PHYSICIAN (M.D.)
APPLICATION FOR LICENSURE
NEVADA STATE BOARD OF
MEDICAL EXAMINERS
1105 Terminal Way, Suite 301 Reno, Nevada 89502
Phone (775) 688-2559

Date Received by Board RECEIVED JAN 06 2016 License No. _____
RECEIVED DEC 16 2015 NEVADA STATE BOARD OF MEDICAL EXAMINERS No. _____
For Board Use Only
NEVADA STATE BOARD OF MEDICAL EXAMINERS

Identity:

1. Present Legal Name TORRES (Last) CARLA (First) Elisse (Middle) (Maiden)

List any other name(s) ever used _____

Address:
The **Public Access Address** will be available to the public on the Board's website, and will also be your contact address once licensed. It can be changed if the Licensee completes the Notification of Address Change form available on the Board's website: www.medboard.nv.gov.
The **Mailing Address** that you choose will be used for communication only during the application process. It can be one and the same.

2. Public Address 1336 Cayetano Dr (Street) Napa (City) Napa (County) CA (State) 94559 (Zip)

☒ Please check if you choose to have your Mailing Address the same as the Public Address you have entered above.

3. Mailing Address _____ (Street) (City) (County) (State) (Zip)

4. Telephone Numbers (832) 721-4278 (Office) ( ) _____ (Fax) ( ) _____ (Home) ( ) _____ (Cellular (Optional))

Email address _____

5. Date of Birth 7/6 (Month / Day / Year) Place of Birth HI (City, State, Country) Gender X F ___ M

6. Citizenship: U.S. Citizen X Alien Registration # _____ Employment Authorization # _____ 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 card or Visa. Please note: Copy of the document authorizing your name change (marriage license, divorce decree, etc.) must be included.

7. Social Security Number ___ _____ Color of Eyes _____ Color of Hair _____ Height _____ Weight _____

NRS 630.197(1)(a) An applicant for the issuance of a license to practice medicine shall include the social security number of the applicant in the application submitted to the Board.
NRS 630.165(5) The applicant bears the burden of proving and documenting his qualifications for licensure.

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 SIGNED WRITTEN EXPLANATION(S) ON A SEPARATE SHEET ATTACHED TO YOUR COMPLETED *APPLICATION FOR LICENSURE* FORM.

8. 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 explanation on separate sheet.) ___ Yes X No

9. 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 explanation on separate sheet.) ___ Yes X No ___ N/A

10. 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 explanation on separate sheet.) ___ Yes X No ___ N/A

11. Have you failed to initiate the performance of public service within one year after the date the public service is required to begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local government for your medical education? (If "Yes," attach explanation on separate sheet.) ___ Yes X No

Malpractice Questions:

12. 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?

X Yes _____ No

12a. 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?

X Yes _____ No

Arrest Question:

13. 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 __X__No

Nevada License History:

14. Have you previously applied for medical licensure in Nevada (including in a Residency program)?
(If "Yes," attach explanation on separate sheet.) ____Yes __X__No

Medical School and Postgraduate Training History:

15. List names and addresses of all medical schools attended. **HAVE EACH MEDICAL SCHOOL SUBMIT AN OFFICIAL TRANSCRIPT DIRECTLY TO THE BOARD.**

Medical School Name	City/State/Country	Place Where Instruction Received	Dates of Attendance From (Mo./Yr.) To (Mo./Yr.)
University of TX - Houston Science Center	Houston, TX		6/98 - 6/02

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

16. Doctor of Medicine Degree granted by:

Medical School Name	City/State/Country	Exact Date of Issuance (Month/Day/Year)
University of TX - Houston Science Center	Houston, TX	6/01/2002

17. List all ACGME* approved postgraduate medical education you have received as an Intern, Resident or Fellowship in the United States or Canada.
*Accreditation Council for Graduate Medical Education

Postgraduate Year (e.g. PGY1, PGY2, etc.)	Hospital/ Institution	City/State	Specify (I =Internship or R = Residency) (F = Fellowship)	Type of Specialty	Dates of Attendance From (Mo./Yr.) To (Mo./Yr.)
PGY1	Keesler Medical Center	Biloxi, MS	I	OB-Gyn	6/02 - 6/03
PGY 2-4	Naval Medical Center	SAN DIEGO, CA	R	OB Gyn	6/03 - 6/06

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

18. List non-ACGME Fellowship training or non-ACGME combined postgraduate medical education attended in the United States or Canada.

