false information in a report is grounds for disciplinary action under Nevada's Medical Practice Act.		
CUVED	I HAVE SUBMITTED A "FORM A" OR "FORM B" REPORT TO THE BOARD.		
SILVER, Frank Paul	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:	Y	1/28/2017
	medboard,nv.gov/forms/in-office_surgery. 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."		
SILVER,	Are you out of compliance with court ordered child support? If this does not apply to you, please answer "no."		
Frank Paul	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 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.		
	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.		
SILVER, Frank Paul	http://www.leg.state.nv.us/NRS/NRS-432B.html#NRS432BSec220 Once you have read the statute regarding the reporting of the abuse	Y	4/28/2017
	or neglect of a child, your answer to this question will be "YES."		
SILVER, Frank Paul	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.		
SILVER,	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		
Frank Paul	http://medboard.nv.gov/licensees/ce/)	Y.	4/28/2017
	If renewing to an <u>Inactive</u> status, CME is not required and "No" can be selected.		
SILVER, Frank Paul	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."	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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.. Paul

ANSWERS I HAVE PROVIDED ARE TRUE AND CORRECT.

BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

)
In The Matter of Charges and)
_) NO. Case No. 06-4041-1
Complaint Against	FILED Home 2008
FRANK SILVER, M.D.,	2 hole
Respondent.	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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The Board, after due consideration of the record, evidence and law, and being fully advised in the premises, hereby finds Respondent not guilty of the count alleged against him in the above identified matter.

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

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

Javaid Anwar, M.D., President Nevada State Board of Medical Examiners