PHYSICIAN (M.D.)
APPLICATION FOR LICENSURE
NEVADA STATE BOARD OF MEDICAL EXAMINERS
9600 Gateway Drive, Reno, Nevada 89521
Phone (775) 688-2559

Date Received by Board
RECEIVED
OCT 21 2020
NEVADA STATE BOARD OF MEDICAL EXAMINERS

License No._____
File No._____

Identity:

1. Present Legal Name Bourne (Last) Christina (First) Marie (Middle) N/A (Maiden)

List any other name(s) ever used N/A

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 455 W. 5th St. (Street) Reno (City) Reno (County) NV (State) 89503 (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 (775) 688-5555 (Office) _____ (Fax) _____ (Home) _____ (Cellular (Optional))

Email address _____

5. Date of Birth ___ 11981e (Month / Day / Year) Place of Birth ___ Arizona (City, State, Country) ___ Gender X F ___M

6. Citizenship: U.S. Citizen X Alien Registration # _____ Employment Authorization # _____ Visa _____

Non U.S. Citizen (without the foregoing): Individual Taxpayer Identification Number (ITIN) _____

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. Non Citizens (without the foregoing) submit an Original ITIN assignment letter from the IRS. 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, however, AB275 (2019) provides that an applicant who does not have a social security number must provide an Individual Taxpayer Identification Number (ITIN) when completing an application for licensure.
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 X 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 X 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?

____Yes _X_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?

____Yes _X_No

Malpractice Explanation(s):

List of all claims or suits for medical malpractice made against you. A claim is any formal or informal demand for payment to any person or organization. If you have not answered "yes" to questions #12 and/or #12a and do not have any such claims or suits, this section will be left blank. If you have more than 1 claim, make a copy or copies of this page and submit all explanations with your application for licensure.

Name of patient involved:

In which state did the action take place?

Case number (if applicable):

Which court?
(If settled before initiation of civil action, state here.)

Current status of claim:

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

Date claim was closed/settled or dismissed: _____
Month/Year

Amount of judgment or settlement $

Month and year of event precipitating claim:

Month and year of lawsuit:

Insurance carrier at time:

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

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

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)
N/A		

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)
N/A		

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

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

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

(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)
USMLE Step 1	2	5/9/14 and 7/15/14	192(fail) and 214
USMLE Step 2 CK	1	8/28/15	225
USMLE Step 2 CS	1	8/4/2015	Pass
USMLE Step 3	1	2/23/2017	202

(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)
N/A		

21f. SPEX (Special Purpose Examination):

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

Specialty:

22. State your scope of practice / specialty(ies) family medicine and psychiatry

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.)
N/A				

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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 at 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 (%)
Residency	Sacramento, CA, Sacramento	6/2016-present	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.)
UCDavis Hospital	4860 Y St #1600 Sacramento, CA 95817	6/2016-present
Trust Women	5107 E. Kellogg DR. Wichita, KS 67218	6/2019-present

(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
California	CA-A150575	4/2017	active
Oklahoma	OK-34798	6/2019	active
Kansas	KS-04-4524	6/2019	active

(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? ____Yes X No

(If "Yes," attach explanation on separate sheet.)

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 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:

__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

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

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: Christina Bourne

Signature of Applicant/Licensee. _____

Electronic Mail Address: _____

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.

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

3-Military occupation specialty or specialties?
- ☐ Administration or Personnel
- ☐ Aviation
- ☐ Civil Engineering
- ☐ Communications
- ☐ Infantry or Armor
- ☐ Legal or Chaplin Corps
- ☐ Logistics or Supply
- ☐ Maintenance
- ☐ Medical Services
- ☐ Security Forces or Military Police
- ☐ 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

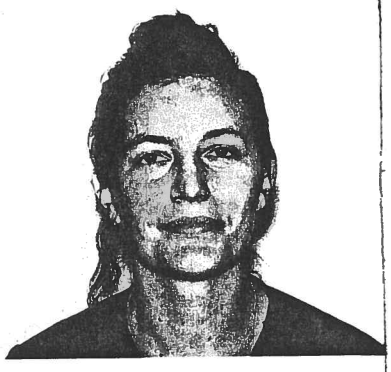
9-Have you ever served the Commissioned Corps of the United States Public Health Service or the Commissioned Corps of the National Oceanic and Atmospheric Administration of the United States in the capacity of a commissioned officer while on active duty in defense of the United States? _____Yes _____No

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 _____N/A

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.

_____ _____ 10/13/2020
Signature of applicant Date

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APPLICATION AFFIRMATION

I, Christina Bourne,
(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.

_____ _____ 10/20/2020
Signature of applicant **Date**

(NOTARY SEAL)

See Attached For Notary Public

State of _____ County of _____
Subscribed and sworn to before me this _____ day of
_____, 2_____
Notary Public for the State of _____
My Commission Expires: _____
Residing at: _____
City State

_____
Signature of Notary

END OF APPLICATION

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JURAT

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California

County of Sacramento

Subscribed and sworn to (or affirmed) before me on this 20 day of October, 2020 by Christina Bourne,

proved to me on the basis of satisfactory evidence to be the person~~(s)~~ who appeared before me.

