Uniform Application for Physician Licensure

UA Username ameliavirostko **Date Submitted** 4/5/2012
FCVS Status No FCVS Packet

1. Name: Indicate your full legal name. If your name has changed at any time during your life and you are not using FCVS, you must submit a copy of the legal document (marriage certificate, divorce decree, etc.) supporting your name change.

1. Full Name (use no initials)

Last Name	Virostko
First Name	Amelia
Middle Name	Elissa
Suffix	
Maiden Name	

M.D. [X] **D.O.** [ ]

All other names used

First	Middle	Last	Suffix

2. Address/Phone: Please complete all sections and indicate which address you wish to be used for public access and which is to be used for mailings from the medical board. Each state's law determines whether each address or phone number is a public record in the state in which you are applying. You may wish to contact the licensing authority for that state for further information. Many boards publish the "Public Access" address on their website, therefore you should consider what your preferred address is for these purposes.

2. Address/Phone

Business

[ ] **Public Access** **Street**

[ ] **Mailing**

City **State/Province** **Zip Code**
Country
Telephone
Fax
Email
Alternate Phone

Home

[X] **Public Access** **Street** PO BOx 760

[X] **Mailing**

City Colorado Springs **State/Province** CO **Zip Code** 80901
Country USA
Telephone
Fax
Email
Alternate Phone

3. Identification: If you are not using FCVS, you must submit either a notarized copy of your birth certificate or a notarized copy of your current, valid passport.

3. Identification

01. 1981	Alexandria	Virginia	USA
Date of Birth (mm/dd/yyyy)	Birth City	Birth State/Province	Birth Country

F (Gender) | Social Security Number | NPI | Are you a U.S. Citizen? [X] Yes [ ] No

Your social security number is required to facilitate reporting to the federal Healthcare Integrity & Protection Data Bank (42 U.S.C. Sections 1320a-7e(b), 5 U.S.C. Section 552a, and 45 C.F.R. pt. 61) and for accurate identification under the federal and state child support enforcement law (42 U.S.C. Section 666 and applicable state law). It may also be used for reporting to the National Practitioner Data Bank (42 U.S.C. Section 11101 and 45 C.F.R. pt. 60) and for other investigative/enforcement purposes in compliance with state laws governing physician discipline or as otherwise required by state or federal law.

The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. For more information on the NPI, please go to http://www.cms.hhs.gov/NationalProvidentStand/.

4. Medical School: List all medical schools you have attended, even those from which you did not graduate, in chronological order. Attach an additional sheet if necessary. If you are not using FCVS, you must complete the attached "Medical Education Verification" form and send it to all medical schools you have attended. You must include a copy of your diploma to which the medical school must attach their seal prior to forwarding it to this Board. Additionally, the medical school must provide this Board with an official copy of your transcripts. The medical school must forward all documentation directly to this Board.

4. Medical School

1

School Name Tufts University School of Medicine
Address 136 Harrison Avenue
City Boston
State/Province MA
ZIP Code 02111
Country USA
Attendance Dates **From (mm/yyyy)** 05/2003 **To (mm/yyyy)** 05/2008
Graduation Date 5/16/2008
Degree PHYS

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5. Fifth Pathway: If you attended a Fifth Pathway program and are not using FCVS, you must complete the attached "Fifth Pathway Verification" form and send it to your medical school and to the institution where you completed your rotations. You must include a copy of your diploma. The medical school and institution must forward all documentation directly to this Board.

5. Fifth Pathway (if applicable)

Medical School Name			
Address			
City			
State/Province			
ZIP Code			
Country			
Attendance Dates	**From (mm/yyyy)**	**To (mm/yyyy)**	**In Progress**
Graduation Date			
Degree			
Institution name where rotations performed			
Address			
City			
State/Province			
ZIP Code			
Country			
Rotation Dates	**From (mm/yyyy)**	**To (mm/yyyy)**	**In Progress**
Certification Date			

6. Postgraduate Training: List all postgraduate programs you have attended, even those you did not complete. Attach an additional sheet if necessary. If you are not using FCVS, you must complete the attached "Postgraduate Training Verification" form and send it to **all** postgraduate training programs you have attended. You must submit a copy of your certificate of program completion to this Board. The postgraduate program must forward all documentation directly to this Board.

