License Information

LICENSE NUMBER: 18212

Person Info

Name: MARCELA SMID

Thursday May 2, 2019

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
Explanation 1: For the above question if your answer is "Yes" for the time period July 1, 2017 - July 1, 2019, 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.	
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
Explanation 2: For the above question if your answer is "Yes" for the time period July 1, 2017 - July 1, 2019, 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.	
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
Explanation 3: For the above question if your answer is "Yes" for the time period July 1, 2017 - July 1, 2019, 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.	
Have you been named as a defendant, or been requested to respond as a defendant, to a legal action involving professional liability, malpractice, including any military tort claims if applicable? Please include: who, what, where (provide state) and when in the text box directly below this question.	Y
Explanation 4: For the above question if your answer is "Yes" for the time period July 1, 2017 - July 1, 2019, 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.**	F '
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, 2017 - July 1, 2019 type an explanation in the text box directly below this question.	Y
Explanation 5: For the above question if your answer is "Yes" for the time period July 1, 2017 - July 1, 2019, 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.	I t n
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
Explanation 6: For the above question if your answer is "Yes" for the time period July 1, 2017 - July 1, 2019, 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.	
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
Explanation 7: For the above question if your answer is "Yes" for the time period July 1, 2017 - July 1, 2019, 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.	
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
Explanation 8: For the above question if your answer is "Yes" for the time period July 1, 2017 - July 1, 2019, 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.	
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
Explanation 9: For the above question if your answer is "Yes" for the time period July 1, 2017 - July 1, 2019, 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.	
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
Explanation 10: For the above question if your answer is "Yes" for the time period July 1, 2017 - July 1, 2019, 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.	
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
Explanation 11: For the above question if your answer is "Yes" for the time period July 1, 2017 - July 1, 2019, 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.	
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, 2017 - July 1, 2019, or since your last renewal, please type your brief explanation in this text box (Fields	

additional information may be faxed to 775-688-2551 or scanned and emailed to elicensensbme@medboard.nv.gov.	
Have you had hospital staff privileges denied, suspended, limited, revoked or not renewed by a hospital, including any and all resignations from any medical staff in lieu of disciplinary or administrative action? If the answer is "Yes," type the name of the hospital, the hospital's mailing address, the type of action taken, and the date(s) of the actions taken in the text box directly below this question. **(Please Note: Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance.)**	N
Explanation 13: For the above question if your answer is "Yes" for the time period July 1, 2017 – July 1, 2019, 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.	
Have you been denied membership, been asked to resign or expelled from a medical society or other professional medical organization?	N
Explanation 14: For the above question if your answer is "Yes" for the time period July 1, 2017 – July 1, 2019, 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.	
Have you actively practiced medicine in Nevada within the past 24 months?	Y
Explanation 15: For the above question if your answer is "No" for the time period July 1, 2017 – July 1, 2019, 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.	
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 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." 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
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 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. **http://www.cdc.gov/injectionsafety/IP07_standardPrecaution.html**	Y
I hereby attest that I am in compliance with the reporting requirements of NRS 630.30665, to wit, that if I have performed a surgery or procedure	

in Nevada outside a "medical facility" as defined by NRS 449.0151, and if that surgery or procedure utilized conscious sedation, deep sedation or general anesthesia, then I have submitted a report to the Board stating the number and type of surgeries or procedures performed, and I 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. **(If you have performed no such surgeries or procedures, then your answer should be "YES.")** **Instructions for in-office surgery/procedure reporting can be located on the Board's website at: medboard.nv.gov/forms/in-office_surgery.**	Y
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, 2017 - July 1, 2019 type an explanation in the text box directly below this question.	N
Explanation 16: For the above question, if your answer is "Yes" for the biennial July 1, 2017 – July 1, 2019, 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. **http://www.leg.state.nv.us/NRS/NRS-432B.html#NRS432BSec220** **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."**	Y
Explanation 17: For the above question if your answer is "No" for the time period July 1, 2017 - July 1, 2019, or since your last renewal, please type your explanation in this text box.	
I have completed the required amount of AMA Category 1 CME within the current biennial. I understand that I may be included in a random audit. I agree to retain CME's taken between July 1, 2017 and July 1, 2019. (Review CME information online at http://medboard.nv.gov/licensees/ce/) **If renewing to an Inactive status, CME is not required and "No" can be selected.**	Y
I hearby attest that I am in compliance with NRS 630.253, as I have completed or will complete between July 1, 2017, and June 30, 2021, a minimum of 2 hours of instruction on evidence-based suicide prevention and awareness.	Y
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
End	

Uniform Application for Licensure

Application ID: 258921
FID: 215131871
License Requested: MD
Submitted to: Nevada State Board of Medical Examiners
Submission Date: 05/24/2018