If combined program list Postgraduate Year (e.g. PGY1, PGY2, etc.)	Hospital/ Institution	City/State	Specify (I =Internship or R = Residency) (F = Fellowship)	Type of Specialty	Dates of Attendance From (Mo./Yr.) To (Mo./Yr.)

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

19. 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 explanation on separate sheet.) ____Yes __X__No

20. If you graduated from a medical school located outside the United States of America or Canada, list your ECFMG#:_____

Examinations:

21. For each of the following licensing examinations, list the location, parts and dates taken, and scores obtained. (Also include failed examinations.) FOR EACH EXAM TAKEN, HAVE CERTIFICATE OF SCORES SUBMITTED FROM THE TESTING ENTITY DIRECTLY TO THE BOARD OFFICE.

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21a. STATE Written Examination:

Location	Date (Mo./Yr.)	Results (Scores)

21b. NATIONAL BOARD (not ABMS Board certification): (ALSO INCLUDE ALL INFORMATION PERTAINING TO ANY AND ALL FAILED EXAMS)

Part Taken	Date (Mo./Yr.)	Results (Scores)

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

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21c. FLEX (Federation Licensing Examination): (ALSO INCLUDE ALL INFORMATION PERTAINING TO ANY AND ALL FAILED EXAMS)

Date (Mo./Yr.)	Results (FLEX weighted average)

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

21d. USMLE (United States Medical Licensing Examination): (ALSO INCLUDE ALL INFORMATION PERTAINING TO ANY AND ALL FAILED EXAMS)

Step Taken	Number of Attempts	Date (Mo./Yr.)	Results (Three Digit Scores)
#1	1	~~8/01~~ 6/00'	Passed 196
#2	1	~~10/02'~~ 10/01'	Passed 205
#3	1	~~6/06~~ 9/03'	Passed 205

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

21e. LMCC (Licentiate of the Medical Counsel of Canada): (ALSO INCLUDE ALL INFORMATION PERTAINING TO ANY AND ALL FAILED EXAMS)

Part Taken	Date (Mo./Yr.)	Results (Scores)

21f. SPEX (Special Purpose Examination):

Date (Mo./Yr.)	Results (Score)

Specialty:

22. State your scope of practice / specialty (ies) OBstetrics & Gynecology

23. List any and all certifications and re-certifications by a board or sub-board recognized by the **AMERICAN BOARD OF MEDICAL SPECIALTIES (ABMS).** INCLUDE ALL INFORMATION PERTAINING TO ANY AND ALL FAILED ATTEMPTS.

ABMS Primary Board	Specialty Board	If you are Lifetime Board Certified, indicate "Lifetime"	Certification #	Dates of Certification and Recertification (Mo./Yr.)
American Board of OBstetrics & Gynecology			9013108	~~12/05~~ 12/2008
				Recertification 12/2015
Recertification annual			12/2009-2015	

Activities:

24. Account for, **in chronological order**, all activities since graduation from medical school. **ALL PERIODS OF TIME MUST BE ACCOUNTED FOR.** Activities include Postgraduate Training, Medical Practice/Physician, Non-Medical (such as seeking employment or vacation), Military Assignment, and Working in a Federal Facility. **Curriculum Vitae cannot be submitted in lieu of your answer to this question.**

Activities	Location (City/State/Country)	From (Mo./Yr.) To (Mo./Yr.)	Percent Clinical (%)
Internship	Biloxi, MS	6/02 - 6/03	100%
Residency	San Diego, CA	6/03 - 6/06	100%
Military Assignment/Physician	Las Vegas, NV	6/06 - 5/2011	100%
Military Assignment/Physician	Travis AFB, CA	5/2011 - Current	100%

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

25. 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.)
Mike O'Callaghan Federal Hospital	4700 N Las Vegas Blvd NV 89191	6/06 - 5/11
David Grant Med Cntr	101 Bodin Circle Travis, AFB, CA 93535	5/11 - current
Olympic Medical Center	939 Caroline St Port Angeles, WA 98362	8/2015 - 11/15

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

26. List any and all licenses **YOU HOLD OR HAVE HELD** (including postgraduate training/resident licenses) to practice medicine in any state, territory or country. Note: You will not be required to verify your training licenses by direct source.

