# STATE OF NEVADA
# BOARD OF MEDICAL EXAMINERS
# APPLICATION FOR LICENSURE

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1. Name Ball (Last) Stephanie (First) NMN (Middle) (Maiden)

If you have ever used another name, please indicate

2. Business and/or Mailing Address P.O. Box 5800, Org. 3320 (Street #), Albuquerque (City), NM (State) 87185 (Zip)

3. Home Address (Street #) (City) (State) (Zip)

4. Telephone Number (505) 845-8039 (Office) ( ) (Home)

5. Date of Birth 3/ '56 Place of Birth Indiana, USA

6. Citizenship: US Citizen Yes Alien Registration # Other
Submit a certified copy of birth certificate, Certificate of Naturalization and/or Alien Registration Card with this application.

7. Have you ever previously applied for medical licensure in Nevada? ☐ Yes ☒ No

If YES, give date of previous application

8. List name and address of all colleges or universities attended other than schools where professional medical instruction was received. Have each school submit an official transcript directly to the board.

| Name | Address | Dates of Attendance | |
|---|---|---|---|
| | | From (Mo/Yr) | To (Mo/Yr) |
| University of NV Reno | Reno, NV 89557 | ~~8~~/73 | 5/81 |
| Western NV Community College | 7000 Dandini Blvd, Reno, NV 89512 | 7/76 | 5/78 |
| UC Davis | Davis, CA 95616 | ~~7/79~~ 7/80 | ~~8/79~~ 8/80 SB |
| Rutgers University | New Brunswick, NJ 08901 | 8/79 | 5/80 |
| Reed College | 3203 SE Woodstock Blvd, Portland, OR 97202-8199 | 8/75 ~~8/74~~ | ~~12/75~~ SB 12/74 |

9. List name and address of all schools where professional medical instruction was received. Have each school submit an official transcript directly to the board.

| Name | Address | Place Where Instruction Received | Dates of Attendance | |
|---|---|---|---|---|
| | | | From (Mo/Yr) | To (Mo/Yr) |
| University of Nevada School of Medicine | Reno, NV 89557 | Reno, NV | 7/81 | 5/85 |
| | | | | |

10. Doctor of Medicine Degree granted by:

| Name of Medical School | Address of Medical School | Exact Date of Issuance |
|---|---|---|
| University of Nevada School of Medicine | Reno, NV 89557 | 5/18/85 |

11. Have you taken any part of the National Boards? ☒ Yes ☐ No If YES, list location, parts taken, date and score(s). Have certificate of scores submitted from National Boards to the board.

| Location | Part Taken | Date | Result (Score(s)) |
|---|---|---|---|
| 538 U. Nevada | Part I | Sept 8-9, 1982 | PASS |
| 515 U.C. Davis | Part II | Sept 25-26, 1984 | 530 - PASS |
| 539 U. New Mexico | Part III | Mar 5, 1986 | 605 - PASS |

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12. Have you taken SPEX or any part of the FLEX? ☐ Yes ☒ No If YES, list location, parts taken, date and score(s). Have certificate of scores submitted from FLEX/SPEX directly to the board.

| Location | Part Taken | Date | Result (Score(s)) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

13. Have you taken any part of ECFMG or FMGEMS? ☐ Yes ☒ No If YES, list part(s) taken, location, date and result(s) of examination. Have certification of examination(s) submitted from the ECFMG directly to the board. List ECFMG #_____

| Location | Part Taken | Date | Result (Score(s)) |
|---|---|---|---|
| | | | |
| | | | |

14. Have you received ACGME* approved postgraduate training in the United States or Canada? ☒ Yes ☐ No If YES, fill in the information requested below.
*Accreditation Council on Graduate Medical Education

| Hospital/ Institution | Mailing Address | Type of Service or Specialty | Dates of Attendance | |
|---|---|---|---|---|
| | | | From (Mo/Yr) | To (Mo/Yr) |
| University of NM Hosp. | 2211 Lomas, NE Albuquerque, NM | Internal Medicine | 5/85 | 8/88 |
| | | | | |
| | | | | |
| | | | | |

15. Have you completed any ACGME*approved Fellowship programs? ☐ Yes ☒ No If YES, fill in the information requested below.

| Institution | Mailing Address | Type of Fellowship | Dates of Attendance | |
|---|---|---|---|---|
| | | | From (Mo/Yr) | To (Mo/Yr) |
| | | | | |

16. List any other postgraduate medical education not accounted for in questions 14 and 15 above.

| Institution | Mailing Address | Type of Service or Specialty | Dates of Attendance | |
|---|---|---|---|---|
| | | | From (Mo/Yr) | To (Mo/Yr) |
| | | | | |
| | | | | |

17. Area of Specialty: Internal Medicine
18. Are you Board Certified by a Board recognized by the American Board of Medical Specialties? ☒ Yes ☐ No If YES, complete the following:

| Specialty Board | Certification # | Dates of: | |
|---|---|---|---|
| | | Certification | Recertification |
| American Board of Internal Medicine | 121534 | 9/13/89 | |
| | | | |

29. Have you ever been denied membership or expelled from a medical society or other professional medical organization? ☐ Yes ☒ No

30. Have you ever received psychiatric or psychologic treatment? ☒ Yes ☐ No

31. Have you ever undergone treatment for a mental illness, drug addiction, or acute or chronic substance, drug or alcohol abuse? ☒ Yes ☐ No

32. Do you regularly take any prescription drugs for therapeutic purposes? ☐ Yes ☒ No

33. Have you ever surrendered your state or federal controlled substance registration or had it restricted in any way? ☐ Yes ☒ No

34. Are you now or were you in the past, addicted to controlled substances, including, but not limited to narcotics or alcohol? ☒ Yes ☐ No

35. Have you ever been investigated for, charged or convicted of, or pled nolo contendere to a violation of any federal, state or local law relating to the manufacture, distribution, or dispensing of controlled substances, or to drug addiction? ☐ Yes ☒ No

36. Have you ever been arrested, investigated for, charged or convicted of, or pled nolo contendere to any offense, misdemeanor or felony in any state, the United States, or a foreign country? (Except violations of traffic laws resulting in fines of $75 or less.) ☐ Yes ☒ No

NOTE: You are required to list any conviction that has been set aside and dismissed under any other provision of law.

**If you answered YES to any of questions 22 through 36 please explain the circumstances and disposition on a separate sheet(s) and attach to this application.**

37. If granted a license, do you intend to practice in Nevada? ☒ Yes ☐ No POSSIBLY.

If YES: Location PART-TIME, TONOPAH & NEVADA TEST SITE Date 1991

38. Personal Information

Age ___ Height ___ Weight ___ lb Color of Eyes ___

Color of Hair ___ Social Security Number ___

39. I, ___, being duly sworn, depose and say: That the answers to the foregoing questions and statements made in the above application 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. It is understood by me, that if any part of this application is found to be false or fraudulent, that I forfeit the right to a medical license in the State of Nevada.

Signature of Applicant

OFFICIAL SEAL
M. JEAN LOPEZ
NOTARY PUBLIC STATE OF NEW MEXICO
Notary Bond Filed with Secretary of State
My Commission Expires 2/17/92

(Notary Seal)

Subscribed and sworn to before me this 31st day of August, 1990

Notary Public for State of New Mexico

My Commission Expires 2/17/92

Residing at Albuquerque, N. M.

M. Jean Lopez

19. Location of medical practice since graduation (Include Military Service). Account for all periods of time.

| City/State | From (Mo/Yr) | To (Mo/Yr) |
|---|---|---|
| Albuquerque, NM | 8/88 | present |
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20. List below the requested information for **all** hospitals of which you are, or have ever been a Staff Member at any level. If none, please indicate. Do not list internship or residency affiliation.

| Hospital | Complete Mailing Address | Date of Appointment | |
|---|---|---|---|
| | | From (Mo/Yr) | To (Mo/Yr) |
| Lovelace Medical Center | 5400 Gibson Blvd, SE<br>Albuquerque, NM 87108 | 6/89 | 4/90 |
| Univ. of NM Hospital | 2211 Lomas Blvd, NE<br>Albuquerque, NM 87106 | 7/87 | 5/89 |
| Veteran's Admin. MC | 2100 Ridgecrest Dr., SE<br>Albuquerque, NM 87108 | 10/86 | 1/89 |
| Vista Sandia Hosp. (closed) | 501 Ridgefield Avenue, NE<br>Albuquerque, NM 87113 | 6/87 | 11/87 |
| Clovis High Plains Hosp. | 2100 N. Thomas<br>Clovis, NM 87101 | 12/86 | 12/86 |

21. Have you ever been licensed to practice medicine in any state or country? ☒ Yes ☐ No If YES, complete the following information:

| State or Country | License # | Date of Issuance | Dates of Practice in Agency's Jurisdiction | |
|---|---|---|---|---|
| | | | From (Mo/Yr) | To (Mo/Yr) |
| New Mexico | 86-368 | 11/17/86 (original)<br>5/21/90 (renewal) | 11/86 | present |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

22. Have any disciplinary or administrative actions ever been taken against any healing arts license which you now hold or have ever held? Include any disciplinary and administrative actions by the U.S. Military, U.S. Public Health Service or other U.S. federal government entity. ☐ Yes ☒ No

23. Have you ever been denied a license, permission to practice medicine or any other healing arts, or permission to take an examination to practice medicine or any other healing art in any state, country or U.S. territory? ☐ Yes ☒ No

24. Have you ever had a medical license revoked, suspended, or limited in any state, country or U.S. territory? ☒ Yes ☐ No

25. Have you ever voluntarily surrendered a license to practice in the healing arts in any state, country or U.S. territory? ☐ Yes ☒ No

26. Have you ever failed a state licensure examination, any part of FLEX, any part of National Boards, or any part of ECFMG, FMGEMS or SPEX, even if subsequently passed? ☐ Yes ☒ No

27. Have you ever had staff privileges in a hospital denied, suspended, limited, revoked or not renewed, or have you ever resigned from a medical staff in lieu of disciplinary or administrative action? (PLEASE NOTE: THIS REQUIREMENT DOES NOT INCLUDE SUSPENSIONS OR RESTRICTIONS FOR FAILURE TO COMPLETE HOSPITAL MEDICAL RECORDS) ☐ Yes ☒ No

28. Have you ever been investigated for, charged with, or convicted of unprofessional conduct, professional incompetence, gross or repeated malpractice, or any other violation of a statute, rule or regulation governing the practice of medicine by any medical licensing board or other agency, hospital or medical society? ☐ Yes ☒ No

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I hereby certify that the attached photograph is a true likeness of myself taken within the last 60 days.

Signature of Applicant

8-31-90

Date

NOTE: All items in this application are mandatory; none are voluntary. Failure to provide any of the requested information will result in the application not being processed or being rejected as incomplete. The information provided will be used for identification and to determine qualification for licensure per Nevada Revised Statute 630 which authorizes the collection of this information.

# INSTRUCTIONS

The Application, and Form A, are to be completed by the applicant, notarized as indicated, and returned to the Nevada State Board of Medical Examiners.

Forms 1 thru 6, are to be completed by the agencies or individuals indicated. It is the responsibility of the applicant to see that these are promptly returned. The completed application must be received 45 days before any examination will be administered. The forms should be separated and mailed individually, then must be returned directly to the Nevada State Board of Medical Examiners by the agencies or individuals responsible for their completion. If additional copies of any forms are needed, please photocopy.

If additional space is required for answers, separate sheets may be attached to application.

No application will be processed prior to receipt of all required fees. See fee schedule on enclosed sheet.

Application fees are non-refundable.