6. Postgraduate Training

1

Hospital Name University of Colorado Department of Family Medicine
Hospital Address 3055 Roslyn St. Suite 100

City Denver
State/Province Colorado
ZIP Code 80238
Country

PGY: (e.g., 1, 2, 3, etc.) [X] **Internship** [X] **Residency** [ ] **Fellowship** [ ] **Research** [ ] **Other**

Department/Specialty Family Medicine

From: 06 /2008 **To:** 06 /2011 **Successfully Completed?** [X] **Yes** [ ] **No** **In Progress** [ ]

Month Year Month Year

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7. Examination History: If you are not using [redacted]VS, you are responsible for contacting the appropriate [redacted]ate examination entity and having a certified transcript of your scores sent directly to this Board.

7. Examination History

List each licensure examination, U.S. or international, you have taken (USMLE, NBME, NBOME, LMCC, Etc.).If additional space is necessary, please enclose a separate sheet with your application and include all the information below

Examination	State	Most Recent Date taken(Month/Year)	Passed (P) or Failed (F)		Number of attempts
USMLE Step 1		06/2005	[X] P	[ ] F	1
USMLE Step 2		02/2007	[X] P	[ ] F	1
USMLE Step2 CS		10/2006	[X] P	[ ] F	1
USMLE Step 3		10/2009	[X] P	[ ] F	1

8. ECFMG: If ECFMG is applicable and you are not using FCVS, you are responsible for contacting ECFMG and having a certified "Status Report" forwarded directly to this Board. There is a separate fee for this report. Reports can be obtained through the ECFMG web site at www.ecfmg.org.

8. ECFMG (if applicable)		
Certificate Number	Issue Date	Valid Through Date

9. State or Professional Licensure: List all state and Canadian provinces where you currently hold or have ever held any type of medical/osteopathic license. You must also complete the attached "Licensure Verification" form (Form #1) and forward it to all states in which you have held any health care license or certification. The verifying entity must forward all documentation directly to this Board. Some state boards charge a fee for this information. Contact the state board where you hold or held a license to determine their requirements.

9. State Licensure

1 **State/Province** CO **Practitioner Type (MD, DO, etc.)** MD **Type of License (Full, Temporary, etc.)** Full License

License Number 49964 **Status** Active **Issue Date** 4/29/2011

10. Chronology of Activities: List ALL activities (medical, non-medical, and postgraduate training) in chronological order beginning with medical school graduation to the PRESENT date, using **MONTH** and **YEAR**. *For any non-working time, you MUST state on the form exactly what your activities were, such as "vacation" or "seeking employment," as well as your permanent address.* If you worked for a physician-staffing group or did locum tenens, you must list all facilities where you worked and include complete dates and addresses. **DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM.** Be sure to indicate the percentage of working time spent in clinical administrative duties.

10. Chronology of Activities

Dates: From/To	Practice/Employment
1 From: Month: 07 Year: 2011 To: Month: Year: In Progress ☒	**Practice/Employment Name** Boulder Valley Women's Health Center (or list non-working time as indicated above) **Practice/Employment Address** 2855 Valmont Rd. **City** Boulder **State/Province** Colorado **ZIP Code** 80301 **Country** USA **Position and Department** Physician-Women's Health **Percent Clinical:** 100% **Percent Administrative:** 0% **Employment** ☐ **Staff Privileges** ☐ **Affiliation** ☐ **Other**
2 From: Month: 08 Year: 2011 To: Month: 02 Year: 2012 In Progress ☐	**Practice/Employment Name** Peak Vista Community Health Centers (or list non-working time as indicated above) **Practice/Employment Address** 340 Printers Parkway **City** Colorado Springs **State/Province** Colorado **ZIP Code** 80910 **Country** USA **Position and Department** Physician-Family Health at International Circle **Percent Clinical:** 100% **Percent Administrative:** 0% **Employment** ☐ **Staff Privileges** ☐ **Affiliation** ☐ **Other**
3 From: Month: 09 Year: 2011 To: Month: Year: In Progress ☒	**Practice/Employment Name** Planned Parenthood of the Rocky Mountains (or list non-working time as indicated above) **Practice/Employment Address** 7155 E. 38th Ave **City** Denver **State/Province** Colorado **ZIP Code** 80207 **Country** USA **Position and Department** Physician-Family Planning **Percent Clinical:** 100% **Percent Administrative:** 0% **Employment** ☐ **Staff Privileges** ☐ **Affiliation** ☐ **Other**

11. Malpractice: List of all claims or suits for medical malpractice made against you. A claim is a formal or informal demand for payment to any person or organization. If you do not have any such claims or suits, this section will be blank. Please have your information available before reviewing this section and contact the state board or FCVS to make changes.