State/Territory Country	License #	Date of Issuance (Mo./Yr.)	Status
MS	18736	~~06/2003~~ 11/04	Active
WA	60514581	2/2015	Military
MS	Resident	10/03	Inactive

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

Disciplinary Questions:

27. 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 X No

28. 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 X No

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

30. 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 X No

31. 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 X No

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

33. 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.)
N/A			

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

Attestations/Affirmations:

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:

__X__ (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

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.

__X__ Yes _____ No

www.leg.state.nv.us/NRS/NRS-432B.html#NRS432BSec220

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.

__X__ Yes _____ No

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 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.

Printed Name of Applicant/Licensee: Carla Torres

Signature of Applicant/Licensee: _____

Electronic Mail Address: _____

MILITARY SERVICE ATTESTATION

Have you ever served in the United States Military (to include National Guard or Reserves)? X Yes ____ No

If your answer is "No", you do not have to complete the remaining questions for the Military Service Attestation.

If yes, which branch of service did you serve?

- [x] Air Force
- [ ] Army
- [ ] Navy
- [ ] Marine Corp
- [ ] Coast Guard

Military occupation specialty or specialties?

- [ ] Administration or Personnel
- [ ] Aviation
- [ ] Civil Engineering
- [ ] Communications
- [ ] Infantry or Armor
- [ ] Legal or Chaplin Corps
- [ ] Logistics or Supply
- [ ] Maintenance
- [x] Medical Services
- [ ] Security Forces or Military Police
- [ ] Other

Dates of service in the Military:

From: 01 / 06 / 2002 **To:** 15 / 12 / 2015
DD MM YYYY DD MM YYYY
current

APPLICANT PHOTOGRAPH

ATTACH A FINISHED PHOTOGRAPH OF PASSPORT QUALITY OF YOUR HEAD AND SHOULDERS ONLY.

PHOTOGRAPH MUST HAVE BEEN TAKEN WITHIN THE LAST SIX MONTHS AND BE AT LEAST 2" x 2" IN SIZE.

I hereby certify that the attached photograph is a true likeness of me taken within the last six months.

Signature of applicant — **Date** 15 Dec 2015

APPLICATION AFFIRMATION

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I, Carla Elisse Toebes,
(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 — 11 December 2015 Date

(NOTARY SEAL)

STACEY L. LOW, TSgt, USAF
Paralegal,
Notary by Federal Statue Title 10 USC 1044a

State of California County of Solano
Subscribed and sworn to before me this 11 day of December, 2015
Notary Public for the State of Title 10 USC 1044a
My Commission Expires: 23 Nov 17
Residing at: Travis AFB CA
City State
Stacey L Low
Signature of Notary

END OF APPLICATION

FORM B

LIST OF MALPRACTICE INSURANCE CARRIERS

If you answered affirmatively to questions #12 and/or #12a on the Application for Licensure, list all malpractice carriers.

Name of Insured: Carla Torres

Insurance Company: Air Force Medical Operating Agency
Address: US Air Force, Lackland AFB 78236
CURRENT

Phone Number:
Fax Number:
Policy Number:
Dates:

Insurance Company:
Address:

Phone Number:
Fax Number:
Policy Number:
Dates:

Insurance Company:
Address:

Phone Number:
Fax Number:
Policy Number:
Dates:

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.)

ATTENTION APPLICANT!

RESPONSIBILITY STATEMENT

Please sign and return this statement with your application for licensure to:
The Nevada State Board of Medical Examiners
1105 Terminal Way Suite 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 Carla Togeos

Sign your name _____

Date 9 Dec 2015

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.