Practitioner Name

Smid, Marcela

Alternate Name(s): Smid, Marcela Carolina

Contact Information

Address

Public Access	Board Contact	Type	Address
Yes	Yes	Business	30 N 1900 E 2B200 SOM SALT LAKE CITY Salt Lake City, UT 84132 UNITED STATES

Phone

Public Access	Board Contact	Type	Phone Number	Phone Extension
Yes	No	Business	(801) 581-8425	
No	Yes	Mobile		

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Email

Public Access	Board Contact	Email
Yes	No	mfm@hsc.utah.edu
No	Yes	marcela.smid@hsc.utah.edu
No	No	

Identification

USMLE Number	SSN	Birth Date	Birth Place	Gender	NPI	Practitioner Type	U.S. Citizen
		11/ 1981	Prague, PR CZECH REPUBLIC	F	1588994727	MD	Yes

Medical School

Medical School Name	Address	Start Date	End Date	Graduation Date	Degree Code
University of California, San Francisco, School of Medicine	513 Parnassus Avenue Room S-224 San Francisco, CA 941430410 UNITED STATES	06/16/2003	06/12/2009	06/12/2009	MD

Fifth Pathway

None Reported

ECFMG

Certificate Number	Issue Date
None Reported	

Postgraduate Training

Hospital Name:	**University of Chicago Program** Chicago, IL UNITED STATES	**Program Code:**	ACGME 2201611092
		Attendance Dates:	
Institution:	University of Chicago Medical Center	**Start Date:**	06/24/2009
Training Specialty:	Obstetrics & Gynecology	**End Date:**	06/30/2010
		Program Type:	Internship
Training Status:	Completed		

Hospital Name:	**University of Chicago Program** Chicago, IL UNITED STATES	**Program Code:**	ACGME 2201611092
		Attendance Dates:	
Institution:	University of Chicago Medical Center	**Start Date:**	07/01/2010
Training Specialty:	Obstetrics & Gynecology	**End Date:**	06/30/2013
		Program Type:	Residency
Training Status:	Completed		

Hospital Name:	**University of North Carolina Hospitals Program** Chapel Hill, NC UNITED STATES	**Program Code:**	ACGME 2303622001
		Attendance Dates:	
Institution:	University of North Carolina Hospitals	**Start Date:**	07/01/2013
Training Specialty:	Obstetrics & Gynecology/Maternal-Fetal Medicine	**End Date:**	06/30/2016
		Program Type:	Fellowship
Training Status:	Completed		

Examination History

Exam	State	Last Attempt	Pass/Fail	Number Of Attempts
USMLE Step 1 Examination		04/12/2006	Pass	1
USMLE Step 2 CK Examination		06/13/2007	Pass	1
USMLE Step 2 CS Examination		02/27/2009	Pass	1
USMLE Step 3 Examination		03/16/2012	Pass	1

State Licensure History

MD, DO, PA License History

License Entity	Licensing State	License Number	Issue Date	Expiration Date	License Type	License Status
Illinois Department of Financial and Professional Regulation	IL	036132507	04/18/2013	07/31/2014		Non-Renew
North Carolina Medical Board	NC	2013-00761	04/30/2013	01/13/2019		Active
Utah Physicians Licensing Board	UT	9855803-1205	07/05/2016	01/31/2020	Full	Active

Physician Reported License History

Practitioner License Type	Licensing State	License Number	Issue Date	Expiration Date	Type	License Status
None Reported						

Chronology of Activity Type

Practice/Emp/ Desc: University of Utah School of Medicine
Chronology Type: Work

Address: 30 N 1900 E
2B200 SOM
SALT LAKE CITY
Salt Lake City, UT 84132
US

Attendance Dates:
Start Date: 09/01/2016
End Date: In Progress

Position/Dept: Assistant Professor - Obstetrics and Gynecology

Clinical %: 20
Admin %: 80

Employment: ● **Staff Privileges:** ● **Affiliation:** ●

Practice/Emp/ Desc: none
Chronology Type: Seeking Employment

Address:
Attendance Dates:
Start Date: 07/01/2016
End Date: 08/31/2016

Position/Dept:

Clinical %: 0
Admin %: 0

Employment: ● **Staff Privileges:** ● **Affiliation:** ●

Practice/Emp/ Desc: University of North Carolina Hospitals Program
Chronology Type: Accredited Training

Address: Chapel Hill, NC
US

Attendance Dates:
Start Date: 07/01/2013
End Date: 06/30/2016

Position/Dept:

Clinical %:
Admin %:

Employment: **Staff Privileges:** **Affiliation:**

Practice/Emp/ Desc: University of North Carolina - Chapel Hill
Chronology Type: PGT/Education

Addr

321 S Columbia St
Chapel Hill, NC
US

Attendance Dates:

Position/Dept: Fellow - Obstetrics and Gynecology

Start Date: 07/01/2013

End Date: 06/20/2016

Clinical %: 0

Admin %: 0

Employment: Staff Privileges: Affiliation:

Practice/Emp/ Desc: University of Chicago Program

Chronology Type: Accredited Training

Address: Chicago, IL
US

Attendance Dates:

Position/Dept:

Start Date: 07/01/2010

End Date: 06/30/2013

Clinical %:

Admin %:

Employment: Staff Privileges: Affiliation:

Practice/Emp/ Desc: University of Chicago Program

Chronology Type: Accredited Training

Address: Chicago, IL
US

Attendance Dates:

Position/Dept:

Start Date: 06/24/2009

End Date: 06/30/2010

Clinical %:

Admin %:

Employment: Staff Privileges: Affiliation:

Practice/Emp/ Desc: University of California, San Francisco, School of Medicine

Chronology Type: Medical Education

Address: San Francisco, CA
US

Attendance Dates:

Position/Dept:

Start Date: 06/16/2003

End Date: 06/12/2009

Clinical %:

Admin %:

Employment: Staff Privileges: Affiliation:

ADDENDUM 1 – RESPONSIBILITY STATEMENT

ATTENTION APPLICANT!

Please sign and return this statement with your application for licensure to:

The Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521

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 Marcela Smid, MD

Sign your name _____

Date 5/24/2018

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 occurs prior to you being granted licensure to practice medicine in the state of Nevada.

ADDENDUM 3 – ADDITIONAL PHYSICIAN INFORMATION

CITIZENSHIP AND IDENTIFICATION

U.S. Citizen Yes ☑ No ☐ Alien Registration #_____

Employment Authorization #_____ Visa #_____

Color of Eyes: Hazel Color of Hair: Brown Height: 5'5" Weight: 160

EXAMINATION SCORES

List all licensure examinations you have taken, whether U.S. or International, on the Examination History tab of the online Uniform Application. Also list below the score you received on each exam taken. INCLUDE ALL INFORMATION PERTAINING TO ANY AND ALL FAILED ATTEMPTS.

Examination Name	Score Received	Examination Name	Score Received
Step 1	pass		
Step 2 CS	pass		
Step 2 CK	pass		
Step 3	227		

SPECIALTY CERTIFICATION

Scope of Practice/Specialty(ies): Maternal-Fetal Medicine

List any and all certifications and re-certifications by a board or sub-board recognized by the **American Board of Medical Specialties.** INCLUDE ALL INFORMATION PERTAINING TO ANY AND ALL FAILED ATTEMPTS.

Board / Specialty Board	If you are Lifetime Board Certified, indicate "Lifetime"	Certification #	Dates of Certification/ Recertification (MM/YY)
ABOG / OB/GYN		9030173	11/7/2014 / 12/31/2019
ABOG / Maternal-Fetal Medicine Subspecialty			4/13/2018 / 12/31/2019

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.

ADDENDUM 4 – ATTESTATION QUESTIONS

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 condition or disorder.

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

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

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? If "Yes," attach an explanation on a separate sheet. — 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, the manner in which you have chosen to practice, or by any other reasonable accommodation? If "Yes," attach an explanation on a separate sheet. — Yes ☐ No ☒

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? If "Yes," attach an explanation on a separate sheet. — Yes ☐ No ☒

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? If "Yes," attach an explanation on a separate sheet. — 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 "Yes," please describe in the space provided on the Malpractice Liability Claims Information page within the online Uniform Application. Also complete addendum 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? If "Yes," please describe in the space provided on the Malpractice Liability Claims Information page within the online Uniform Application. Also complete addenda 5 and 6. — 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 an explanation on a separate sheet. — Yes ☐ No ☒

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 question 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.

ATTESTATION REGARDING THE REPORTING OF THE ABUSE OR NEGLECT OF A CHILD

Yes ☒ No ☐ I attest and affirm that I am aware and understand the reporting requirements found in Nevada Revised Statute 432B.220 regarding the abuse or neglect of a child.
http://www.leg.state.nv.us/NRS/NRS-432B.html#NRS432BSec220

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MAY 31 2018
NEVADA STATE BOARD OF MEDICAL EXAMINERS

SAFE INJECTION PRACTICE ATTESTATION

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

Yes ☒ No ☐ 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

COMMUNICATIONS AFFIRMATION

Consent to accept communications and service of process from the Nevada State Board of Medical Examiners (Board) by electronic mail, for physicians and physician assistants who practice medicine in the state of Nevada or via telemedicine and whose physical presence exists outside the state of Nevada or the United States.

I hereby agree that as a condition of obtaining or maintaining licensure with the Board, I am willing to accept Board communications to me, to include service of process as defined under Nevada Revised Statute (NRS) 630.344, via electronic mail (more commonly known as e-mail). Further, should the electronic mail address provided below change for any reason, I agree to apprise the Board in writing of my new electronic mail address within 30 days after the change, and that the failure to do so may subject me to a fine or disciplinary action as allowed in NRS 630.244.