Please submit the application and Form A along with all required fees to:

Nevada State Board of Medical Examiners
P. O. Box 7238
Reno, NV 89510
(702) 329-2559

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**APPLICANT**
**Do Not Write In This Box**
**For Use At Time Of Interview**

I verify that all statements made on my application for licensure in the State of Nevada received on 09-24-90, are still true and valid on 12-1-90, the date of my oral examination

Signed: _____

Witness: Rebecca Tom Cain
(Board Member)

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MEDICAL EXAMINERS

# N O T I C E

**FAILURE TO RETURN THIS FORM CAN RESULT IN THE DELAY OF YOUR APPLICATION FOR LICENSURE**

(1)
Have you taken the Special Purpose Examination (SPEX)? ___yes X no

If answer is yes, please indicate date taken_____

(2)
Have you taken all parts of the examination given by the National Board of Medical Examiners? X yes ___no

If answer is yes, indicate date Part III taken 03/05/86

(3)
Have you taken Component II of the Federal Licensing Examination (FLEX) within the last eight (8) years? ___yes X no

If answer is yes, please indicate date taken_____

(4)
Have you taken the written part of the examination for certification or recertification by a specialty board of the American Board of Medical Specialties? X yes ___no

If answer is yes, please indicate date taken Sept. 12-13, 1989

_____ 9-3-90
Signature of Applicant Date

PHYSICIAN

**APPLICATION FOR REGISTRATION RENEWAL**
**FOR THE BIENNIAL REGISTRATION PERIOD 2005 - 2007**
**NEVADA STATE BOARD OF MEDICAL EXAMINERS**

Post Office Box 7238 Reno, Nevada 89510 Phone (775) 688-2559
Physical Address: 1105 Terminal Way, Suite 301 Reno, Nevada 89502

Date Received by Board
MAR 2 1 2005
(For Board Use Only)

License No. 6164
File No. [illegible]
12/1/90

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

__X__ ACTIVE STATUS $600.00
_____ INACTIVE STATUS $300.00.....(*INACTIVE STATUS DOES NOT PERMIT THE PRACTICE OF MEDICINE INCLUDING THE WRITING OF PRESCRIPTIONS IN NEVADA*)
_____ I REQUEST NON-RENEWAL OF MY LICENSE*
(*IF YOU ARE REQUESTING NON-RENEWAL, SEE BELOW)

BALL, Stephanie
Sandia National Laboratories
Mailstop 9112
Livermore CA 94550

Make checks payable to:
**NEVADA STATE BOARD OF MEDICAL EXAMINERS**
(Foreign checks must indicate "U.S. FUNDS")

## *Request for NON-RENEWAL of License to Practice Medicine In Nevada*

**I hereby represent that I am the person named in this *APPLICATION FOR REGISTRATION RENEWAL* of license to practice medicine in the state of Nevada.**

**By signing on the signature line below, I am requesting that my license to practice medicine in Nevada NOT be renewed by the Nevada State Board of Medical Examiners. I will return this signed form to the Board office.**

Date _____ Signature **(SIGNATURE STAMP UNACCEPTABLE)** _____

## *PLEASE NOTE:*

- **YOUR CURRENT M.D. LICENSE EXPIRES ON JUNE 30, 2005. COMPLETED *APPLICATION FOR REGISTRATION RENEWAL* FORMS NOT RECEIVED AT THE BOARD OFFICE BY JULY 1, 2005 AT 5:00 P.M. ARE AUTOMATICALLY SUSPENDED FOR NON-PAYMENT. EXTENSIONS OF TIME ARE NOT ALLOWED FOR ANY REASON, AS NEVADA HAS NO GRACE PERIOD. (USE THE ENCLOSED ENVELOPE TO MAIL YOUR COMPLETED *APPLICATION FOR REGISTRATION RENEWAL* FORM.)**
- **YOUR LICENSE WILL NOT BE RENEWED UNLESS YOU ANSWER ALL QUESTIONS ON THIS *APPLICATION FOR REGISTRATION RENEWAL* FORM. YOU MUST PROVIDE WRITTEN EXPLANATIONS FOR ALL QUESTIONS ANSWERED "YES."**
- **ALL INFORMATION YOU PROVIDE ON THIS *APPLICATION FOR REGISTRATION RENEWAL* FORM IS PUBLIC INFORMATION.**

## PLEASE TYPE OR PRINT LEGIBLY

1. Active status registration renewal requires the submission of proof of completion of 44 hours of AMA Category 1 continuing medical education (CME), which includes 2 hours of CME in medical ethics and 20 hours of CME in your scope of practice or specialty **completed during the period July 1, 2003 through June 30, 2005**. Additionally, pursuant to Nevada Revised Statutes (NRS) 630.253(2)(b), an applicant must complete a course of instruction relating to the medical consequences of an act of terrorism that involves the use of a weapon of mass destruction. "The course must provide at least 4 hours of instruction that includes instruction in the following subjects: (1) An overview of acts of terrorism and weapons of mass destruction; (2) Personal protective equipment required for acts of terrorism; (3) Common symptoms and methods of treatment associated with exposure to, or injuries caused by, chemical, biological, radioactive and nuclear agents; (4) Syndromic surveillance and reporting procedures for acts of terrorism that involve biological agents; and (5) An overview of the information available on, and the use of, the Health Alert Network." Submit your proof of completion of CME with your completed *Application for Registration Renewal* form. (See last page of this form for CME statement.)

2. If your name and/or address has changed from that printed on the label on this form, clearly indicate the change in the space provided below. Also, please indicate your current telephone and fax numbers. [Please note: a notarized or certified copy of the document authorizing your name change (marriage license, divorce decree, etc.) must be included.]

Name _____
Street _____
City _____ County _____ State _____ Zip _____
Phone Number 925-294-2700 Fax Number 925-294-2392

3. **IF YOU HAVE RETIRED OR MOVED YOUR PRACTICE,** indicate the location of patient records below:

Name_____

Street_____

City_____ County_____ State_____ Zip_____

Phone Number_____

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

## SCOPES OF PRACTICE CODES

1 ADDICTION MEDICINE
2 ADOLESCENT MEDICINE
3 AEROSPACE MEDICINE
4 ALLERGY
5 ALLERGY/IMMUNOLOGY
6 AMBULATORY MEDICINE
7 ANESTHESIOLOGY
8 BLOODBANKING
9 BRONCO-ESOPHAGOLOGY
10 CARDIOVASCULAR DISEASES
11 CATSCAN/ULTRASOUND
12 CHILD NEUROLOGY
13 CHILD PSYCHIATRY
14 CLINICAL PHARMACOLOGY
15 CRITICAL CARE
16 DERMATOLOGY
17 DERMATOPATHOLOGY
18 EMERGENCY MEDICINE
19 ENDOCRINOLOGY
20 FAMILY PRACTICE
21 FORENSIC MEDICINE
22 GASTROENTEROLOGY
23 GENERAL PRACTICE
24 GERIATRIC PSYCHIATRY
25 GERIATRICS
26 GYNECOLOGY
27 HAIR TRANSPLANTATION
28 HEMATOLOGY
29 HOMEOPATHY
30 HYPNOSIS
31 IMMUNOLOGY
32 INFECTIOUS DISEASES
33 INFERTILITY
34 INTERNAL MEDICINE
35 LARYNGOLOGY
36 LEGAL MEDICINE
37 MATERNAL/FETAL MEDICINE
38 MEDICAL ACUPUNCTURE
39 MEDICAL ETHICS
40 MEDICAL GENETICS
41 NEO/PERINATAL MEDICINE
42 NEOPLASTIC DISEASES
43 NEPHROLOGY
44 NEUROLOGY
45 NEURO-OPHTHALMOLOGY
46 NEUROPATHOLOGY
47 NEURORADIOLOGY
48 NEUROTOLOGY
49 NON-CONVENTIONAL MEDICINE
50 NUCLEAR MEDICINE
51 NUTRITION
52 OBSTETRICS
53 OBSTETRICS/GYNECOLOGY
54 OCCUPATIONAL MEDICINE
55 ONCOLOGY
56 ONCOLOGY, GYNECOLOGICAL
57 ONCOLOGY, HEMATOLOGY
58 ONCOLOGY, RADIATION
59 ONCOLOGY, SURGICAL
60 OPHTHALMOLOGY
61 OTOLARYNGOLOGY
62 OTOLOGY
63 PAIN MANAGEMENT
64 PATHOLOGY
65 PATHOLOGY, ANATOMIC
66 PATHOLOGY, CLINICAL
67 PATHOLOGY, FORENSIC
68 PEDIATRIC, ALLERGY
69 PEDIATRIC, ANESTHESIOLOGY
70 PEDIATRIC, CARDIOLOGY
71 PEDIATRIC, CRITICAL CARE
72 PEDIATRIC, EMERGENCY MEDICINE
73 PEDIATRIC, ENDOCRINOLOGY
74 PEDIATRIC, GASTROENTEROLOGY
75 PEDIATRIC, HEMATOLOGY/ONCOLOGY
76 PEDIATRIC, INFECTIOUS DISEASES
77 PEDIATRIC, INTENSIVIST
78 PEDIATRIC, NEPHROLOGY
79 PEDIATRIC, NEUROLOGY
80 PEDIATRIC, OPHTHALMOLOGY
81 PEDIATRIC, PHYSIATRY
82 PEDIATRIC, PULMONARY
83 PEDIATRIC, RADIOLOGY
84 PEDIATRIC, RHEUMATOLOGY
85 PEDIATRIC, SURGERY
86 PEDIATRIC, UROLOGY
87 PEDIATRICS
88 PHYSICAL MEDICINE/REHABILITATION
89 PREVENTIVE MEDICINE
90 PSYCHIATRY
91 PSYCHOANALYSIS
92 PSYCHOMATIC MEDICINE
93 PUBLIC HEALTH
94 PULMONARY DISEASES
95 OCCUPATIONAL MEDICINE
96 RADIOLOGY
97 RADIOLOGY, DIAGNOSTIC
98 RADIOLOGY, INTERVENTIONAL
99 RADIOLOGY, NUCLEAR
100 RADIOLOGY, THERAPEUTIC
101 RADIOLOGY, VASCULAR
102 RHEUMATOLOGY
103 RHINOLOGY
104 SLEEP DISORDERS
105 SPORTS MEDICINE
106 SURGERY, ABDOMINAL
107 SURGERY, CARDIOTHORACIC
108 SURGERY, CARDIOVASCULAR
109 SURGERY, COLON/RECTAL
110 SURGERY, CRANIOFACIAL
111 SURGERY, GENERAL
112 SURGERY, HAND
113 SURGERY, HEAD/NECK
114 SURGERY, MAXILLOFACIAL
115 SURGERY, NEUROLOGICAL
116 SURGERY, ORTHOPEDIC
117 SURGERY, PLASTIC
118 SURGERY, THORACIC
119 SURGERT, TRANSPLANT
120 SURGERY, TRAUMATIC
121 SURGERY, UROLOGIC
122 SURGERY, VASCULAR
123 TOXICOLOGY
124 TRANSPLANTATION
125 URGENT CARE
126 UROLOGY

**Primary Scope of Practice** Code: 54

**Secondary Scope of Practice** Code: _____

**PLEASE INDICATE AMERICAN BOARD OF MEDICAL SPECIALTIES BOARD CERTIFICATION & RECERTIFICATION**

**Board** AMERICAN BOARD OF INTERNAL MEDICINE — **Date of Initial Certification** 09/1989 (Mo./Yr.) — **Date of Last Recertification** _____ (Mo./Yr.)

**Subboard** _____ (Mo./Yr.) _____ (Mo./Yr.)

## All of the following questions refer to the time period July 1, 2003, through the present date only.

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

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

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

3. The physical capability to perform medical tasks such as physician examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

**"Medical condition"** includes physiological, mental or psychological conditions or disorders, such as, but not limited to, orthopedic, vision, speech, hearing, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, emotional or mental illness, HIV disease, tuberculosis, drug addiction, and alcoholism.

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

## FOR ALL "YES" RESPONSES TO THE FOLLOWING QUESTIONS, YOU MUST SUBMIT YOUR WRITTEN EXPLANATION(S) ON A SEPARATE SHEET ATTACHED TO YOUR COMPLETED *APPLICATION FOR REGISTRATION RENEWAL* FORM.

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

_____Yes __X__No

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

_____Yes _____No __X__N/A

3. If you use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety?

_____Yes __X__No _____N/A

4. Have you failed to initiate the performance of public service within one year after the date the public service is required to begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local government for your medical education?

_____Yes __X__No _____N/A

5. Have you been a defendant in a legal action involving professional liability (malpractice) or had a professional liability claim paid in your behalf or paid such a claim yourself?

_____Yes __X__No

6. Have you ever been investigated for, charged with, convicted of, or plead guilty or nolo contendere to any offense or violation of any federal, state or local law, including any foreign country, which is a misdemeanor, gross misdemeanor, or felony, excluding any minor traffic offense (driving or in control of a motor vehicle while under the influence of any chemical substance is **not** considered **a minor traffic offense**) or which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances?

_____Yes __X__No

7. 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? _____Yes __X__No

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

_____Yes __X__No

9. Have you ever voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory?

_____Yes __X__No

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

_____Yes __X__No

11. Have you ever been: a) notified that you were under investigation for; b) investigated for; c) charged with; or d) convicted of any violation of a statute, rule or regulation governing your practice as a physician by any medical licensing board, hospital, medical society, governmental entity or other agency other than the Nevada State Board of Medical Examiners?