ERIKA RAMOS
Comm. #2279998
Notary Public·California
Sacramento County
Comm. Expires Mar 8, 2023

Signature (Seal)

OPTIONAL INFORMATION

DESCRIPTION OF THE ATTACHED DOCUMENT

Application
(Title or description of attached document)

Affirmation
(Title or description of attached document continued)

Number of Pages ____ Document Date ____

Additional information

INSTRUCTIONS

The wording of all Jurats completed in California after January 1, 2015 must be in the form as set forth within this Jurat. There are no exceptions. If a Jurat to be completed does not follow this form, the notary must correct the verbiage by using a jurat stamp containing the correct wording or attaching a separate jurat form such as this one with does contain the proper wording. In addition, the notary must require an oath or affirmation from the document signer regarding the truthfulness of the contents of the document. The document must be signed AFTER the oath or affirmation. If the document was previously signed, it must be re-signed in front of the notary public during the jurat process.

- State and county information must be the state and county where the document signer(s) personally appeared before the notary public.
- Date of notarization must be the date the signer(s) personally appeared which must also be the same date the jurat process is completed.
- Print the name(s) of the document signer(s) who personally appear at the time of notarization.
- Signature of the notary public must match the signature on file with the office of the county clerk.
- The notary seal impression must be clear and photographically reproducible. Impression must not cover text or lines. If seal impression smudges, re-seal if a sufficient area permits, otherwise complete a different jurat form.
  - ❖ Additional information Is not required but could help to ensure this jurat is not misused or attached to a different document.
  - ❖ Indicate title or type of attached document, number of pages and date.
- Securely attach this document to the signed document with a staple.

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FORM D

REQUEST FOR LICENSURE BY A RESIDENT

(You must be currently enrolled in an approved postgraduate training program.)

ONLY complete this form if you are currently enrolled in a postgraduate training program, have completed at least 24 months of progressive postgraduate training and meet all requirements for an unlimited license in the state of Nevada, including having passed all 3 steps of USMLE within the time period allowed by NAC 630.080.

Acknowledgement of statutory requirements NRS 630.160

I, Christina Bourne, am a Resident who is enrolled in a progressive postgraduate
(print your name)
training program in the United States or Canada, approved by the Board, the Accreditation Council for Graduate Medical Education or the Coordinating Council of Medical Education of the Canadian Medical Association, and have completed at least 24 months of the program, and now commit in writing to the Nevada State Board of Medical Examiners (Board) that I will complete the program; and I hereby acknowledge that I will provide or cause to be provided to the Board proof of satisfactory completion of the program within sixty (60) days after the scheduled completion of the program.

If, after issuing a license to practice medicine to me, the Board obtains information from a primary or other source of information, and that information differs from the information provided by me (the applicant) or otherwise received by the Board, or if I fail to provide or cause to be provided to the Board proof of satisfactory completion of the program within sixty (60) days after the scheduled completion of the program, the Board may take action pursuant to Sections 4 and 5 of NRS 630.160, as well as any other disciplinary action deemed appropriate.

Applicant Signature

10/20/2020
Date

See Attached For Notary Public

(NOTARY SEAL)

State of _____ County of _____

Subscribed and sworn to before me this _____ day of

_____, 2_____.

Notary Public for the State of California

My Commission Expires: March 8, 2023

Residing at: Sacramento, CA
City State

_____
Signature of Notary

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OCT 21 2020
NEVADA STATE BOARD OF MEDICAL EXAMINERS

JURAT

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California

County of Sacramento

Subscribed and sworn to (or affirmed) before me on this 20 day of October, 2020 by Christina Bourne,

proved to me on the basis of satisfactory evidence to be the person~~(s)~~ who appeared before me.

ERIKA RAMOS
Comm. #2279998
Notary Public·California
Sacramento County
Comm. Expires Mar 8, 2023

Signature (Seal)

OPTIONAL INFORMATION

DESCRIPTION OF THE ATTACHED DOCUMENT

Request For Licensure
(Title or description of attached document)

By a Resident
(Title or description of attached document continued)

Number of Pages ____ Document Date____

Additional information

INSTRUCTIONS

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- Date of notarization must be the date the signer(s) personally appeared which must also be the same date the jurat process is completed.
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- Signature of the notary public must match the signature on file with the office of the county clerk.
- The notary seal impression must be clear and photographically reproducible. Impression must not cover text or lines. If seal impression smudges, re-seal if a sufficient area permits, otherwise complete a different jurat form.
  - ❖ Additional information Is not required but could help to ensure this jurat is not misused or attached to a different document.
  - ❖ Indicate title or type of attached document, number of pages and date.
- Securely attach this document to the signed document with a staple.

ATTENTION APPLICANT!

RESPONSIBILITY STATEMENT

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 Christina Bourne

Sign your name _____

Date 10/13/2020

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.