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Enabling Responsive Government
MyLicense Transaction Reports

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Renewal Questions for License Number 16265

POWERED BY MyLicense

Licensee	Question	Answer	Date
TORRES, Carla Elisse	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	4/24/2017
TORRES, Carla Elisse	**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 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.**		
TORRES, Carla Elisse	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	4/24/2017
TORRES, Carla Elisse	**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 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.**		
TORRES, Carla Elisse	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	4/24/2017
TORRES, Carla Elisse	**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 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.**		
TORRES, Carla Elisse	Have you been named as a defendant, or been requested to respond as a defendant, to a legal action involving professional liability, malpractice, including any military tort claims if applicable? Please include: who, what, where (provide state) and when in the text box directly below this question.	Y	4/24/2017
TORRES, Carla Elisse	**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 email to elicensensbme@medboard.nv.gov.**		4/24/2017

TORRES, Carla Elisse	Have you had a professional liability, malpractice, claim paid on your behalf or paid such a claim yourself including any military tort claims if applicable? If "Yes" during the time period July 1, 2015 - June 30, 2017 type an explanation in the text box directly below this question.	N	4/24/2017
TORRES, Carla Elisse	**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.		
TORRES, Carla Elisse	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	4/24/2017
TORRES, Carla Elisse	**Explanation 6: For the above question if your answer is "Yes" for the time period July 1, 2015 - June 30, 2017, or since your last renewal, please type your brief explanation in this text box (Fields are space limited to 256 characters). Lengthy explanations or additional information may be faxed to 775-688-2551 or scanned and emailed to elicensensbme@medboard.nv.gov.**		
TORRES, Carla Elisse	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	4/24/2017
TORRES, Carla Elisse	**Explanation 7: For the above question if your answer is "Yes" for the time period July 1, 2015 - June 30, 2017, or since your last renewal, please type your brief explanation in this text box (Fields are space limited to 256 characters). Lengthy explanations or additional information may be faxed to 775-688-2551 or scanned and emailed to elicensensbme@medboard.nv.gov.**		
TORRES, Carla Elisse	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	4/24/2017
TORRES, Carla Elisse	**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, 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.		
TORRES, Carla Elisse	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	4/24/2017
TORRES, Carla Elisse	**Explanation 9: For the above question if your answer is "Yes" for the time period July 1, 2015 - June 30, 2017, or since your last renewal, please type your brief explanation in this text box (Fields are space limited to 256 characters). Lengthy explanations or additional information may be faxed to 775-688-2551 or scanned and emailed to elicensensbme@medboard.nv.gov.**		
TORRES, Carla Elisse	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	4/24/2017
TORRES, Carla Elisse	**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.**		
TORRES, Carla Elisse	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	4/24/2017
TORRES, Carla Elisse	**Explanation 11: For the above question if your answer is "Yes" for the time period July 1, 2015 – June 30, 2017, or since your last renewal, please type your brief explanation in this text box (Fields are space limited to 256 characters). Lengthy explanations or additional information may be faxed to 775-688-2551 or scanned and emailed to elicensensbme@medboard.nv.gov.**		
TORRES, Carla Elisse	Have you surrendered your state or federal controlled substance registration or had it revoked or restricted in any way?	N	4/24/2017
TORRES, Carla Elisse	**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.**		
TORRES, Carla Elisse	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	4/24/2017

TORRES, Carla Elisse	**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 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.**		
TORRES, Carla Elisse	Have you been denied membership, been asked to resign or expelled from a medical society or other professional medical organization?	N	4/24/2017
TORRES, Carla Elisse	**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 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.**		
TORRES, Carla Elisse	Have you actively practiced medicine in Nevada within the past 24 months?	Y	4/24/2017
TORRES, Carla Elisse	**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 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.**		
TORRES, Carla Elisse	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	4/24/2017
TORRES, Carla Elisse	**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	4/24/2017
		Y	4/24/2017

TORRES, Carla Elisse	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: 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."**		
TORRES, Carla Elisse	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, 2015 - June 30, 2017 type an explanation in the text box directly below this question.	N	4/24/2017
TORRES, Carla Elisse	**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.**		
TORRES, Carla Elisse	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	4/24/2017
TORRES, Carla Elisse	**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.**		
TORRES, Carla Elisse	I have completed the required amount of AMA Category 1 CME within the current biennial. I understand that I may be included in a random audit. I agree to retain CME's taken between July 1, 2015 and June 30, 2017. (Review CME information online at http://medboard.nv.gov/licensees/ce/) **If renewing to an Inactive status, CME is not required and "No" can be selected.**	Y	4/24/2017
TORRES, Carla Elisse	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	4/24/2017
TORRES, Carla Elisse	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	4/24/2017

PHYSICIAN
APPLICATION FOR REGISTRATION RENEWAL
FOR THE BIENNIAL REGISTRATION PERIOD 2019 – 2021
NEVADA STATE BOARD OF MEDICAL EXAMINERS
Phone: (775) 688-2559
Address: 9600 Gateway Drive Reno, Nevada 89521