_____Yes __X__No

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

_____Yes __X__No

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

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

## CHILD SUPPORT STATEMENT

**Please place a check mark next to one of the following statements:**

_____ (a) I am not subject to a court order for the support of a child;

__X__ (b) I am subject to a court order for the support of one or more children and am in compliance with a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order; **OR**

_____ (c) I am subject to a court order for the support of one or more children and am NOT in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

## CONTINUING MEDICAL EDUCATION (CME) STATEMENT

**Please place a check mark next to one of the following statements:**

__X__ (a) I completed a minimum of 44 hours of AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics and 20 hours of which were in my scope of practice or specialty, and an additional 4 hours of AMA Category 1 continuing medical education in acts of terrorism, during the past biennial period of July 1, 2003 through June 30, 2005;

_____ (b) I was initially licensed in Nevada during the time period January 1, 2004 through June 30, 2004, the second six months of the past biennial period, and completed a minimum of 34 hours of AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics and 20 hours of which were in my scope of practice or specialty, and an additional 4 hours of AMA Category 1 continuing medical education in acts of terrorism;

_____ (c) I was initially licensed in Nevada during the time period July 1, 2004 through December 31, 2004, the third six months of the past biennial period, and completed a minimum of 24 hours of AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics and 18 hours of which were in my scope of practice or specialty, and an additional 4 hours of AMA Category 1 continuing medical education in acts of terrorism;

_____ (d) I was initially licensed in Nevada during the time period January 1, 2005 through June 30, 2005, the fourth six months of the past biennial period, and completed a minimum of 14 hours of AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics and 8 hours of which were in my scope of practice or specialty, and an additional 4 hours of AMA Category 1 continuing medical education in acts of terrorism; **OR**

_____ (e) I am exempt from submitting proof of completion of continuing medical education (CME) because I have completed a full year of residency or fellowship training during the biennial period July 1, 2003 through June 30, 2005.

- **ATTACH COPIES OF PROOF OF YOUR COMPLETION OF CONTINUING MEDICAL EDUCATION (CME) HOURS.**
- **IF YOU COMPLETED A FULL YEAR OF RESIDENCY OR FELLOWSHIP TRAINING DURING THE BIENNIAL PERIOD JULY 1, 2003 THROUGH JUNE 30, 2005, ATTACH A COPY OF PROOF OF COMPLETION OF YOUR TRAINING.**
- **YOUR COPIES OF PROOF OF CME OR TRAINING COMPLETION WILL NOT BE RETURNED TO YOU.**

**I HAVE __X__ HAVE NOT _____ *(CHECK ONE)* ACTIVELY PRACTICED MEDICINE IN NEVADA WITHIN THE PAST 12 MONTHS.**

**BY SIGNING ON THE SIGNATURE LINE BELOW:**

1) **I HEREBY REPRESENT THAT I AM THE PERSON NAMED IN THIS *APPLICATION FOR REGISTRATION RENEWAL* OF LICENSE TO PRACTICE MEDICINE IN THE STATE OF NEVADA AND THAT ALL STATEMENTS I HAVE MADE HEREIN ARE TRUE;**

2) **I UNDERSTAND THAT THIS *APPLICATION FOR REGISTRATION RENEWAL* WILL BE DENIED IF I HAVE NOT PLACED A CHECK MARK NEXT TO (a), (b), OR (c) UNDER THE CHILD SUPPORT STATEMENT SECTION; AND**

3) **I UNDERSTAND THAT THIS *APPLICATION FOR REGISTRATION RENEWAL* WILL BE DENIED IF I HAVE NOT ANSWERED ALL QUESTIONS THEREON AND/OR ATTACHED THERETO: (a) THE APPROPRIATE COPIES OF PROOF OF CONTINUING MEDICAL EDUCATION (CME), OR RESIDENCY OR FELLOWSHIP TRAINING COMPLETION; (b) PAYMENT OF THE APPROPRIATE REGISTRATION RENEWAL FEE; AND (c) WRITTEN EXPLANATION(S) TO ANY "YES" ANSWER(S).**

2/24/2005
**Date**

**Signature (SIGNATURE STAMP UNACCEPTABLE)**

PHYSICIAN
**APPLICATION FOR REGISTRATION RENEWAL**
**FOR THE BIENNIAL REGISTRATION PERIOD 2003- 2005**
**NEVADA STATE BOARD OF MEDICAL EXAMINERS**
Post Office Box 7238 Reno, Nevada 89510 Phone (775) 688-2559
Physical Address: 1105 Terminal Way, Suite 301 Reno, Nevada 89502

Date Received by Board
MAR 3 1 2003
(For Board Use Only)

License No. 6164

File No.

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

__X__ ACTIVE STATUS $400.00
_____ INACTIVE STATUS $200.00.....(*INACTIVE STATUS DOES NOT PERMIT THE PRACTICE OF MEDICINE INCLUDING THE WRITING OF PRESCRIPTIONS IN NEVADA)*
_____ I REQUEST NON-RENEWAL OF MY LICENSE*
(*IF YOU ARE REQUESTING NON-RENEWAL, SEE BELOW)

File no:
License no: 6164

Stephanie BALL M.D.
Sandia National Laboratories
7011 East Ave, Mailstop 9112
Livermore CA 94550

Make checks payable to:
**NEVADA STATE BOARD OF MEDICAL EXAMINERS**
(Foreign checks must indicate "U.S. FUNDS")

## *Request for NON-RENEWAL of License to Practice Medicine In Nevada*

**I hereby represent that I am the person named in this *APPLICATION FOR REGISTRATION RENEWAL* of license to practice medicine in the state of Nevada.**

**By signing on the signature line below, I am requesting that my license to practice medicine in Nevada NOT be renewed by the Nevada State Board of Medical Examiners. I will return this signed form to the board office.**

Date _____ Signature **(SIGNATURE STAMP UNACCEPTABLE)** _____

## *PLEASE NOTE:*

- **YOUR CURRENT M.D. LICENSE EXPIRES ON JUNE 30, 2003. COMPLETED *APPLICATION FOR REGISTRATION RENEWAL* FORMS NOT RECEIVED AT THE BOARD OFFICE BY JULY 1, 2003 AT 5:00 P.M. ARE AUTOMATICALLY SUSPENDED FOR NON-PAYMENT. EXTENSIONS OF TIME ARE NOT ALLOWED FOR ANY REASON, AS NEVADA HAS NO GRACE PERIOD. (USE THE ENCLOSED ENVELOPE TO MAIL YOUR COMPLETED *APPLICATION FOR REGISTRATION RENEWAL* FORM.)**
- **YOUR LICENSE WILL NOT BE RENEWED UNLESS YOU ANSWER ALL QUESTIONS ON THIS *APPLICATION FOR REGISTRATION RENEWAL* FORM. YOU MUST PROVIDE WRITTEN EXPLANATIONS FOR ALL QUESTIONS ANSWERED "YES."**
- **ALL INFORMATION YOU PROVIDE ON THIS *APPLICATION FOR REGISTRATION RENEWAL* FORM IS PUBLIC INFORMATION.**

## PLEASE TYPE OR PRINT LEGIBLY

1. Active status registration renewal requires the submission of proof of completion of 40 hours of AMA Category 1 continuing medical education (CME), which includes 2 hours of CME in medical ethics and 20 hours of CME in your scope of practice or specialty **completed during the period July 1, 2001 through June 30, 2003.** Submit your proof of completion of CME with your completed *Application for Registration Renewal* form. (See last page of this form for CME statement.)

2. If your name and/or address has changed from that printed on the label on this form, clearly indicate the change in the space provided below. Also, please indicate your current telephone and fax numbers. [Please note: a notarized or certified copy of the document authorizing your name change (marriage license, divorce decree, etc.) must be included.]

Name STEPHANIE BALL
Street _____
City _____ County _____ State _____ Zip _____
Phone Number 925-294-2700 Fax Number 925-294-2392

3. **IF YOU HAVE RETIRED OR MOVED YOUR PRACTICE,** indicate the location of patient records below:

Name _____
Street _____
City _____ County _____ State _____ Zip _____
Phone Number _____

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

## SCOPES OF PRACTICE CODES

1 ADDICTION MEDICINE
2 ADOLESCENT MEDICINE
3 AEROSPACE MEDICINE
4 ALLERGY
5 ALLERGY/IMMUNOLOGY
6 AMBULATORY MEDICINE
7 ANESTHESIOLOGY
8 BLOODBANKING
9 BRONCO-ESOPHAGOLOGY
10 CARDIOVASCULAR DISEASES
11 CATSCAN/ULTRASOUND
12 CHILD NEUROLOGY
13 CHILD PSYCHIATRY
14 CLINICAL PHARMACOLOGY
15 CRITICAL CARE
16 DERMATOLOGY
17 DERMATOPATHOLOGY
18 EMERGENCY MEDICINE
19 ENDOCRINOLOGY
20 FAMILY PRACTICE
21 GASTROENTEROLOGY
22 GENERAL PRACTICE
23 GERIATRIC PSYCHIATRY
24 GERIATRICS
25 GYNECOLOGY
26 HAIR TRANSPLANTATION
27 HEMATOLOGY
28 HOMEOPATHY
29 HYPNOSIS
30 IMMUNOLOGY
31 INFECTIOUS DISEASES
32 INFERTILITY
33 INTERNAL MEDICINE
34 LARYNGOLOGY
35 LEGAL MEDICINE
36 MATERNAL/FETAL MEDICINE
37 MEDICAL ACUPUNCTURE
38 MEDICAL ETHICS
39 MEDICAL GENETICS
40 NEO/PERINATAL MEDICINE
41 NEOPLASTIC DISEASES
42 NEPHROLOGY
43 NEUROLOGY
44 NEURO-OPHTHALMOLOGY
45 NEUROPATHOLOGY
46 NEURORADIOLOGY
47 NON-CONVENTIONAL MEDICINE
48 NUCLEAR MEDICINE
49 NUTRITION
50 OBSTETRICS
51 OBSTETRICS/GYNECOLOGY
52 OCCUPATIONAL MEDICINE
53 ONCOLOGY
54 ONCOLOGY, GYNECOLOGICAL
55 ONCOLOGY, HEMATOLOGY
56 ONCOLOGY, RADIATION
57 ONCOLOGY, SURGICAL
58 OPHTHALMOLOGY
59 OTOLARYNGOLOGY
60 OTOLOGY
61 PAIN MANAGEMENT
62 PATHOLOGY
63 PATHOLOGY, ANATOMIC
64 PATHOLOGY, CLINICAL
65 PATHOLOGY, FORENSIC
66 PEDIATRIC, ALLERGY
67 PEDIATRIC, CARDIOLOGY
68 PEDIATRIC, CRITICAL CARE
69 PEDIATRIC, EMERGENCY MEDICINE
70 PEDIATRIC, ENDOCRINOLOGY
71 PEDIATRIC, GASTROENTEROLOGY
72 PEDIATRIC, HEMATOLOGY/ONCOLOGY
73 PEDIATRIC, INFECTIOUS DISEASES
74 PEDIATRIC, INTENSIVIST
75 PEDIATRIC, NEPHROLOGY
76 PEDIATRIC, NEUROLOGY
77 PEDIATRIC, OPHTHALMOLOGY
78 PEDIATRIC, PHYSIATRY
79 PEDIATRIC, PULMONARY
80 PEDIATRIC, RADIOLOGY
81 PEDIATRIC, RHEUMATOLOGY
82 PEDIATRIC, SURGERY
83 PEDIATRIC, UROLOGY
84 PEDIATRICS
85 PHYSICAL MEDICINE/REHABILITATION
86 PREVENTIVE MEDICINE
87 PSYCHIATRY
88 PSYCHOANALYSIS
89 PUBLIC HEALTH
90 PSYCHOMATIC MEDICINE
91 PULMONARY DISEASES
92 RADIOLOGY
93 RADIOLOGY, DIAGNOSTIC
94 RADIOLOGY, INTERVENTIONAL
95 RADIOLOGY, NUCLEAR
96 RADIOLOGY, THERAPEUTIC
97 RADIOLOGY, VASCULAR
98 RHEUMATOLOGY
99 RHINOLOGY
100 SLEEP DISORDERS
101 SPORTS MEDICINE
102 SURGERY, ABDOMINAL
103 SURGERY, CARDIOTHORACIC
104 SURGERY, CARDIOVASCULAR
105 SURGERY, COLON/RECTAL
106 SURGERY, GENERAL
107 SURGERY, HAND
108 SURGERY, HEAD/NECK
109 SURGERY, MAXILLOFACIAL
110 SURGERY, NEUROLOGICAL
111 SURGERY, ORTHOPEDIC
112 SURGERY, PLASTIC
113 SURGERY, THORACIC
114 SURGERY, TRANSPLANT
115 SURGERY, TRAUMATIC
116 SURGERY, UROLOGIC
117 SURGERY, VASCULAR
118 TOXICOLOGY
119 URGENT CARE
120 UROLOGY

| | Code | | Code |
|---|---|---|---|
| **Primary Scope of Practice** | 52 | **Secondary Scope of Practice** | |

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

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

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

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments;
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks such as physician examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"**Medical condition**" includes physiological, mental or psychological conditions or disorders, such as, but not limited to, orthopedic, vision, speech, hearing, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, emotional or mental illness, HIV disease, tuberculosis, drug addiction, and alcoholism.