Printed Name of Applicant/Licensee: Marcela Amid

Signature of Applicant/Licensee: _____ Email Address: _____

7. Have you previously applied for medical licensure in Nevada (including in a Residency program)? If "Yes," attach an explanation on a separate sheet. 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, 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 an explanation on a 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 an explanation on a 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 an explanation on a 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 an explanation on a 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 an explanation on a 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 <u>other than</u> the Nevada State Board of Medical Examiners? If "Yes," attach an explanation on a separate sheet. Yes ☐ No ☒

14. Have you EVER surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? If "Yes," attach an explanation on a separate sheet. Yes ☐ No ☒

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.

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

Hospital	Mailing Address	Type of Action	Dates of Action (From MM/YY to MM/YY)

MILITARY SERVICE ATTESTATION

1-Have you ever served in the United States Military (to include National Guard or Reserves)? _____Yes X No
If your answer is "No", you do not have to complete the remaining questions for the Military Service Attestation.

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2-If yes, which branch of service did you serve?
- ☐ Air Force
- ☐ Army
- ☐ Navy
- ☐ Marine Corp
- ☐ Coast Guard

3-Military occupation specialty or specialties?
- ☐ Administration or Personnel
- ☐ Aviation
- ☐ Civil Engineering
- ☐ Communications
- ☐ Logistics or Supply
- ☐ Maintenance
- ☐ Medical Services
- ☐ Security Forces or Military

Police

- ☐ Infantry or Armor
- ☐ Legal or Chaplin Corps
- ☐ Other

4&5-Dates of service in the Military:

4-From: ____/____/____ (DD / MM / YYYY) 5-To: ____/____/____ (DD / MM / YYYY)

6-Are you still serving? __Yes ___No

7-Have you ever served on active duty in the Armed Forces of the United States? _____Yes _____No

8-Have you ever been assigned to duty for a minimum of 6 continuous years in the National Guard or a reserve component of the Armed Forces of the United States? _____Yes _____No

9-Have you ever served the Commissioned Corps of the United States Public Health Service or the Commissioned Corps of the National Oceanic and Atmospheric Administration of the United States in the capacity of a commissioned officer while on active duty in defense of the United States? _____Yes _____No

10-If the answer to question(s) 7, 8 and/or 9 is "yes," did you separate from such service under conditions other than dishonorable? _____Yes _____No

APPLICATION AFFIRMATION

I, Marcela Carolina Smid
(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 occurs prior to my being granted licensure to practice medicine in the state of Nevada.

Signature of applicant — Date: 5/24/2018

State of UT County of SALT LAKE

Subscribed and sworn to before me this 24 day of MAY, 2018.

(NOTARY SEAL)
CHELSEY ZAMIR
Notary Public – State of Utah
Comm. No. 695943
My Commission Expires on
Jul 24, 2021

Notary Public for the State of UT

My Commission Expires: 7/24/2020

Residing at: SALT LAKE (City) UT (State)

Signature of Notary

ADDENDUM 5 – LIST OF MALPRACTICE INSURANCE CARRIERS

If you have answered in the affirmative ("Yes") to questions 5a and/or 5b of Addendum 4 of the UA, list all malpractice carriers.

Name of Insured: Marcela Smid, MD

Insurance Company: UNC Liability Insurance Trust Fund
Address: 101 Manning Drive, 2nd Floor, Wing E
Chapel Hill, NC 27514
Phone Number: 984-974-3041
Fax Number:
Policy Number: N/A
Dates: 7/1/2013 - 6/1/2016

Insurance Company: University of Chicago Professional Idemnification Plan
Address: Office of Legal Affairs: 5841 S. Maryland Avenue, MC 1132
Chicago, IL 60637
Phone Number: 773-702-1057
Fax Number: 773-702-9310
Policy Number: N/A
Dates: 7/1/2009 - 6/1/2013

Insurance Company: University of Utah Health Care, Risk Management
Address: 525 East 100 South, RM 4325
Salt Lake City, UT 84102
Phone Number: 801-585-0944 or 801-581-2031
Fax Number: 801-581-3042
Policy Number: N/A
Dates: 9/1/2016 - present

Insurance Company:
Address:
Phone Number:
Fax Number:
Policy Number:
Dates:

Insurance Company:
Address:
Phone Number:
Fax Number:
Policy Number:
Dates:

(If more space is needed, please copy this page or attach a separate sheet.)

Appl

Appl

Date

[Ple

State of UT, County of

I certify that on the date set forth below, the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document.

The statements on this document are subscribed and sworn to before me by the applicant on this 24 day of MAY, 2018.

Notary Public Signature _____ My Notary Commission Expires 7/24/2021