Date Received by Board
RECEIVED
JUN 14 2019
NEVADA STATE BOARD OF MEDICAL EXAMINERS

License No. 16265

File No. _____ (For Board Use Only)

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

☒ ACTIVE STATUS ---------- $780.00

☐ INACTIVE STATUS ------- $405.00

SAVE $20 by renewing online at www.medboard.nv.gov

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

PLEASE NOTE THE FOLLOWING IMPORTANT INSTRUCTIONS REGARDING YOUR APPLICATION:

- Your current physician's license expires on **JULY 1, 2019**. If this form is not received by the Nevada State Board of Medical Examiners' (Board) office by July 1, 2019, at 5:00 p.m. PDT, your license will be automatically expired and you will not be able to practice medicine until you reinstate your license. **NEVADA HAS NO GRACE PERIOD**.
- Your license will not be renewed unless you answer **ALL** questions on this application and provide written explanation(s) for any/all question(s) answered "yes."
- Your license will not be renewed until the Board receives your original signed *Application for Registration Renewal* form. **A faxed copy is not acceptable.**
- Your license will not be renewed unless it is accompanied by a check or credit card authorization for the proper fee.
- You may have been selected in a random continuing medical education (CME) audit of all licensees. If you were randomly selected, you will be contacted by the Board for proof of your CME. Your license will not be renewed if you do not have proof of the required CME. Refer to page 5 for a review of your CME requirement. Please retain proof of your CME as the Board does not retain copies.
- All information provided on this application is **PUBLIC** information.
- If you select "INACTIVE STATUS," you are prohibited from practicing medicine and prohibited from writing prescriptions in the state of Nevada. Inactive licensees are not required to submit proof of CME.
- **PLEASE TYPE OR PRINT LEGIBLY.**

RENEWED
7/1/19 - 6/30/21
BIENNIAL

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

Name Carla Torres MD

Street PO Box 98978

City Las Vegas County Clark State NV

Zip 89193

Phone Number 702-216-3346 Cell Phone Number _____

Fax Number 702-671-6883 E-mail address fmc.credentialing@hcpnv.com

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

CARLA TORROE MD

Indicate any American Board of Medical Specialties Board Certification or Recertification:

01/16 Date of Initial Certification (Mo./Yr.) Date of Last Recertification (Mo./Yr.)

Board: American Board of Obstetrics & Gynecology

Subboard: Obstetrics and Gynecology

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

QUESTIONS

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

"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.

Please answer all of the following questions for the time period July 1, 2017 – July 1, 2019, or since your last renewal.

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

1. Do you currently have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety?
   ____Yes __X__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?
   ____Yes __X__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 __X__No ____N/A
4. Have you been named as a defendant, or been requested to respond as a defendant, to a legal action involving professional liability, or malpractice, including any military tort claims if applicable?
   ____Yes __X__No
5. Have you had a professional liability, malpractice, claim paid on your behalf, or paid such a claim yourself including any military tort claims if applicable?
   ____Yes __X__No
6. Have you been arrested, investigated for, charged with, convicted of, or pled guilty or nolo contendere to any offense or violation of any federal (including the Uniform Code of Military Justice), state or local law, or the laws of any foreign country, which is a misdemeanor, gross misdemeanor, felony, violation of the Uniform Code of Military Justice, or synonymous thereto in a foreign jurisdiction, excluding any minor traffic offense (driving or being in control of a motor vehicle while under the influence of a chemical substance, including alcohol, is not considered a minor traffic offense), or for any offense which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? *Please note that you MUST disclose ANY investigation or arrest, including those where the final disposition was dismissal, or expungement during this time period.
   ____Yes __X__No
7. Have you been denied a license, permission to practice medicine or any other healing art, or permission to take an examination to practice medicine or any other healing art in any state, country or U.S. territory?
   ____Yes __X__No

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

9. 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?
_____Yes _X_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 _X_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 _X_No

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

13. Have you had 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," 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 _X_No

14. Have you been denied membership, asked to resign, or expelled from a medical society or other professional medical organization?
_____Yes _X_No

15. I hereby 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.
_X_Yes _____No

16. Have you actively practiced medicine in Nevada within the past 24 months?
_X_Yes _____No

ATTESTATIONS / AFFIRMATIONS

CHILD SUPPORT STATEMENT

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

_X_ 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.