11. Malpractice Liability Claims Information

Name of patient involved:

In which state did the action take place? **Case number (if applicable)**

Which court?
(If private compromise or settled before initiation of civil action, state here)

Current status of claim:

☐ Open (pending) ☐ Closed (settled or judgment) ☐ Dismissed (no money paid out) ☐ Other

Amount of judgement or settlement $ **Amount paid on your behalf $**

Month and year of event precipitating claim:

Month and year of lawsuit:

Insurance carrier at time:

What is/or was your status? ☐ **Primary defendant** ☐ **Co-defendant** ☐ **Other**

Please provide specifics in reference to the adverse event including the allegations and your role in the event:

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Medical School:

Dates of Attendance: 8/2003-1/2008
Date of Graduation: 5/18/2008

USMLE Scores:

USMLE Step 1: 90
USMLE Step 2 CK: 90
USMLE Step 3: 85

State Licensure:

Colorado Resident License 6/23/2008-4/18/2011 Inactive
Colorado Unlimited License 4/18/2011-4/30/2011 Active

Activities:

6/2008-6/2011: Family Medicine Residency at the University of Colorado Hospital Denver Health Track. Contact: Alice Skram. Address: 3055 Roslyn St. Suite 100. Denver, CO 80238.
7/2011: Studied for and took the Family Medicine Board exam

NEVADA STATE BOARD OF
MEDICAL EXAMINERS
Post Office Box 7238 Reno, Nevada 89510 Phone (775) 688-2559

File No._____
(For Board Use Only)

ADDENDUM 2

INITIAL APPLICATION INFORMATION

1. Present Legal Name Virostko (Last) Amelia (First) Elissa (Middle) (Maiden)

2. Contact Information: Telephone Number (_____) (Office) (617) 620 1388 (Home)

Fax Number (____)_____ Cellular Number (Optional) (_____)_____

Email address_____

3. Please indicate the COUNTY in which your home address and practice address are located.

County of Home Address: El Paso

County of Practice Address: _____

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4. Date of Birth 1 , 1981 (Month / Day / Year)

5. Social Security Number_____

6. Citizenship: Are you a U.S. Citizen? ✓ Yes

_____ No Alien Registration #_____ Employment Authorization #_____

Applying for Visa_____

Submit a certified birth certificate or original Certificate of Naturalization or current U.S. passport or copy of the front and back of your alien registration card, Employment Authorization or Visa. Please note: Copy of document authorizing a name change (marriage license, divorce decree, etc) must be included.

7. Physical Identification:

Color of Eyes _____ Color of Hair _____ Height _____ Weight _____

8. State your scope of practice/specialty(ies): Family Medicine

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

Specialty Board	Certification #	Dates of Certification/Recertification (Mo/Yr)

Print Name: Last Virostko **First** Amelia **Middle** Elissa

10. If you hold "lifetime or historical" ABMS Board certification, please provide a notarized statement agreeing to maintain Board certification for the duration of your licensure in the state of Nevada.

11. List below the requested information for all hospitals or surgery centers in which you **ARE, OR HAVE EVER BEEN** a staff member at any level during the last ten years. If none, please indicate. Do not list internship, residency or fellowship affiliation.

Hospital	Complete Mailing Address	Dates of Appointment From (Mo./Yr.)	To (Mo./Yr.)

(All information must begin on this form, if more space is needed, please attach a separate sheet.)

Print Name: Last Virostko **First** Amelia **Middle** Elissa

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

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

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

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

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

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

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

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

4. Have you 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

5a. Have you EVER 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? (IF ANSWER IS "YES", YOU MUST COMPLETE ADDENDUMS 4 AND 5.) ____Yes ✓No

5b. Have you EVER had a professional liability, malpractice, claim paid on your behalf, or paid such a claim yourself including any military tort claims if applicable? ____Yes ✓No

6. Have you EVER 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. (If "Yes," attach explanation on separate sheet.) ____Yes ✓No

7. Have you previously applied for medical licensure in Nevada (including a residency program)? ____Yes ✓No

8. Have you EVER been the subject of an investigation (including matters that resulted in no adverse action or outcome to you) have you resigned, been dismissed, or have any actions, form of remediation(s), restrictions, limitations, probations, terminations or any other disciplinary actions ever been imposed on you while participating in any type of training program? (If "Yes," attach explanation on separate sheet.) ____Yes ✓No

9. Have you EVER been denied a license, permission to practice medicine or any other healing art, or permission to take an examination to practice medicine or any other healing art in any state, country or U.S. territory? (If "Yes," attach explanation on separate sheet.) ____Yes ✓No

10. 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? (If "Yes," attach explanation on separate sheet.) ____Yes ✓No

11. Have you EVER voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory? (If "Yes," attach explanation on separate sheet.) ____Yes ✓No

12. Have you EVER been denied membership, asked to resign, or expelled from a medical society or other professional medical organization? (If "Yes," attach explanation on separate sheet.) ____Yes ✓No

13. Have you EVER 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? (If "Yes," attach explanation on separate sheet.) ____Yes ✓No

Print Name: Last Virostko **First** Amelia **Middle** Elissa

14. Have you EVER surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? ____Yes ✓ No
(If "Yes," attach explanation on separate sheet.)