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

**FOR ALL "YES" RESPONSES TO THE FOLLOWING QUESTIONS, YOU MUST SUBMIT YOUR WRITTEN EXPLANATION(S) ON A SEPARATE SHEET ATTACHED TO YOUR COMPLETED *APPLICATION FOR REGISTRATION RENEWAL* FORM.**

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

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

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

4. Have you failed to initiate the performance of public service within one year after the date the public service is required to begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local government for your medical education?
_____Yes__X__No_____N/A

5. Have you been a defendant in a legal action involving professional liability (malpractice) or had a professional liability claim paid in your behalf or paid such a claim yourself?
_____Yes __X__No

6. Have you ever been investigated for, charged with, convicted of, or plead guilty or nolo contendere to any offense or violation of any federal, state or local law, including any foreign country, which is a misdemeanor, gross misdemeanor, or felony, excluding any minor traffic offense (driving or in control of a motor vehicle while under the influence of any chemical substance is **not** considered **a minor traffic offense**) or which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances?
_____Yes __X__No

7. 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? _____Yes __X__No

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

9. Have you ever voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory?
_____Yes__X__No

10. Have you ever been denied membership or expelled from a medical society or other professional medical organization?
_____Yes __X__No

11. Have you ever been: a) notified that you were under investigation for; b) investigated for; c) charged with; or d) convicted of any violation of a statute, rule or regulation governing your practice as a physician by any medical licensing board, hospital, medical society, governmental entity or other agency <u>other than</u> the Nevada State Board of Medical Examiners?
_____Yes __X__No

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

13. List all hospitals where you have had staff privileges denied, suspended, limited, revoked or not renewed by the hospital. List any and all resignations from any medical staff in lieu of disciplinary or administrative action. (<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 (Mo./Yr.) To (Mo./Yr.) |
|---|---|---|---|
| NONE | | | |
| | | | |
| | | | |
| | | | |

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

**CHILD SUPPORT STATEMENT**

**Please place a check mark next to one of the following statements:**

_____ (a) I am not subject to a court order for the support of a child;

__✓__ (b) I am subject to a court order for the support of one or more children and am in compliance with the order or am in compliance with a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order; **OR**

_____ (c) I am subject to a court order for the support of one or more children and am NOT in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

**CONTINUING MEDICAL EDUCATION (CME) STATEMENT**

**Please place a check mark next to one of the following statements:**

__✓__ (a) I completed a minimum of 40 hours of AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics and 20 hours of which were in my scope of practice or specialty, during the past biennial period of July 1, 2001 through June 30, 2003;

_____ (b) I was initially licensed in Nevada during the time period January 1, 2002 through June 30, 2002, the second six months of the past biennial period, and completed a minimum of 30 hours of AMA Category I continuing medical education (CME), 2 hours of which were in medical ethics and 20 hours of which were in my scope of practice or specialty;

_____ (c) I was initially licensed in Nevada during the time period July 1, 2002 through December 31, 2002, the third six months of the past biennial period, and completed a minimum of 20 hours of AMA Category I continuing medical education (CME), 2 hours of which were in medical ethics and 18 hours of which were in my scope of practice or specialty;

_____ (d) I was initially licensed in Nevada during the time period January 1, 2003 through June 30, 2003, the fourth six months of the past biennial period, and completed a minimum of 10 hours of AMA Category I continuing medical education (CME), 2 hours of which were in medical ethics and 8 hours of which were in my scope of practice or specialty; **OR**

_____ (e) I am exempt from submitting proof of completion of continuing medical education (CME) because I have completed a full year of residency or fellowship training during the biennial period July 1, 2001 through June 30, 2003.

- **ATTACH COPIES OF PROOF OF YOUR COMPLETION OF CONTINUING MEDICAL EDUCATION (CME) HOURS.**
- **IF YOU COMPLETED A FULL YEAR OF RESIDENCY OR FELLOWSHIP TRAINING DURING THE BIENNIAL PERIOD JULY 1, 2001 THROUGH JUNE 30, 2003, ATTACH A COPY OF PROOF OF COMPLETION OF YOUR TRAINING.**
- **YOUR COPIES OF PROOF OF CME OR TRAINING COMPLETION WILL NOT BE RETURNED TO YOU.**

I HAVE__✓__ HAVE NOT ____ ***(CHECK ONE)*** ACTIVELY PRACTICED MEDICINE IN NEVADA WITHIN THE PAST 12 MONTHS.

## BY SIGNING ON THE SIGNATURE LINE BELOW:

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

2/14/03

Date

Signature (SIGNATURE STAMP UNACCEPTABLE)

RR

**PHYSICIAN**
**APPLICATION FOR REGISTRATION RENEWAL**
**FOR THE BIENNIAL REGISTRATION PERIOD 2001- 2003**
**NEVADA STATE BOARD OF MEDICAL EXAMINERS**
Post Office Box 7238 Reno, Nevada 89510 Phone (775) 688-2559

Date Received by Board: APR 26 2001 (For Board Use Only)

License No. G1164

File No.__

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

| | | |
|---|---|---|
| X | ACTIVE STATUS | $600.00 |
| | INACTIVE STATUS | $200.00 |
| | RETIRED STATUS | $ 50.00 |
| | SUPERVISING/COLLABORATING PHYSICIAN | $200.00 |

(*RETIRED STATUS REQUIRES THAT THE APPLICANT NOT PRACTICE MEDICINE ANYWHERE*)

12-1-00

file no: candidate no: 3293

Stephanie BALL M.D.
7011 East Ave
Sandia National Laboratories
**Livermore CA 94550**

Make checks payable to:
**NEVADA STATE BOARD OF MEDICAL EXAMINERS**
(Foreign checks must indicate "U.S. FUNDS")

## *PLEASE NOTE:*

- **YOUR CURRENT M.D. LICENSE EXPIRES ON JUNE 30, 2001. COMPLETED *APPLICATION FOR REGISTRATION RENEWAL* FORMS NOT RECEIVED AT THE BOARD OFFICE BY JULY 1, 2001 AT 5:00 P.M. ARE AUTOMATICALLY SUSPENDED FOR NON-PAYMENT. EXTENSIONS OF TIME ARE NOT ALLOWED FOR ANY REASON, AS NEVADA HAS NO GRACE PERIOD. (USE THE ENCLOSED ENVELOPE TO MAIL YOUR COMPLETED *APPLICATION FOR REGISTRATION RENEWAL* FORM.)**
- **YOUR LICENSE WILL NOT BE RENEWED UNLESS YOU ANSWER ALL QUESTIONS ON THIS *APPLICATION FOR REGISTRATION RENEWAL* FORM. YOU MUST PROVIDE WRITTEN EXPLANATIONS FOR ALL QUESTIONS ANSWERED "YES."**
- **ALL INFORMATION YOU PROVIDE ON THIS *APPLICATION FOR REGISTRATION RENEWAL* FORM IS PUBLIC INFORMATION.**

## PLEASE TYPE OR PRINT LEGIBLY

1. To be eligible to act as a **SUPERVISING PHYSICIAN FOR A PHYSICIAN ASSISTANT**, and/or as a **COLLABORATING PHYSICIAN FOR AN ADVANCED PRACTITIONER OF NURSING** for the biennial period of July 1, 2001 through June 30, 2003, you must complete the enclosed ***Application for Approval as Supervising/Collaborating Physician*** and return it with your payment in the amount of $200.00 in the enclosed envelope.

2. Active status registration renewal requires the submission of proof of completion of 40 hours of AMA Category 1 continuing medical education (CME), which includes 2 hours of CME in medical ethics and 20 hours of CME in your scope of practice or specialty **completed during the period July 1, 1999 through June 30, 2001**. Submit your proof of completion of CME with your completed *Application for Registration Renewal* form. (See last page of this form for CME statement.)

3. If your name and/or address has changed from that printed on the label on this form, clearly indicate the change in the space provided below. Also, please indicate your current telephone and fax numbers. [Please note: a notarized or certified copy of the document authorizing your name change (marriage license, divorce decree, etc.) must be included.]

Name_____ Addition.
Street 7011 EAST AVENUE, Mailstop 9112
City_____ County_____ State_____ Zip_____
Phone Number (925) 294-2700 Fax Number (925) 294-2392

4. **IF YOU HAVE RETIRED OR MOVED YOUR PRACTICE,** indicate the location of patient records below:

Name_____
Street_____
City_____ County_____ State_____ Zip_____
Phone Number_____

5. Indicate below the **EXACT NAME AND LOCATION** of the Medical School from which you graduated and your **EXACT DATE** of graduation:

UNIVERSITY OF NEVADA SCHOOL OF MEDICINE — 5-18-85
Medical School Name and Location — Date of Graduation (Month/Day/Year)

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

**SCOPE OF PRACTICE SPECIALTY CODES**

1 ADDICTION MEDICINE
2 ADOLESCENT MEDICINE
3 AEROSPACE MEDICINE
4 ALLERGY
5 ALLERGY/IMMUNOLOGY
6 ANESTHESIOLOGY
7 BLOODBANKING
8 BRONCO-ESOPHAGOLOGY
9 CARDIOVASCULAR DISEASES
10 CATSCAN/ULTRASOUND
11 CHILD NEUROLOGY
12 CHILD PSYCHIATRY
13 CLINICAL PHARMACOLOGY
14 CRITICAL CARE
15 DERMATOLOGY
16 DERMATOPATHOLOGY
17 EMERGENCY MEDICINE
18 ENDOCRINOLOGY
19 FAMILY PRACTICE
20 GASTROENTEROLOGY
21 GENERAL PRACTICE
22 GERIATRICS
23 GYNECOLOGY
24 HEMATOLOGY
25 HOMEOPATHY
26 HYPNOSIS
27 IMMUNOLOGY
28 INFECTIOUS DISEASES
29 INFERTILITY
30 INTERNAL MEDICINE
31 LARYNGOLOGY
32 LEGAL MEDICINE
33 MATERNAL/FETAL MEDICINE
34 MEDICAL ACUPUNCTURE
35 MEDICAL ETHICS
36 MEDICAL GENETICS
37 NEO/PERINATAL MEDICINE
38 NEOPLASTIC DISEASES
39 NEPHROLOGY
40 NEUROLOGY
41 NEURO-OPHTHALMOLOGY
42 NEUROPATHOLOGY
43 NEURORADIOLOGY
44 NON-CONVENTIONAL MEDICINE
45 NUCLEAR MEDICINE
46 NUTRITION
47 OBSTETRICS
48 OBSTETRICS/GYNECOLOGY
49 OCCUPATIONAL MEDICINE
50 ONCOLOGY
51 ONCOLOGY, GYNECOLOGICAL
52 ONCOLOGY, HEMATOLOGY
53 ONCOLOGY, RADIATION
54 ONCOLOGY, SURGICAL
55 OPHTHALMOLOGY
56 OTOLARYNGOLOGY
57 OTOLOGY
58 PAIN MANAGEMENT
59 PATHOLOGY
60 PATHOLOGY, ANATOMIC
61 PATHOLOGY, CLINICAL
62 PATHOLOGY, FORENSIC
63 PEDIATRIC, ALLERGY
64 PEDIATRIC, CARDIOLOGY
65 PEDIATRIC, CRITICAL CARE
66 PEDIATRIC, EMERGENCY MEDICINE
67 PEDIATRIC, ENDOCRINOLOGY
68 PEDIATRIC, GASTROENTEROLOGY
69 PEDIATRIC, HEMATOLOGY/ONCOLOGY
70 PEDIATRIC, INFECTIOUS DISEASES
71 PEDIATRIC, INTENSIVIST
72 PEDIATRIC, NEPHROLOGY
73 PEDIATRIC, NEUROLOGY
74 PEDIATRIC, OPHTHALMOLOGY
75 PEDIATRIC, PHYSIATRY
76 PEDIATRIC, PULMONARY
77 PEDIATRIC, RADIOLOGY
78 PEDIATRIC, SURGERY
79 PEDIATRIC, UROLOGY
80 PEDIATRICS
81 PHYSICAL MEDICINE/REHABILITATION
82 PREVENTIVE MEDICINE
83 PSYCHIATRY
84 PSYCHOANALYSIS
85 PSYCHOMATIC MEDICINE
86 PUBLIC HEALTH
87 PULMONARY DISEASES
88 RADIOLOGY
89 RADIOLOGY, DIAGNOSTIC
90 RADIOLOGY, INTERVENTIONAL
91 RADIOLOGY, NUCLEAR
92 RADIOLOGY, THERAPEUTIC
93 RADIOLOGY, VASCULAR
94 RHEUMATOLOGY
95 RHINOLOGY
96 SLEEP DISORDERS
97 SPORTS MEDICINE
98 SURGERY, ABDOMINAL
99 SURGERY, CARDIOTHORACIC
100 SURGERY, CARDIOVASCULAR
101 SURGERY, COLON/RECTAL
102 SURGERY, GENERAL
103 SURGERY, HAND
104 SURGERY, HEAD/NECK
105 SURGERY, MAXILLOFACIAL
106 SURGERY, NEUROLOGICAL
107 SURGERY, ORTHOPEDIC
108 SURGERY, PLASTIC
109 SURGERY, THORACIC
110 SURGERY, TRANSPLANT
111 SURGERY, TRAUMATIC
112 SURGERY, UROLOGIC
113 SURGERY, VASCULAR
114 URGENT CARE
115 UROLOGY

| | Code | | Code | | Code |
|---|---|---|---|---|---|
| **Primary Specialty** | 49 | **Secondary Specialty** | 30 | **Tertiary Specialty** | |