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

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.
_X_Yes _____No

http://www.leg.state.nv.us/NRS/NRS-432B.html#NRS432BSec220

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. X Yes ____ No

http://www.cdc.gov/injectionsafety/IP07_standardPrecaution.html

MILITARY SERVICE ATTESTATION

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

2-If yes, which branch of service did you serve?

- [X] Air Force
- [ ] Army
- [ ] Navy
- [ ] Marine Corps
- [ ] Coast Guard

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3-Military occupation specialty or specialties?

- [ ] Administration or Personnel
- [ ] Aviation
- [ ] Civil Engineering
- [ ] Communications
- [ ] Infantry or Armor
- [ ] Legal or Chaplin Corps
- [ ] Logistics or Supply
- [ ] Maintenance
- [X] Medical Services
- [ ] Security Forces or Military Police
- [ ] Other

4&5-Dates of service in the Military:

4-From: 01 / 06 / 2002 (DD / MM / YYYY) 5-To: 01 / 06 / 2022 (DD / MM / YYYY)

6-Are you still serving? X Yes _____ No

7-Have you ever served on active duty in the Armed Forces of the United States? X 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? ~~X~~ Yes X 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 X No

10-If your answer to question(s) 7, 8 and/or 9 is "Yes," did you separate from such service under conditions other than dishonorable? (Unless you were dishonorably discharged, your answer should be "Yes.") ____ Yes ____ No

BUSINESS LICENSE ATTESTATION

Do you hold a Nevada state business license issued in your individual name? ____ Yes X No

If yes, provide the business license number: _____

CONSCIOUS SEDATION, DEEP SEDATION, OR GENERAL ANESTHESIA ATTESTATION

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 procedure 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, then your answer should be "YES.")

X Yes _____ No

Forms and instructions are located on the Board's website: http://medboard.nv.gov/Forms/In-Office_Surgery/

COMMUNICATIONS AFFIRMATION

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.

Printed Name of Licensee: [redacted] Carla Torres

Signature of Licensee: _____

Electronic Mail Address: [redacted] carla.torresmd@gmail.com

CONTINUING EDUCATION

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ALL CONTINUING MEDICAL EDUCATION MUST HAVE BEEN COMPLETED DURING THE PERIOD OF JULY 1, 2017 THROUGH July 1, 2019. Please place a check mark next to the statement that applies to you.

✓ I was initially licensed in Nevada prior to July 1, 2017 or during the first 6 months of the biennial period of registration (July 1, 2017 through December 31, 2017) and have completed a minimum of forty (40) hours of AMA Category 1 continuing medical education (CME), two (2) hours of which were in medical ethics, pain management and/or addiction care, and twenty (20) hours of which were in my scope of practice or specialty. (At least 2 hours every 4 years must be on suicide detection, intervention and prevention.)

_____ I was initially licensed in Nevada during the second 6 months of the biennial period of registration (January 1, 2018 through June 30, 2018) and have completed a minimum of thirty (30) hours of AMA Category 1 CME, two (2) hours of which were in medical ethics, pain management and/or addiction care, and fifteen (15) hours of which were in my scope of practice or specialty. (At least 2 hours every 4 years must be on suicide detection, intervention and prevention.)

_____ I was initially licensed in Nevada during the third 6 months of the biennial period of registration (July 1, 2018 through December 31, 2018) and have completed a minimum of twenty (20) hours of AMA Category 1 CME, two (2) hours of which were in medical ethics, pain management and/or addiction care, and ten (10) hours of which were in my scope of practice or specialty. (At least 2 hours every 4 years must be on suicide detection, intervention and prevention.)

_____ I was initially licensed in Nevada during the fourth 6 months of the biennial period of registration (January 1, 2019 through July 1, 2019) and completed a minimum of ten (10) hours of AMA Category 1 CME, two (2) hours of which were in medical ethics, pain management and/or addiction care, and five (5) hours of which were in my scope of practice or specialty. (At least 2 hours every 4 years must be on suicide detection, intervention and prevention.)