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

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

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(All information must begin on the application, if more space is needed, please attach separate sheet.)

CHILD SUPPORT STATEMENT

The law of the state of Nevada requires that all applicants for issuance of a license be required to provide the following information concerning the support of a child. You are advised that this questions is part of your application, your response is given under oath, and any response hereto which is false, fraudulent, misleading, inaccurate or incomplete, may result in your application being denied. You must mark one of the following responses, and failure to mark one of the responses may result in denial of your application.

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.

SAFE INJECTION PRACTICE ATTESTATION

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

I hereby attest to knowledge of and compliance with the guidelines of the Centers for Disease Control and Prevention concerning the prevention of transmission of infectious agents through safe and appropriate injection practices. I also attest that any person who is currently, or will be under my control as their supervising physician in the future, and who is not licensed pursuant to chapter 630 of the Nevada Revised Statutes and whose duties involve injection practices, has knowledge of and is in compliance with the guidelines of the Centers for Disease Control and Prevention concerning the prevention of transmission of infectious agents through safe and appropriate injection practices.

Applicant: _____ Date: 3/28/12

Print Name: Last Virostko **First** Amelia **Middle** Elissa

I, Amelia Elissa Virostko
(print your full name)

being duly sworn, depose and say: That the answers to the foregoing questions and statements made in the above application as well as any and all further explanations contained on any separate attached pages are true and correct, that I am the person named in the credentials to be submitted, and that the same were procured in the regular course of instruction and examination without fraud or misrepresentation. I understand that if any of my responses on this application are false, fraudulent, misleading, inaccurate, or incomplete, my application for licensure will be denied.

I am responsible to keep the Board informed of any circumstance or event that would require a change to my initial responses provided to the Board in my application for licensure, and which occur prior to my being granted licensure to practice medicine in the State of Nevada.

Signature of applicant _____ Date 4/6/12

FALISHA WINKELSPECHT
NOTARY PUBLIC
STATE OF COLORADO
My Commission Expires 11/22/2015

(NOTARY SEAL)

State of Colorado County of El Paso
Subscribed and sworn to before me this 10th day of April, 2012.
Notary Public for the State of Colorado
My Commission Expires: 11/22/15
Residing at: Colorado Springs (City) CO (State)
Signature of Notary

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Print Name: Last Virostko First Amelia Middle Elissa

Applicant's Signature (must be signed in the presence of a notary)

Virostko
Applicant's Printed Last Name

Amelia E Virostko
Applicant's Printed First Name, Middle Initial, and Suffix (e.g., Jr.)

4/16/12
Date of Signature

Dated 4/16/2012 Signed [signature] NOTARY

State of Colorado County of El Paso

SUBSCRIBED AND SWORN TO before me this 16th day of, April 20 12.

My commission expires: 11/22/15 (NOTARY PUBLIC SIGNATURE & SEAL)

FALISHA WINKELSPECHT
NOTARY PUBLIC
STATE OF COLORADO
My Commission Expires 11/22/2015

Applicant Name: Amelia Virostko Date: 3/28/12

ATTENTION APPLICANT!

RESPONSIBILITY STATEMENT

Please sign and return this statement with your application for licensure to:
The Nevada State Board of Medical Examiners,
P.O. Box 7238, Reno, NV 89510
or
1105 Terminal Way, Ste 301, Reno, NV 89502

Because you are applying for the privilege of practicing medicine in Nevada, you should know that our state has some of the most stringent licensing requirements and comprehensive investigation programs in the United States.

Via FBI fingerprinting and other investigative modalities, our licensing specialists are likely to discover if data you have submitted on your application is erroneous or incomplete; therefore, you must answer all questions truthfully and completely. Specifically, this includes any sanctions or disciplinary actions you may have experienced during medical school or your postgraduate training, or any involvement you may have had with the legal system, either civil or criminal — criminal to include charges that may have ultimately been expunged, lessened, or dismissed, and no matter how long ago the event(s) occurred.