# All of the following questions refer to the time period July 1, 1999, through the present date only.

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

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

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments;
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks such as physician examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

**"Medical condition"** includes physiological, mental or psychological conditions or disorders, such as, but not limited to, orthopedic, vision, speech, hearing, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, emotional or mental illness, HIV disease, tuberculosis, drug addiction, and alcoholism.

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

**FOR ALL "YES" RESPONSES TO THE FOLLOWING QUESTIONS, YOU MUST SUBMIT YOUR WRITTEN EXPLANATION(S) ON A SEPARATE SHEET ATTACHED TO YOUR COMPLETED *APPLICATION FOR REGISTRATION RENEWAL* FORM.**

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

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

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

4. Have you failed to initiate the performance of public service within one year after the date the public service is required to begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local government for your medical education?
_____Yes __X__No_____N/A

5. Have you been a defendant in a legal action involving professional liability (malpractice) or had a professional liability claim paid in your behalf or paid such a claim yourself?
_____Yes __X__No

6. Have you ever been investigated for, charged with, convicted of, or plead guilty or nolo contendere to any offense or violation of any federal, state or local law, including any foreign country, which is a misdemeanor, gross misdemeanor, or felony, excluding any minor traffic offense (driving or in control of a motor vehicle while under the influence of any chemical substance is **not** considered **a minor traffic offense**) or which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances?
_____Yes __X__No

7. 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? _____Yes __X__No

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

9. Have you ever voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory?
_____Yes__X__No

10. Have you ever been denied membership or expelled from a medical society or other professional medical organization?
_____Yes __X__No

11. Have you ever been: a) notified that you were under investigation for; b) investigated for; c) charged with; or d) convicted of any violation of a statute, rule or regulation governing your practice as a physician by any medical licensing board, hospital, medical society, governmental entity or other agency <u>other than</u> the Nevada State Board of Medical Examiners?
_____Yes __X__No

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

13. List all hospitals where you have had staff privileges denied, suspended, limited, revoked or not renewed by the hospital. List any and all resignations from any medical staff in lieu of disciplinary or administrative action. (<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 (Mo./Yr.) To (Mo./Yr.) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

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

**CHILD SUPPORT STATEMENT**

**Please place a check mark next to one of the following statements:**

_____ (a) I am not subject to a court order for the support of a child;

__X__ (b) I am subject to a court order for the support of one or more children and am in compliance with the order or am in compliance with a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order; **OR**

_____ (c) I am subject to a court order for the support of one or more children and am NOT in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

**CONTINUING MEDICAL EDUCATION (CME) STATEMENT**

**Please place a check mark next to one of the following statements:**

__X__ (a) I completed a minimum of 40 hours of AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics and 20 hours of which were in my scope of practice or specialty, during the past biennial period of July 1, 1999 through June 30, 2001;

_____ (b) I was initially licensed in Nevada during the time period January 1, 2000 through June 30, 2000, the second six months of the past biennial period, and completed a minimum of 30 hours of AMA Category I continuing medical education (CME), 2 hours of which were in medical ethics and 20 hours of which were in my scope of practice or specialty;

_____ (c) I was initially licensed in Nevada during the time period July 1, 2000 through December 31, 2000, the third six months of the past biennial period, and completed a minimum of 20 hours of AMA Category I continuing medical education (CME), 2 hours of which were in medical ethics and 18 hours of which were in my scope of practice or specialty;

_____ (d) I was initially licensed in Nevada during the time period January 1, 2001 through June 30, 2001, the fourth six months of the past biennial period, and completed a minimum of 10 hours of AMA Category I continuing medical education (CME), 2 hours of which were in medical ethics and 8 hours of which were in my scope of practice or specialty; **OR**

_____ (e) I am exempt from submitting proof of completion of continuing medical education (CME) because I have completed a full year of residency or fellowship training during the biennial period July 1, 1999 through June 30, 2001.

- **ATTACH COPIES OF PROOF OF YOUR COMPLETION OF CONTINUING MEDICAL EDUCATION (CME) HOURS.**
- **IF YOU COMPLETED A FULL YEAR OF RESIDENCY OR FELLOWSHIP TRAINING DURING THE BIENNIAL PERIOD JULY 1, 1999 THROUGH JUNE 30, 2001, ATTACH A COPY OF PROOF OF COMPLETION OF YOUR TRAINING.**
- **YOUR COPIES OF PROOF OF CME OR TRAINING COMPLETION WILL NOT BE RETURNED TO YOU.**

I HAVE__X__ HAVE NOT ____ ***(CHECK ONE)*** ACTIVELY PRACTICED MEDICINE IN NEVADA WITHIN THE PAST 12 MONTHS.

## BY SIGNING ON THE SIGNATURE LINE BELOW:

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

4/23/01 _____ _____

**PHYSICIAN**
**APPLICATION FOR RENEWAL REGISTRATION**
**NEVADA STATE BOARD OF**
**MEDICAL EXAMINERS**

Post Office Box 7238 Reno, Nevada 89510 Phone (775) 688-2559

Date Received by Board
JUN 0 1 1999
(Board Use Only)

License No._____

File No._____

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

| | | |
|---|---|---|
| X | ACTIVE STATUS | $600.00 |
| | INACTIVE STATUS | $200.00 |
| | RETIRED STATUS | $ 50.00 |
| | SUPERVISING/COLLABORATING PHYSICIAN | $200.00 |

Stephanie Ball, MD
PO Box 5800 Medical MS1015
Albuquerque NM 87185-1015

Make checks payable to:
**NEVADA STATE BOARD OF MEDICAL EXAMINERS**
(Foreign checks must indicate "U.S. FUNDS")

## PLEASE NOTE

**NEVADA HAS NO GRACE PERIOD - - - - - LICENSES NOT RENEWED BY JULY 1, 1999 ARE AUTOMATICALLY SUSPENDED FOR NON-PAYMENT.**
**EXTENSIONS OF TIME ARE NOT ALLOWED FOR ANY REASON.**
**YOUR LICENSE WILL NOT BE RENEWED WITHOUT ANSWERING ALL QUESTIONS.**
**ALL YES ANSWERS MUST BE EXPLAINED.**
**YOU MUST INCLUDE PROOF OF 40 HOURS OF AMA CATEGORY 1 CME WHICH INCLUDES 2 HOURS IN MEDICAL ETHICS AND 20 HOURS IN YOUR SCOPE OF PRACTICE OR SPECIALTY.**
**ALL FEES MUST BE PAID AND ARE NON-REFUNDABLE.**
**DO NOT SEND CASH THROUGH THE MAIL.**
**PLEASE ALLOW SIXTY (60) DAYS FOR PROCESSING OF YOUR APPLICATION.**

## PLEASE TYPE OR PRINT LEGIBLY

1. **YOUR CURRENT M.D. LICENSE EXPIRES ON JUNE 30, 1999. THIS IS THE NOTICE TO RENEW YOUR M.D. LICENSE.**

2. To be eligible to act as a supervising physician for a physician's assistant, or as a collaborating physician for an advanced practitioner of nursing, complete the enclosed Application for Approval as Supervising/Collaborating Physician.

3. **ACTIVE STATUS REGISTRATION RENEWAL REQUIRES THE SUBMISSION OF PROOF OF 40 HOURS OF AMA CATEGORY 1 CONTINUING MEDICAL EDUCATION** which includes 2 hours of medical ethics and 20 hours in your scope of practice or specialty completed during the period July 1, 1997 through June 30, 1999. Submit your proof of CME with your completed Application for Registration Renewal form.

4. In order to provide sufficient time for processing, please complete and return your Application for Registration Renewal form and Application for Approval as Supervising/Collaborating Physician form (if applicable) with your proof of 40 hours AMA Category I CME and the correct fee(s) **BY JUNE 30, 1999.** Use the enclosed self-addressed envelope to return your completed form(s) and fee(s).

5. If your name and/or address has changed from that printed on this form, clearly indicate the change in the space provided. A notarized or certified copy of the document authorizing your name change (marriage license, divorce decree, etc.) must be included.

Name_____

Street_____

City_____ County_____ State_____ Zip_____

**IF YOU HAVE RETIRED OR MOVED YOUR PRACTICE, INDICATE THE LOCATION OF PATIENT RECORDS BELOW:**

Name_____

Street_____

City_____ County_____ State_____ Zip_____

7. Are you currently active in medicine

a. [ ] YES, in training.
b. [X] YES, working full-time
c. [ ] YES, working part-time
d. [ ] NO, retired.
e. [ ] NO, other (specify_____)

8. Please indicate your primary, secondary and tertiary specialties and percent of practice time spent in each, using the following codes:

**SCOPE OF PRACTICE SPECIALTY CODES**

| | | | | | |
|---|---|---|---|---|---|
| 102 | ADDICTION MEDICINE | 31 | NEOPLASTIC DISEASES | 62 | PEDIATRIC, RADIOLOGY |
| 1 | ADOLESCENT MEDICINE | 32 | NEPHROLOGY | 63 | PEDIATRIC, SURGERY |
| 2 | AEROSPACE MEDICINE | 33 | NEUROLOGY | 64 | PEDIATRIC, UROLOGY |
| 3 | ALLERGY/IMMUNOLOGY | 34 | NEUROPATHOLOGY | 65 | PEDIATRICS |
| 104 | ALTERNATIVE MEDICINE | 35 | NEURORADIOLOGY | 66 | PHYSICAL MEDICINE/REHABILITATION |
| 4 | ANESTHESIOLOGY | 36 | NUCLEAR MEDICINE | 67 | PREVENTIVE MEDICINE |
| 5 | BLOODBANKING | 37 | NUTRITION | 68 | PSYCHIATRY |
| 6 | BRONCO-ESOPHAGOLOGY | 38 | OBSTETRICS/GYNECOLOGY | 69 | PSYCHOANALYSIS |
| 7 | CARDIOVASCULAR DISEASES | 39 | OBSTETRICS | 70 | PSYCHOMATIC MEDICINE |
| 8 | CATSCAN/ULTRASOUND | 40 | OCCUPATIONAL MEDICINE | 71 | PUBLIC HEALTH |
| 9 | CHILD NEUROLOGY | 41 | ONCOLOGY | 72 | PULMONARY DISEASES |
| 10 | CHILD PSYCHIATRY | 45 | ONCOLOGY, GYNECOLOGICAL | 73 | RADIOLOGY |
| 11 | CLINICAL PHARMACOLOGY | 42 | ONCOLOGY, HEMATOLOGY | 74 | RADIOLOGY, DIAGNOSTIC |
| 12 | CRITICAL CARE | 43 | ONCOLOGY, RADIATION | 75 | RADIOLOGY, NUCLEAR |
| 13 | DERMATOLOGY | 44 | ONCOLOGY, SURGICAL | 76 | RADIOLOGY, THERAPEUTIC |
| 14 | EMERGENCY MEDICINE | 46 | OPHTHALMOLOGY | 77 | RHEUMATOLOGY |
| 15 | ENDOCRINOLOGY | 47 | OTOLARYNGOLOGY | 78 | RHINOLOGY |
| 16 | FAMILY PRACTICE | 48 | OTOLOGY | 79 | SLEEP DISORDERS |
| 17 | GASTROENTEROLOGY | 49 | PAIN MANAGEMENT | 100 | SPORTS MEDICINE |
| 18 | GENERAL PRACTICE | 50 | PATHOLOGY | 80 | SURGERY, ABDOMINAL |
| 19 | GERIATRICS | 51 | PATHOLOGY, ANATOMIC | 103 | SURGERY, CARDIOTHORACIC |
| 20 | GYNECOLOGY | 52 | PATHOLOGY, CLINICAL | 81 | SURGERY, CARDIOVASCULAR |
| 21 | HEMATOLOGY | 53 | PATHOLOGY, FORENSIC | 91 | SURGERY, COLON/RECTAL |
| 105 | HOMEOPATHY | 54 | PEDIATRIC, ALLERGY | 82 | SURGERY, GENERAL |
| 22 | HYPNOSIS | 55 | PEDIATRIC, CARDIOLOGY | 83 | SURGERY, HAND |
| 23 | IMMUNOLOGY | 99 | PEDIATRIC, CRITICAL CARE | 84 | SURGERY, HEAD/NECK |
| 24 | INFECTIOUS DISEASES | 97 | PEDIATRIC, EMERGENCY MEDICINE | 92 | SURGERY, MAXILLOFACIAL |
| 25 | INFERTILITY | 56 | PEDIATRIC, ENDOCRINOLOGY | 93 | SURGERY, NEUROLOGICAL |
| 26 | INTERNAL MEDICINE | 57 | PEDIATRIC, HEMATOLOGY/ONCOLOGY | 85 | SURGERY, ORTHOPEDIC |
| 27 | LARYNGOLOGY | 58 | PEDIATRIC, INFECTIOUS DISEASES | 86 | SURGERY, PLASTIC |
| 28 | LEGAL MEDICINE | 59 | PEDIATRIC, INTENSIVIST | 87 | SURGERY, THORACIC |
| 29 | MATERNAL/FETAL MEDICINE | 60 | PEDIATRIC, NEPHROLOGY | 88 | SURGERY, TRAUMATIC |
| 106 | MEDICAL ACUPUNCTURE | 98 | PEDIATRIC, NEUROLOGY | 89 | SURGERY, UROLOGIC |
| 107 | MEDICAL ETHICS | 101 | PEDIATRIC, OPHTHALMOLOGY | 90 | SURGERY, VASCULAR |
| 30 | NEO/PERINATAL MEDICINE | 61 | PEDIATRIC, PHYSIATRY | 94 | UROLOGY |
| | | 95 | PEDIATRIC, PULMONARY | | |

| | Code | Percent of Time | Board Certified (Indicate Yes/No) |
|---|---|---|---|
| Primary | 40 | 100% | NO |
| Secondary | 26 | -0- | YES |
| Tertiary | | | |

**PLEASE INDICATE ALL AMERICAN BOARD OF MEDICAL SPECIALTIES BOARD OR SUBBOARD CERTIFICATIONS:**

| | Date of Initial Certification (Mo./Yr.) | Date of Last Certification (Mo./Yr.) |
|---|---|---|
| Board AMERICAN BOARD OF INTERNAL MEDICINE | 9/89 | 9/89 |
| Subboard | | |
| Board | | |
| Subboard | | |

9. Form of employment is 1006. (Use one of the following codes.)

**SELF-EMPLOYED:**
1001 Solo Practice
1002 Partnership or Group Practitioners

**SALARIED, EMPLOYED BY:**
1003 Individual Practitioner
1004 Partnership or Group of Practitioners
1005 Group Health Plan Facility (such as H.M.O.)

**SALARIED, EMPLOYED BY:** (continued)
1006 Other Non-Government Employer (hospital, school, etc.)
1007 Federal Government (armed services personnel only)
1008 Federal Government (civilian, P.H.S., etc.)
1009 State Government
1010 County Government
1011 Local Government

1012 Other (specify)_____

# All of the following questions refer to the time period July 1, 1997, through the present date only.

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

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

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments;
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks such as physician examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

**"Medical condition"** includes physiological, mental or psychological conditions or disorders, such as, but not limited to, orthopedic, vision, speech, hearing, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, emotional or mental illness, HIV disease, tuberculosis, drug addiction, and alcoholism.

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

**"Currently"** does not mean on the day of, or even in the weeks or months preceding the completing of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee.

## FOR ALL "YES" RESPONSES TO THE FOLLOWING QUESTIONS, YOU MUST SUBMIT YOUR EXPLANATION(S) ON A SEPARATE SHEET ATTACHED TO YOUR COMPLETED REGISTRATION APPLICATION FORM

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

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

3. If you use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety? _____Yes _____No __X__N/A

4. Have you failed to initiate the performance of public service within one year after the date the public service is required to begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local government for your medical education? _____Yes _____No __X__N/A

5. Have you been a defendant in a legal action involving professional liability (malpractice) or had a professional liability claim paid in your behalf or paid such a claim yourself? _____Yes __X__No

6. Have you ever been investigated for, charged with, convicted of, or plead guilty or nolo contendere to any offense or violation of any federal, state or local law, including any foreign country, which is a misdemeanor, gross misdemeanor, or felony, excluding any minor traffic offense (driving or in control of a motor vehicle while under the influence of any chemical substance is **not** considered **a minor traffic offense**) or which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? _____Yes __X__No

7. Have you ever been denied a license, permission to practice medicine or any other healing art(s), or permission to take an examination to practice medicine or any other healing art(s) in any state, country or U.S. territory? _____Yes __X__No

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

9. Have you ever voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory? _____Yes __X__No

10. Have you ever been denied membership or expelled from a medical society or other professional medical organization? _____Yes __X__No

11. Have you ever been investigated, charged with, or convicted of any violation of statute, rule or regulation governing the practice of medicine by any medical licensing board, hospital, medical society, governmental entity or other agency?

_____Yes__X__No

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

_____Yes__X__No

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

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

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

**PLEASE CHECK ONE OF THE FOLLOWING:**

_____ I am not subject to a court order for the support of a child.

__X__ I am subject to a court order for the support of one or more children and am in compliance with the order or am in compliance with a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order; or

_____ I am subject to a court order for the support of one or more children and am NOT in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

Signature_____

(SIGNATURE STAMP UNACCEPTABLE)

**PLEASE CHECK ONE OF THE FOLLOWING:**

__X__ 1. I have earned a minimum of 40 hours approved AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics, and 20 hours of which were in my scope of practice or specialty during the biennial period July 1, 1997, through June 30, 1999.

_____ 2. I was initially licensed in Nevada during the second six months of the biennial period July 1, 1997, through June 30, 1999, and have earned a minimum of 30 hours approved AMA Category I continuing medical education (CME).

_____ 3. I was initially licensed in Nevada during the third six months of the biennial period July 1, 1997, through June 30, 1999, and have earned a minimum of 20 hours approved AMA Category I continuing medical education (CME).

_____ 4. I was initially licensed in Nevada during the fourth six months of the biennial period July 1, 1997, through June 30, 1999, and have earned a minimum of 10 hours approved AMA Category I continuing medical education (CME).

_____ 5. I am exempt from submitting proof of continuing medical education (CME) because I have completed a full year of residency or fellowship training during the biennial period July 1, 1997, through June 30, 1999.

## IMPORTANT

**ATTACH COPIES OF PROOF OF DECLARED CME CREDITS. PROOF OF CME CREDITS WILL NOT BE RETURNED.**

Signature_____

**(SIGNATURE STAMP UNACCEPTABLE)**

I HAVE__X__ HAVE NOT____ ACTIVELY PRACTICED IN NEVADA WITHIN THE PAST 12 MONTHS. (CHECK ONE)

**I HEREBY CERTIFY THAT I AM THE PERSON NAMED IN THIS APPLICATION FOR REGISTRATION RENEWAL OF LICENSE TO PRACTICE MEDICINE IN THE STATE OF NEVADA AND THAT ALL STATEMENTS I HAVE MADE HEREIN ARE TRUE.**

~~(505)845-8039~~ (505)844-3319 Business Telephone #

5/10/99 5/24/99 Date

Signature **(SIGNATURE STAMP UNACCEPTABLE)**

**APPLICATION FOR RENEWAL REGISTRATION**
**NEVADA STATE BOARD OF**
**MEDICAL EXAMINERS**

Post Office Box 7238 Reno, Nevada 89510 Phone (702) 688-2559

Date received by Bo
APR 15 1997
(Board Use Only)

License No.

File No.

I hereby apply for renewal of biennial registration and enclose the appropriate fees as indicated below:

| | | | |
|---|---|---|---|
| X | ACTIVE STATUS | $600.00 | **PLEASE NOTE:** |
| | INACTIVE STATUS | $150.00 | |
| | RETIRED STATUS | $ 50.00 | |
| | P.A. SUPERVISING PHYSICIAN | $200.00 | |

**NEVADA HAS NO GRACE PERIOD. LICENSES NOT RENEWED BY JULY 1, 1997 ARE AUTOMATICALLY SUSPENDED FOR NON-PAYMENT**

Stephanie Ball, MD
POBox 5800 ~~Medical MS1018~~
Albuquerque, NM 87185-~~1018~~

Make checks payable to:
**VADA STATE BOARD OF MEDICAL EXAMINERS**
(Foreign checks must indicate "U.S. FUNDS")

## INSTRUCTIONS - TYPE OR PRINT LEGIBLY

**1. YOUR CURRENT M.D. LICENSE EXPIRES ON JUNE 30, 1997. THIS IS THE NOTICE TO RENEW YOUR M.D. LICENSE.**

2. To be eligible to act as a supervising physician for a physician assistant, complete the enclosed Application for Approval as Supervising Physician form.

**3. ACTIVE STATUS REGISTRATION RENEWAL REQUIRES THE SUBMISSION OF PROOF OF 40 HOURS OF AMA CATEGORY I, CONTINUING MEDICAL EDUCATION** completed during the period July 1, 1995 through June 30, 1997. Submit your proof of CME with your completed Application for Registration Renewal form.

4. In order to provide sufficient time for processing, please complete and return your Application for Registration Renewal form and Application for Approval as Supervising Physician form (if applicable) with your proof of 40 hours AMA Category I CME and the correct fee(s) **PRIOR TO JULY 1, 1997.** Use the enclosed self-addressed envelope to return your completed form(s) and fee(s).

5. If your name and/or address has changed from that printed on this form, clearly indicate the change in the space provided. A notarized or certified copy of the document authorizing your name change (marriage license, divorce decree, etc.) must be included.

Name
Street P.O. Box 5800 MS 1015
City County Bernalillo State Zip 87185-1015

**6. IF YOU HAVE RETIRED OR MOVED YOUR PRACTICE, PLEASE INDICATE THE LOCATION OF FORMER PATIENT RECORDS BELOW:**

Name
Street
City County State Zip

**YOUR LICENSE REGISTRATION WILL NOT BE RENEWED WITHOUT SUBMISSION OF THE CORRECT FEE(S), PROPERLY COMPLETED FORM(S) AND PROOF OF 40 HOURS OF AMA CATEGORY I, CME'S**

**ALL PAGES OF THE FORM(S) MUST BE COMPLETED AND RETURNED**

**ALL FEES ARE NON-REFUNDABLE**

**DO NOT SEND CASH THROUGH THE MAIL**

**PLEASE ALLOW SIXTY (60) DAYS FOR THE PROCESSING OF YOUR REGISTRATION RENEWAL**

1. Are you currently active in medicin
   a. [ ] YES, in training.
   b. [X] YES, working full-time
   c. [ ] YES, working part-time
   d. [ ] NO, retired.
   e. [ ] NO, other (specify_____)

2. Please indicate your primary, secondary and tertiary specialties and percent of time spent in each, using the following codes.