_____ I am exempt from submitting proof of completion of CME because I have completed a full year of residency or fellowship training during the biennial period of July 1, 2017 through June 30, 2019. ***If you checked this statement, please attach a copy of proof of completion of your training.***

RENEWAL APPLICATION AFFIRMATION

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

_____ 4/27/19

Signature *(Stamp Unacceptable)* **Date**

NEVADA STATE BOARD OF MEDICAL EXAMINERS

Search

Licensee Details

Person Information	
Name:	Carla Elisse TORRES
Address:	PO Box 98978 Las Vegas NV 89193
Phone:	7022163346

License Information			
License Type:	Medical Doctor		
License Number:	16265	Status:	Active
Issue Date:	1/11/2016	Expiration Date:	6/30/2021

Scope of Practice

Scope of Practice: Obstetrics / Gynecology

Education & Training

School:	University of Texas Medical School / Houston, TX
Degree\Certificate:	Medical Doctor Degree
Date Enrolled:	
Date Graduated:	6/1/2002
Scope of Practice:	

School:	Keesler Medical Center / Biloxi, MS
Degree\Certificate:	Internship
Date Enrolled:	6/23/2002
Date Graduated:	6/24/2003
Scope of Practice:	Obstetrics/Gynecology

School:	Naval Medical Center / San Diego, CA
Degree\Certificate:	Residency
Date Enrolled:	6/24/2003
Date Graduated:	6/30/2006
Scope of Practice:	Obstetrics/Gynecology

School:	Obstetrics/Gynecology
Degree\Certificate:	American Board

Date Enrolled:	
Date Graduated:	12/12/2008
Scope of Practice:	Obstetrics/Gynecology

School:	Obstetrics/Gynecology
Degree\Certificate:	Am Bd Recertification
Date Enrolled:	
Date Graduated:	12/31/2009
Scope of Practice:	Obstetrics/Gynecology

School:	Obstetrics/Gynecology
Degree\Certificate:	Am Bd Recertification
Date Enrolled:	
Date Graduated:	12/31/2010
Scope of Practice:	Obstetrics/Gynecology

School:	Obstetrics/Gynecology
Degree\Certificate:	Am Bd Recertification
Date Enrolled:	
Date Graduated:	12/31/2011
Scope of Practice:	Obstetrics/Gynecology

School:	Obstetrics/Gynecology
Degree\Certificate:	Am Bd Recertification
Date Enrolled:	
Date Graduated:	12/16/2012
Scope of Practice:	Obstetrics/Gynecology

School:	Obstetrics/Gynecology
Degree\Certificate:	Am Bd Recertification
Date Enrolled:	
Date Graduated:	12/31/2013
Scope of Practice:	Obstetrics/Gynecology

School:	Obstetrics/Gynecology
Degree\Certificate:	Am Bd Recertification
Date Enrolled:	
Date Graduated:	12/31/2014
Scope of Practice:	Obstetrics/Gynecology

School:	Obstetrics/Gynecology
Degree\Certificate:	Am Bd Recertification
Date Enrolled:	
Date Graduated:	12/31/2015
Scope of Practice:	Obstetrics/Gynecology

CURRENT EMPLOYMENT STATUS/CONDITIONS/RESTRICTIONS ON LICENSE AND MALPRACTICE INFORMATION

PROFESSIONAL LIABILITY CLAIM, SETTLEMENT OR JUDGEMENT OF $5,000 OR MORE: 1)Date received by the Board: 8/23/18 Reported by: Airforce Date of act/omission: 3/3/15 Details: The patient claimed personal injury for permanent loss of one ovary and fallopian tube with a reduced chance for future child bearing, egregious pain-suffering. Extreme mental anguish and psychologic/physical trauma. lost wages, family disruption, missed career advancement opportunity resulting in diminished earnings, and violation of informed consent. Settlement amount: $75,000 Court Case Number:NA Total pages:0

Board Actions

NONE

Please note that the settlement of a medical malpractice action may occur for a variety of reasons that do not necessarily reflect negatively on the professional competence or conduct of the provider. Therefore, there may be no disciplinary action appearing for a licensee even though there is a closed malpractice claim on file. A payment in the settlement of medical malpractice does not create a presumption that medical malpractice occurred. Sometimes insurance companies settle a case without the knowledge and/or agreement of the physician. This database represents information from insurers to date. Please note: All insurers may not have submitted claim information to the Board.

Close Window