Explaining and documenting a problem to your licensing specialist will be much less painful than discussing your veracity before the entire Board of Medical Examiners due to inconsistencies between your application and incongruent input from outside sources.

ONLY YOU — NOT A LAWYER, DOCTOR, SPOUSE, OR CREDENTIALING COMPANY — ARE RESPONSIBLE FOR READING AND ANSWERING EVERY QUESTION ACCURATELY AND COMPLETELY.

If you have *any* questions about your application, ASK YOUR LICENSING SPECIALIST. Our licensing specialists are here to help you.

o o o o o

I have read this responsibility statement and understand that I alone am accountable for completing my application for medical licensure in Nevada.

Print your name Amelia Virostko

Sign your name _____

Date 3/28/12

Note: It is your responsibility to keep the Board informed of any circumstance or event that would require a change to your initial responses provided to the Board in your application for licensure, and which occur prior to you being granted licensure to practice medicine in the State of Nevada.

Print Name: Last Virostko **First** Amelia **Middle** Elissa

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Renewal Questions for License Number 14406

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Licensee	Question	Answer	Date
Amelia Elissa VIROSTKO	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	6/16/2013
Amelia Elissa VIROSTKO	If you have a medical condition which in any way impairs or limits your ability to practice medicine, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? **If you do not have a medical condition, select No.**	N	6/16/2013
Amelia Elissa VIROSTKO	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	6/16/2013
Amelia Elissa VIROSTKO	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	6/16/2013
Amelia Elissa VIROSTKO	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, 2011 - June 30, 2013 type an explanation in the textbox directly below this question.	N	6/16/2013
Amelia Elissa VIROSTKO	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	6/16/2013
Amelia Elissa VIROSTKO	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	6/16/2013
Amelia Elissa VIROSTKO	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	6/16/2013
Amelia Elissa VIROSTKO	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	6/16/2013

Amelia Elissa VIROSTKO	Have you failed to initiate the performance of public service within one year after the date the public service is required to begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local government for your medical education?	N	6/16/2013
Amelia Elissa VIROSTKO	Have you been: a) asked to respond to an investigation; b) notified that you were under investigation for; c) investigated for; d) charged with; or e) convicted of any violation of a statute, rule or regulation governing your practice as a physician by any medical licensing board, hospital, medical society, governmental entity or agency other than the Nevada State Board of Medical Examiners?	N	6/16/2013
Amelia Elissa VIROSTKO	**If you believe that you are in compliance with the Centers for Disease Control safe injection practices, your answer should be "YES".** I hereby attest to knowledge of and compliance with the guidelines of the Centers for Disease Control and Prevention concerning the prevention of transmission of infectious agents through safe and appropriate injection practices. I also attest that any person who is currently, or will be under my control as their supervising physician in the future, and who is not licensed pursuant to chapter 630 of the Nevada Revised Statutes and whose duties involve injection practices, has knowledge of and is in compliance with the guidelines of the Centers for Disease Control and Prevention concerning the prevention of transmission of infectious agents through safe and appropriate injection practices. **http://www.cdc.gov/injectionsafety/IP07_standardPrecaution.html**	Y	6/16/2013
Amelia Elissa VIROSTKO	Have you surrendered your state or federal controlled substance registration or had it revoked or restricted in any way?	N	6/16/2013
Amelia Elissa VIROSTKO	Have you had hospital staff privileges denied, suspended, limited, revoked or not renewed by the hospital, including any and all resignations from any medical staff in lieu of disciplinary or administrative action? If the answer is " Yes," type the name of the hospital, the hospital`s mailing address, the type of action taken, and the date or dates of the actions taken in the textbox directly below this question. **(Please Note: Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance.)**	N	6/16/2013
Amelia Elissa VIROSTKO	Have you actively practiced medicine in Nevada within the past 12 months?	Y	6/16/2013
Amelia Elissa VIROSTKO	I hereby request my license to be placed on Inactive status, which means I will not physically practice in the state of Nevada. If you choose to place your license on Inactive status, make certain to select "Yes" to this question **AND** choose the Inactive status in the dropdown box located at the end of the questions.	N	6/16/2013
Amelia Elissa VIROSTKO	**The submission of the in-office surgery/procedure forms is required for all medical doctors, whether in state, out of state, active or inactive status! THIS IS NOT OPTIONAL. DO NOT answer this attestation until you have completed the requisite form. Once you have completed this action, you may proceed in answering the renewal attestations and questions. The online renewal site will retain your previous responses.**	Y	6/16/2013