**SPECIALTY CODE:**

| | | | | | |
|---|---|---|---|---|---|
| 1 | ADOLESCENT MEDICINE | 35 | NEURORADIOLOGY | 64 | PED. UROLOGY |
| 2 | AEROSPACE MEDICINE | 36 | NUCLEAR MEDICINE | 65 | PEDIATRICS |
| 3 | ALLERGY/IMMUNOLOGY | 37 | NUTRITION | 66 | PHYSICAL MED/REHAB |
| 4 | ANESTHESIOLOGY | 38 | OBSTETRIC/GYNECOLOGY | 96 | PHYSICIAN ASSISTANT |
| 5 | BLOODBANKING | 39 | OBSTETRICS | 67 | PREVENTIVE MED |
| 6 | BRONCO-ESOPHAGOLOGY | 40 | OCCUPATIONAL MED | 68 | PSYCHIATRY |
| 7 | CARDIOVASC DISEASES | 41 | ONCOLOGY | 69 | PSYCHOANALYSIS |
| 8 | CATSCAN/ULTRASOUND | 45 | ONCOLOGY, GYNECOLOGIC | 70 | PSYCHOMATIC MEDICINE |
| 9 | CHILD NEUROLOGY | 42 | ONCOLOGY, HEMATOLOGY | 71 | PUBLIC HEALTH |
| 10 | CHILD PSYCHIATRY | 43 | ONCOLOGY, RADIATION | 72 | PULMONARY DISEASES |
| 11 | CLINICAL PHARMACOL | 44 | ONCOLOGY, SURGICAL | 73 | RADIOLOGY |
| 12 | CRITICAL CARE | 46 | OPHTHALMOLOGY | 74 | RADIOLOGY, DIAGNOSTIC |
| 13 | DERMATOLOGY | 47 | OTOLARYNGOLOGY | 75 | RADIOLOGY, NUCLEAR |
| 14 | EMERGENCY MEDICINE | 48 | OTOLOGY | 76 | RADIOLOGY, THERAPEUT |
| 15 | ENDOCRINOLOGY | 49 | PAIN MANAGEMENT | 77 | RHEUMATOLOGY |
| 16 | FAMILY PRACTICE | 50 | PATHOLOGY | 78 | RHINOLOGY |
| 17 | GASTROENTEROLOGY | 51 | PATHOLOGY, ANATOMIC | 79 | SLEEP DISORDERS |
| 18 | GENERAL PRACTICE | 52 | PATHOLOGY, CLINICAL | 100 | SPORTS MEDICINE |
| 19 | GERIATRICS | 53 | PATHOLOGY, FORENSIC | 80 | SURGERY, ABDOMINAL |
| 20 | GYNECOLOGY | 54 | PED. ALLERGY | 81 | SURGERY, CARDIOVASC |
| 21 | HEMATOLOGY | 55 | PED. CARDIOLOGY | 91 | SURGERY, COLON/RECTAL |
| 22 | HYPNOSIS | 99 | PED. CRITICAL CARE | 82 | SURGERY, GENERAL |
| 23 | IMMUNOLOGY | 97 | PED. EMERGENCY MED | 83 | SURGERY, HAND |
| 24 | INFECTIOUS DISEASES | 56 | PED. ENDOCRINOLOGY | 84 | SURGERY, HEAD/NECK |
| 25 | INFERTILITY | 57 | PED. HEMAT/ONCOLOGY | 92 | SURGERY, MAXILLOFAC |
| 26 | INTERNAL MEDICINE | 58 | PED. INFECTIOUS DIS | 93 | SURGERY, NEUROLOGICAL |
| 27 | LARYNGOLOGY | 59 | PED. INTENSIVIST | 85 | SURGERY, ORTHOPEDIC |
| 28 | LEGAL MEDICINE | 60 | PED. NEPHROLOGY | 86 | SURGERY, PLASTIC |
| 29 | MATERNAL/FETAL MED | 98 | PED. NEUROLOGY | 87 | SURGERY, THORACIC |
| 30 | NEO/PERINATAL MED | 101 | PED. OPHTHALMOLOGY | 88 | SURGERY, TRAUMATIC |
| 31 | NEOPLASTIC DISEASES | 61 | PED. PHYSIATRY | 89 | SURGERY, UROLOGIC |
| 32 | NEPHROLOGY | 95 | PED. PULMONARY | 90 | SURGERY, VASCULAR |
| 33 | NEUROLOGY | 62 | PED. RADIOLOGY | 94 | UROLOGY |
| 34 | NEUROPATHOLOGY | 63 | PED. SURGERY | | |

| | Code | Percent of Time | Board Certified (Indicate Yes/No) |
|---|---|---|---|
| Primary | 40 | 100 | N |
| Secondary | 36 | -0- | Y |
| Tertiary | | | |

**PLEASE INDICATE AMERICAN BOARD OF MEDICAL SPECIALTIES BOARD CERTIFICATION:**

| | Date of Initial Certification | Date of Last Certification |
|---|---|---|
| Board Internal Medicine | September, 1989 | |
| | (Mo./Yr.) | (Mo./Yr.) |
| Subboard | | |
| | (Mo./Yr.) | (Mo./Yr.) |

3. Form of employment is 1006 (Use the following codes)

SELF-EMPLOYED
1001 Solo Practice
1002 Partnership or Group Practitioners

SALARIED, EMPLOYED BY:
1003 Individual Practitioner
1004 Partnership or Group of Practitioners
1005 Group Health Plan Facility (such as H.M.O.)

SALARIED, EMPLOYED BY (continued)
1006 Other Non-Government Employer (hospital, school, etc.)
1007 Federal Government (armed services personnel only)
1008 Federal Government (civilian, P.H.S., etc.)
1009 State Government
1010 County Government
1011 Local Government
1012 Other (specify)_____

**All of the following questions refer to the time period July 1, 1995, through the present date only. FOR ALL YES RESPONSES, PLEASE EXPLAIN ON A SEPARATE SHEET AND RETURN WITH THIS REGISTRATION APPLICATION**

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

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

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments; and
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physician capability to perform medical tasks such as physician examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

**"Medical condition"** includes physiological, mental or psychological conditions or disorders, such as, but not limited to, orthopedic, vision, speech, and hearing, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, emotional or mental illness, HIV disease, tuberculosis, drug addiction, and alcoholism.

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

**"Currently"** does not mean on the day of, or even in the weeks or months preceding the completing of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee.

**ALL QUESTIONS ANSWERED 'YES' MUST BE EXPLAINED ON A SEPARATE ATTACHED SHEET OF PAPER**

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

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

3. If you use chemical substances, does your use of chemical substance(s) in any way impair or limit your ability to practice medicine with reasonable skill and safety? ____Yes X No ____N/A

4. Have you failed to initiate the performance of public service within one year after the date the public service is required to begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local government for your medical education? ____Yes X No

5. Have you been a defendant in a legal action involving professional liability (malpractice) or had a professional liability claim paid in your behalf or paid such a claim yourself? ____Yes X No

6. Have you ever been investigated for, charged with, convicted of, or plead guilty or nolo contendere to, any offense or violation of any federal, state or local law, including any foreign country, which is a misdemeanor, gross misdemeanor, or felony, excluding any minor traffic offense (Driving or in control of a motor vehicle while under the influence of any substance is not considered a minor traffic offense) or which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? ____Yes X No

7. Have you ever been denied a license, permission to practice medicine or any other healing arts, or permission to take an examination to practice medicine or any other healing arts in any state, country or U.S. territory? ____Yes X No

8. Have you ever had a medical license revoked, suspended, limited, or restricted in any state, country or U.S. territory? ____Yes X No

9. Have you ever voluntarily surrendered a license to practice a healing art in any state, country or U.S. territory? ____Yes X No

10. Have you ever been denied membership or expelled from a medical society or other professional medical organization? ____Yes X No

11. Have you ever been investigated for, charged with, or convicted of any violation of a statute, rule or regulation governing the practice of medicine by any medical licensing board, hospital, medical society, governmental entity or other agency? ____Yes X No

12. Have you ever surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? ____Yes X No

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

| Hospital | Mailing Address | Type of Action | Dates of Action From (Mo./Yr.) | To (Mo./Yr.) |
|---|---|---|---|---|
| N/A | | | | |

If more space is needed, attach separate sheet.

PLEASE CHECK ONE OF THE FOLLOWING:

✓ 1. I have earned a minimum of 40 hours approved AMA Category I continuing medical education (CME) for the biennial period July 1, 1995, through June 30, 1997.

____ 2. I was initially licensed in Nevada during the second six months of the biennial period July 1, 1995, through June 30, 1997 and have earned a minimum of 30 hours approved AMA Category I continuing medical education (CME).

____ 3. I was initially licensed in Nevada during the third six months of the biennial period July 1, 1995, through June 30, 1997 and have earned a minimum of 20 hours approved AMA Category I continuing medical education (CME).

____ 4. I was initially licensed in Nevada during the fourth six months of the biennial period July 1, 1995, through June 3, 1997 and have earned a minimum of 10 hours approved AMA Category I continuing medical education (CME).

____ 5. I am exempt from submitting proof of continuing medical education (CME) because I have completed a full year of residency or fellowship training during the biennial period July 1, 1995, through June 30, 1997.

Signature ✓ Signature stamp unacceptable

**IMPORTANT: ATTACH COPIES OF PROOF OF DECLARED CME CREDITS. PROOF OF CME CREDITS WILL NOT BE RETURNED.**

I HAVE X HAVE NOT ____ ACTIVELY PRACTICED IN NEVADA WITHIN THE PAST 12 MONTHS. (CHECK ONE)

I HEREBY CERTIFY THAT I AM THE PERSON NAMED IN THIS APPLICATION FOR REGISTRATION RENEWAL OF LICENSE TO PRACTICE MEDICINE IN THE STATE OF NEVADA AND THAT ALL STATEMENTS I HAVE MADE HEREIN ARE TRUE.

(505)845-8039 Business Telephone # 3-31-97 Date

Signature (SIGNATURE STAMP UNACCEPTABLE)

**APPLICATION FOR REGISTRATION RENEWAL**
**NEVADA STATE BOARD OF MEDICAL EXAMINERS**
Post Office Box 7238 Reno, Nevada 89510 Phone (702) 688-2559

Date Received by State Board: MAY 2 2 1995

License No. _____
File No _____

This shaded section for BOARD USE ONLY

...reby apply for renewal of biennial registration and enclose the appropriate fees as indicated below:

_X_ ACTIVE STATUS $420
_____ INACTIVE STATUS $150 (see attached NRS 630.255 & 630.257)
_____ RETIRED STATUS $ 50 (see attached NRS 630.256 & 630.257) (MUST NOT BE PRACTICING MEDICINE IN ANY STATE)
_____ P.A. SUPERVISING PHYSICIAN $200

**PLEASE NOTE:** NEVADA HAS NO GRACE PERIOD. LICENSES NOT RENEWED BY JULY 1, 1995 ARE AUTOMATICALLY SUSPENDED FOR NON-PAYMENT.

Stephanie Ball, MD
PO Box 5800 Medical ~~7030~~ 1018
Albuquerque NM 87185-~~0000~~ 1018

Make checks payable to
NEVADA STATE BOARD OF MEDICAL EXAMINERS
(Foreign checks must indicate "U.S. FUNDS")

## INSTRUCTIONS - TYPE OR PRINT LEGIBLY

1. YOUR CURRENT M.D. LICENSE EXPIRES ON **JUNE 30, 1995.** THIS IS THE NOTICE TO RENEW YOUR M.D. LICENSE.
2. To be eligible to act as a supervising physician for a physician assistant, complete the enclosed Application for Approval as Supervising Physician form.
3. ACTIVE STATUS REGISTRATION RENEWAL REQUIRES THE SUBMISSION OF PROOF OF 40 HOURS AMA CATEGORY I, CONTINUING MEDICAL EDUCATION completed during July 1, 1993 through June 30, 1995. Submit your proof of CME with your completed Application for Registration Renewal form.
4. In order to provide sufficient time for processing, please complete and return your Application for Registration Renewal form and Application for Approval as Supervising Physician form (if applicable) with your proof of 40 hours AMA Category I CME and the correct fee(s) **PRIOR TO JULY 1, 1995.** Use the enclosed self-addressed envelope to return your completed form(s) and fee(s).
5. If your name and/or address has changed from that printed on this form, clearly indicate that change in the space provided. A notarized or certified copy of the document authorizing your name change (marriage license, divorce decree, etc.) must be included.