	Please go to the website, click on the following link for instructions and complete the required form. Click on the following link for the instructions and forms: http://medboard.ny.gov/New_In_Office_Surgery_Forms.htm **If you have submitted your In-Office Surgery/Procedure Reporting Forms (A/B forms) to the Board and are in compliance with NRS 630.30665, your answer should be "YES".** Nevada Revised Statutes (NRS) require the Nevada State Board of Medical Examiners to obtain from each applicant who seeks renewal of his or her license to practice medicine, a report stating the number and type of surgeries requiring conscious sedation, deep sedation or general anesthesia performed by the holder of the license at his or her office or any other facility, excluding any surgical care performed at a medical facility as defined in NRS 449.0151, or outside the state of Nevada. I hereby attest that I am in compliance with the reporting requirements of NRS 630.30665, and am aware that failure to submit a report or filing false information in a report is grounds for disciplinary action under Nevada`s Medical Practice Act.		
Amelia Elissa VIROSTKO	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, 2011 - June 30, 2013 type an explanation in the textbox directly below this question.	N	6/16/2013
Amelia Elissa VIROSTKO	I have completed the required amount of AMA Category 1 CME within the current biennial. I understand that I may be included in a random audit. I agree to retain CME's taken between July 1, 2011 and June 30, 2013. (Review CME information online at www.medboard.ny.gov) If renewing to an Inactive status, CME is not required and "No" can be selected.	Y	6/16/2013
Amelia Elissa VIROSTKO	I SWEAR OR AFFIRM UNDER THE PENALTY OF PERJURY THAT I PERSONALLY ANSWERED ALL OF THE QUESTIONS IN THIS APPLICATION AND THAT THE ANSWERS I HAVE PROVIDED ARE TRUE AND CORRECT.	Y	6/16/2013

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Renewal Questions for License Number 14406

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Licensee	Question	Answer	Date
Amelia Elissa VIROSTKO	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	6/23/2015
Amelia Elissa VIROSTKO	**Explanation 1: For the above question if your answer is "Yes" for the time period July 1, 2013 – June 30, 2015, or since your last renewal, please type your brief explanation in this text box (Fields are space limited to 256 characters). Lengthy explanations or additional information may be faxed to 775-688-2551 or scanned and Email to elicensensbme@medboard.nv.govl.**		
Amelia Elissa VIROSTKO	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	6/23/2015
Amelia Elissa VIROSTKO	**Explanation 2: For the above question if your answer is "Yes" for the time period July 1, 2013 - June 30, 2015, or since your last renewal, please type your brief explanation in this text box (Fields are space limited to 256 characters). Lengthy explanations or additional information may be faxed to 775-688-2551 or scanned and Email to elicensensbme@medboard.nv.govl.**		
Amelia Elissa VIROSTKO	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	6/23/2015
Amelia Elissa VIROSTKO	**Explanation 3: For the above question if your answer is "Yes" for the time period July 1, 2013 - June 30, 2015, or since your last renewal, please type your brief explanation in this text box (Fields are space limited to 256 characters).Lengthy explanations or additional information may be faxed to 775-688-2551 or scanned and Email to elicensensbme@medboard.nv.govl.**		
Amelia Elissa VIROSTKO	Have you been named as a defendant, or been requested to respond as a defendant, to a legal action involving professional liability, malpractice, including any military tort claims if applicable? Please include: who, what, where (provide state), and when in the textbox directly below this question.	Y	6/23/2015
Amelia Elissa VIROSTKO	**Explanation 4: For the above question if your answer is "Yes" for the time period July 1, 2013 - June 30, 2015, or since your last renewal, please type your explanation in this text box.** Please fax a copy of the Complaint, Settlement and/or Dismissal, civil or otherwise to 775-688-2551 or email to elicensensbme@medboard.nv.gov.		6/23/2015

Amelia Elissa VIROSTKO	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	6/23/2015
Amelia Elissa VIROSTKO	**Explanation 5: For the above question if your answer is "Yes" for the time period July 1, 2013 - June 30, 2015, or since your last renewal, please type your explanation in this text box.** Please fax a copy of the Complaint, Settlement and/or Dismissal, civil or otherwise to 775-688-2551 or email to elicensensbme@medboard.ny.gov.		
Amelia Elissa VIROSTKO	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	6/23/2015
Amelia Elissa VIROSTKO	**Explanation 6: For the above question if your answer is "Yes" for the time period July 1, 2013 - June 30, 2015, or since your last renewal, please type your brief explanation in this text box (Fields are space limited to 256 characters).Lengthy explanations or additional information may be faxed to 775-688-2551 or scanned and Email to elicensensbme@medboard.ny.gov!.**		
Amelia Elissa VIROSTKO	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	6/23/2015
Amelia Elissa VIROSTKO	**Explanation 7: For the above question if your answer is "Yes" for the time period July 1, 2013 - June 30, 2015, or since your last renewal, please type your brief explanation in this text box (Fields are space limited to 256 characters).Lengthy explanations or additional information may be faxed to 775-688-2551 or scanned and Email to elicensensbme@medboard.ny.gov!.**		
Amelia Elissa VIROSTKO	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	6/23/2015
Amelia Elissa VIROSTKO	**Explanation 8: For the above question if your answer is "Yes" for the time period July 1, 2013 - June 30, 2015, or since your last renewal, please type your brief explanation in this text box (Fields are space limited to 256 characters).Lengthy explanations or additional information may be faxed to 775-688-2551 or scanned and Email to elicensensbme@medboard.ny.gov!.**		
		N	6/23/2015

Amelia Elissa VIROSTKO	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?		
Amelia Elissa VIROSTKO	**Explanation 9: For the above question if your answer is "Yes" for the time period July 1, 2013 - June 30, 2015, or since your last renewal, please type your brief explanation in this text box (Fields are space limited to 256 characters).Lengthy explanations or additional information may be faxed to 775-688-2551 or scanned and Email to elicensensbme@medboard.ny.gov.**		
Amelia Elissa VIROSTKO	Have you failed to initiate the performance of public service within one year after the date the public service is required to begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local government for your medical education?	N	6/23/2015
Amelia Elissa VIROSTKO	**Explanation 10: For the above question if your answer is "Yes" for the time period July 1, 2013 – June 30, 2015, or since your last renewal, please type your brief explanation in this text box (Fields are space limited to 256 characters). Lengthy explanations or additional information may be faxed to 775-688-2551 or scanned and Email to elicensensbme@medboard.ny.govl.**		
Amelia Elissa VIROSTKO	Have you been: a) asked to respond to an investigation; b) notified that you were under investigation for; c) investigated for; d) charged with; or e) convicted of any violation of a statute, rule or regulation governing your practice as a physician by any medical licensing board, hospital, medical society, governmental entity or agency other than the Nevada State Board of Medical Examiners?	N	6/23/2015
Amelia Elissa VIROSTKO	**Explanation 11: For the above question if your answer is "Yes" for the time period July 1, 2013 – June 30, 2015, or since your last renewal, please type your brief explanation in this text box (Fields are space limited to 256 characters). Lengthy explanations or additional information may be faxed to 775-688-2551 or scanned and Email to elicensensbme@medboard.ny.govl.**		
Amelia Elissa VIROSTKO	Have you surrendered your state or federal controlled substance registration or had it revoked or restricted in any way?	N	6/23/2015
Amelia Elissa VIROSTKO	**Explanation 12: For the above question if your answer is "Yes" for the time period July 1, 2013 – June 30, 2015, or since your last renewal, please type your brief explanation in this text box (Fields are space limited to 256 characters). Lengthy explanations or additional information may be faxed to 775-688-2551 or scanned and Email to elicensensbme@medboard.ny.govl.**		
Amelia Elissa VIROSTKO	Have you had hospital staff privileges denied, suspended, limited, revoked or not renewed by the hospital, including any and all resignations from any medical staff in lieu of disciplinary or administrative action? If the answer is "Yes," type the name of the hospital, the hospital's mailing address, the type of action taken, and the date or dates of the actions taken in the textbox directly below this question. **(Please Note: Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance.)**	N	6/23/2015
Amelia Elissa VIROSTKO	**Explanation 13: For the above question if your answer is "Yes" for the time period July 1, 2013 – June 30, 2015, or since your last renewal, please type your brief explanation in this text box (Fields are space limited to 256 characters). Lengthy explanations or additional information may be faxed to 775-688-2551 or scanned**		

	and Email to elicensensbme@medboard.nv.govl.		
Amelia Elissa VIROSTKO	Have you actively practiced medicine in Nevada within the past 12 months?	Y	6/23/2015
Amelia Elissa VIROSTKO	**Explanation 14: For the above question if your answer is "No" for the time period July 1, 2013 – June 30, 2015, or since your last renewal, please type your brief explanation in this text box (Fields are space limited to 256 characters).Lengthy explanations or additional information may be faxed to 775-688-2551 or scanned and Email to elicensensbme@medboard.nv.govl.**		
Amelia Elissa VIROSTKO	OPTION TO CHANGE LICENSE STATUS FROM ACTIVE TO INACTIVE: NOTE: If you choose to drop to Inactive status during this renewal, your status will be changed to "Inactive" **as of the date of your renewal.** If you do NOT wish to change your status to "Inactive" as of today, DO NOT COMPLETE YOUR RENEWAL UNTIL SUCH TIME AS YOU ARE PREPARED TO HAVE YOUR STATUS CHANGED (prior to JULY 1ST). For your information, your answers to the questions that you've already completed will remain, but you should not complete the renewal and pay until such time as you are prepared to change your status to "Inactive." I hereby request my license to be placed on Inactive status, which means I will not physically practice in the state of Nevada. If you choose to place your license on Inactive status, make certain to select "Yes" to this question **AND** choose the Inactive status in the dropdown box located at the end of the questions.	N	6/23/2015
Amelia Elissa VIROSTKO	**If you believe that you are in compliance with the Centers for Disease Control safe injection practices, your answer should be "YES".** I hereby attest to knowledge of and compliance with the guidelines of the Centers for Disease Control and Prevention concerning the prevention of transmission of infectious agents through safe and appropriate injection practices. I also attest that any person who is currently, or will be under my control as their supervising physician in the future, and who is not licensed pursuant to chapter 630 of the Nevada Revised Statutes and whose duties involve injection practices, has knowledge of and is in compliance with the guidelines of the Centers for Disease Control and Prevention concerning the prevention of transmission of infectious agents through safe and appropriate injection practices. **http://www.cdc.gov/injectionsafety/IP07_standardPrecaution.html**	Y	6/23/2015
Amelia Elissa VIROSTKO	I hereby attest that I am in compliance with the reporting requirements of NRS 630.30665, and am aware that failure to submit a report or filing false information in a report is grounds for disciplinary action under Nevada's Medical Practice Act. I HAVE SUBMITTED A "FORM A" OR "FORM B" REPORT TO THE BOARD. Instructions and Forms A and B for in-office surgery/procedure reporting can be located on the Board's website by clicking the red "In-Office Surgery Reporting" link on the home page of the Board's website: www.medboard.nv.gov. **If you have submitted your in-office surgery/procedure reporting forms (A/B Forms) to the Board and are in compliance with NRS 630.30665, your answer should be "YES."**	Y	6/23/2015
Amelia Elissa VIROSTKO	Are you out of compliance with court ordered child support? **If this does not apply to you, please answer "no".**	N	6/23/2015

	If "Yes" during the time period July 1, 2013 - June 30, 2015 type an explanation in the textbox directly below this question.		
Amelia Elissa VIROSTKO	**Explanation 15: For the above question, if your answer is "Yes" for the biennial July 1, 2013 – June 30, 2015, please type your brief explanation in this text box (Fields are space limited to 256 characters). Lengthy explanations or additional information may be faxed to 775-688-2551 or scanned and Email to elicensensbme@medboard.nv.govl.**		
Amelia Elissa VIROSTKO	Once you have read the statute regarding the reporting of the abuse or neglect of a child, your answer to this question will be "YES". **I attest and affirm that I am aware of and understand the reporting requirements found in Nevada Revised Statute 432B.220 regarding the abuse or neglect of a child.** **www.leg.state.nv.us/NRS/NRS-432B.html#NRS432BSec220**	Y	6/23/2015
Amelia Elissa VIROSTKO	**Explanation 16: For the above question if your answer is "No" for the time period July 1, 2013 - June 30, 2015, or since your last renewal, please type your explanation in this text box.**		
Amelia Elissa VIROSTKO	Have you ever served in the United States Military (to include National Guard or Reserves)?	N	6/23/2015
Amelia Elissa VIROSTKO	**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.** 1. If yes, in which branch of service did you serve? 2. What was your Military occupation specialty or specialties? 3. Provide your dates of service in the Military.		
Amelia Elissa VIROSTKO	Do you hold a Nevada state business license issued in your individual name?	N	6/23/2015
Amelia Elissa VIROSTKO	**Explanation 18: If yes, provide the business license number:**		
Amelia Elissa VIROSTKO	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 selected.	Y	6/23/2015
Amelia Elissa VIROSTKO	I SWEAR OR AFFIRM UNDER THE PENALTY OF PERJURY THAT I PERSONALLY ANSWERED ALL OF THE QUESTIONS IN THIS APPLICATION AND THAT THE ANSWERS I HAVE PROVIDED ARE TRUE AND CORRECT.	Y	6/23/2015