Name _____

Street P.O. Box 5800 Medical. MS1018

City _____ County _____ State NM Zip Code 87185-1018

6. IF YOU HAVE RETIRED OR MOVED YOUR PRACTICE, PLEASE INDICATE THE LOCATION OF FORMER PATIENT RECORDS BELOW:

Name _____

Street _____

City _____ County _____ State _____ Zip Code _____

**YOUR LICENSE REGISTRATION WILL NOT BE RENEWED WITHOUT SUBMISSION OF THE CORRECT FEE(S), PROPERLY COMPLETED FORM(S) AND PROOF OF 40 HOURS OF CME.**

**ALL PAGES OF THE FORM(S) MUST BE COMPLETED AND RETURNED.**

**ALL FEES ARE NON-REFUNDABLE. DO NOT SEND CASH THROUGH THE MAIL.**

**PLEASE ALLOW 60 DAYS FOR THE PROCESSING OF YOUR REGISTRATION RENEWAL.**

**PLEASE PROVIDE ALL INFORMATION AS REQUESTED.**

1. Are you currently active in medicine?
   a. ( ) YES, in training.
   b. (X) YES, working full-time.
   c. ( ) YES, working part-time.
   d. ( ) NO, retired.
   e. ( ) NO, other (specify _____)

2. Please indicate your primary, secondary and tertiary specialties and percent of time spent in each, using the following codes.

**SPECIALTY CODE:**

| | | | | | |
|---|---|---|---|---|---|
| 1 | ADOLESCENT MEDICINE | 35 | NEURORADIOLOGY | 64 | PED, UROLOGY |
| 2 | AEROSPACE MEDICINE | 36 | NUCLEAR MEDICINE | 65 | PEDIATRICS |
| 3 | ALLERGY / IMMUNOLOGY | 37 | NUTRITION | 66 | PHYSICAL MED / REHAB |
| 4 | ANESTHESIOLOGY | 38 | OBSTETRIC / GYNECOLOGY | 96 | PHYSICIAN ASSISTANT |
| 5 | BLOODBANKING | 39 | OBSTETRICS | 67 | PREVENTIVE MED |
| 6 | BRONCO-ESOPHAGOLOGY | 40 | OCCUPATIONAL MED | 68 | PSYCHIATRY |
| 7 | CARDIOVASC DISEASES | 41 | ONCOLOGY | 69 | PSYCHOANALYSIS |
| 8 | CATSCAN / ULTRASOUND | 45 | ONCOLOGY, GYNECOLOGIC | 70 | PSYCHOMATIC MEDICINE |
| 9 | CHILD NEUROLOGY | 42 | ONCOLOGY, HEMATOLOGY | 71 | PUBLIC HEALTH |
| 10 | CHILD PSYCHIATRY | 43 | ONCOLOGY, RADIATION | 72 | PULMONARY DISEASES |
| 11 | CLINICAL PHARMACOL | 44 | ONCOLOGY, SURGICAL | 73 | RADIOLOGY |
| 12 | CRITICAL CARE | 46 | OPHTHALMOLOGY | 74 | RADIOLOGY, DIAGNOSTIC |
| 13 | DERMATOLOGY | 47 | OTOLARYNGOLOGY | 75 | RADIOLOGY, NUCLEAR |
| 14 | EMERGENCY MEDICINE | 48 | OTOLOGY | 76 | RADIOLOGY, THERAPEUT |
| 15 | ENDOCRINOLOGY | 49 | PAIN MANAGEMENT | 77 | RHEUMATOLOGY |
| 16 | FAMILY PRACTICE | 50 | PATHOLOGY | 78 | RHINOLOGY |
| 17 | GASTROENTEROLOGY | 51 | PATHOLOGY, ANATOMIC | 79 | SLEEP DISORDERS |
| 18 | GENERAL PRACTICE | 52 | PATHOLOGY, CLINICAL | 100 | SPORTS MEDICINE |
| 19 | GERIATRICS | 53 | PATHOLOGY, FORENSIC | 80 | SURGERY, ABDOMINAL |
| 20 | GYNECOLOGY | 54 | PED, ALLERGY | 81 | SURGERY, CARDIOVASC |
| 21 | HEMATOLOGY | 55 | PED, CARDIOLOGY | 91 | SURGERY, COLON/RECTAL |
| 22 | HYPNOSIS | 99 | PED, CRITICAL CARE | 82 | SURGERY, GENERAL |
| 23 | IMMUNOLOGY | 97 | PED, EMERGENCY MED | 83 | SURGERY, HAND |
| 24 | INFECTIOUS DISEASES | 56 | PED, ENDOCRINOLOGY | 84 | SURGERY, HEAD/NECK |
| 25 | INFERTILITY | 57 | PED, HEMAT / ONCOLOGY | 92 | SURGERY, MAXILLOFAC |
| 26 | INTERNAL MEDICINE | 58 | PED, INFECTIOUS DIS | 93 | SURGERY, NEUROLOGICAL |
| 27 | LARYNGOLOGY | 59 | PED, INTENSIVIST | 85 | SURGERY, ORTHOPEDIC |
| 28 | LEGAL MEDICINE | 60 | PED, NEPHROLOGY | 86 | SURGERY, PLASTIC |
| 29 | MATERNAL / FETAL MED | 98 | PED, NEUROLOGY | 87 | SURGERY, THORACIC |
| 30 | NEO / PERINATAL MED | 101 | PED, OPHTHALMOLOGY | 88 | SURGERY, TRAUMATIC |
| 31 | NEOPLASTIC DISEASES | 61 | PED, PHYSIATRY | 89 | SURGERY, UROLOGIC |
| 32 | NEPHROLOGY | 95 | PED, PULMONARY | 90 | SURGERY, VASCULAR |
| 33 | NEUROLOGY | 62 | PED, RADIOLOGY | 94 | UROLOGY |
| 34 | NEUROPATHOLOGY | 63 | PED, SURGERY | | |

| | Code | Percent of Time | Board Certified (Indicate Yes/No) |
|---|---|---|---|
| Primary | 40 | 100 | NO |
| Secondary | 26 | -0- | YES |
| Tertiary | | | |

**PLEASE INDICATE AMERICAN BOARD OF MEDICAL SPECIALTIES BOARD CERTIFICATION:**

| | Date of Initial Certification (Mo./Yr.) | Date of Last Recertification (Mo./Yr.) |
|---|---|---|
| Board INTERNAL MEDICINE | | |
| Subboard | | |

3. How many hours per week do you spend in each of the following activities?
   10 hours Patient care or services
   40 hours Administration (schools, agencies, associations, etc.)
   _____ hours Teaching medical courses
   _____ hours Research
   _____ hours Other (specify _____)

4. Form of employment is 1012. (Use the following codes.)

SELF-EMPLOYED
1001 Solo Practice
1002 Partnership or Group Practitioners

SALARIED, EMPLOYED BY
1003 Individual Practitioner
1004 Partnership or Group of Practitioners
1005 Group Health Plan Facility (such as H.M.O.)
1006 Other Non-Government Employer (hospital, school, etc.)
1007 Federal Government (armed services personnel only)
1008 Federal Government (civilian, P.H.S., etc.)
1009 State Government
1010 County Government
1011 Local Government
1012 Other (specify Corporate Clinic)

**All of the following questions refer to the time period of July 1, 1993 through the present date only.**
**FOR ALL YES RESPONSES, PLEASE EXPLAIN ON A SEPARATE SHEET AND RETURN WITH THIS REGISTRATION APPLICATION.**

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

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

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments; and
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physician capability to perform medical tasks such as physician examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental or psychological conditions or disorder, such as, but not limited to, orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

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

"Currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or within the past two years.

"Illegal use of controlled dangerous substances" means the use of controlled dangerous substances obtained illegally (e.g. heroin or cocaine) as well as the use of controlled dangerous substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

1. Have you failed to repay, in accordance with the terms of the loan, any direct loan or loan which is insured or guaranteed by the Federal Government or a state or local government which you received to finance all or any part of your medical education? ☐ Yes ☒ No
2. Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? ☐ Yes ☒ No
3. Does your use of chemical substance(s) in any way impair or limit your ability to practice medicine with reasonable skill and safety? ☐ Yes ☒ No
4. Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? ☐ Yes ☒ No
5. Have you been diagnosed as having, or have you been treated for pedophilia, exhibitionism, or voyeurism? ☐ Yes ☒ No
6. Are you currently engaged in the illegal use of controlled dangerous substances? ☐ Yes ☒ No
7. Have you been a defendant in a legal action involving professional liability (malpractice) or had a professional liability claim paid in your behalf or paid such a claim yourself? ☒ Yes ☐ No
8. Have you been investigated for, charged with or convicted of, or pled nolo contendere to a violation of any federal, state or local law relating to the manufacture, distribution, prescribing, or dispensing of controlled substances? ☐ Yes ☒ No
9. Have you been arrested, investigated for, charged with or convicted of, or pled nolo contendere to any offense, misdemeanor or felony in any state, the United States, or a foreign country? ☐ Yes ☒ No
10. Have you previously applied for medical licensure in Nevada (including a residency program)? ☒ Yes ☐ No
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? ☐ Yes ☒ No
12. Have you been denied a license, permission to practice medicine or any other healing arts, or permission to take an examination to practice medicine or any other healing arts in any state, country or U.S. territory? ☐ Yes ☒ No
13. Have you had a medical license revoked, suspended, limited, or restricted in any state, country or U.S. territory? ☒ Yes ☐ No
14. Have you voluntarily surrendered a license to practice in the healing arts in any state, country or U.S. territory? ☐ Yes ☒ No
15. Have you been denied membership or expelled from a medical society or other professional medical organization? ☐ Yes ☒ No
16. List all hospitals where you have had staff privileges denied, suspended, limited, revoked or not renewed by the hospital. List any and all resignations from any medical staff in lieu of disciplinary or administrative action. (Please Note: Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance.)

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

17. Have you been investigated for, charged with, or convicted of any violation of a statute, rule or regulation governing the practice of medicine by any medical licensing board, hospital, medical society, governmental entity or other agency? ☐ Yes ☒ No
18. Have you surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? ☐ Yes ☒ No

## CONTINUING MEDICAL EDUCATION

**630.153 Continuing education: General requirements; exemption; failure to comply.**

1. Except as otherwise provided in subsection 2 and NAC 630.157, each holder of a license to practice medicine shall, at the time of the biennial registration, submit to the board by the final date set by the board for submitting applications for biennial registration evidence, in such form as the board requires, that he has completed 40 full hours of continuing medical education during the preceding 2 years in one or more educational programs. Each educational program must:

(a) Offer, upon successful completion of the program, a certificate of Category 1 credit as recognized by the American Medical Association to the holder of the license;

(b) Be approved by the board; and

(c) Be sponsored in whole or in part by an organization accredited or deemed to be an equivalent organization to offer such programs by the American Medical Association or the Liaison Committee on Continuing Medical Education.

2. Any holder of a license who has completed a full year of residency or fellowship any time during the period for biennial registration immediately

preceding the submission of the application for biennial registration is exempt from the requirements set forth in subsection 1.

3. If the holder of a license fails to submit evidence of his completion of continuing medical education within the time and in the manner prescribed by subsection 1, his license will not be renewed. Such a person may not resume the practice of medicine unless, within 2 years after the end of the biennial period of registration, he:

(a) Pays a fee to the board which is twice the fee for biennial registration otherwise prescribed by subsection 1 of NRS 630.290;

(b) Submits to the board, in such form as it requires, evidence that he has completed 40 full hours of continuing medical education in addition to that otherwise required by subsection 1 or NAC 630.157; and

(c) Is found by the board to be otherwise qualified for active status pursuant to the provisions of this chapter and chapter 630 of NRS.

(Added to NAC by Bd. of Medical Exam'rs, 7-31-85, eff. 8-1-85; A 6-23-86; 11-21-88; 9-12-91)

**PLEASE CHECK ONE OF THE FOLLOWING:**

X 1. I have earned a minimum of 40 hours approved AMA Category I continuing medical education (CME) for the biennial period July 1, 1993 through June 30, 1995.

____ 2. I was initially licensed in Nevada during the second six months of the biennial period July 1, 1993, through June 30, 1995 and have earned a minimum of 30 hours approved AMA Category I continuing medical education (CME).

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

____ 4. I was initially licensed in Nevada during the fourth six months of the biennial period July 1, 1993, through June 30, 1995 and have earned a minimum of 10 hours approved AMA Category I continuing medical education (CME).

____ 5. I am exempt from submitting proof of continuing medical education (CME) because I have completed a full year of residency or fellowship training during the biennial period July 1, 1993 through June 30, 1995.

Signature _____

(SIGNATURE STAMP UNACCEPTABLE)

**IMPORTANT: ATTACH COPIES OF PROOF OF DECLARED CME CREDITS.**
**PROOF OF CME CREDITS WILL NOT BE RETURNED.**

I hereby certify that I am the person named in this Application for Registration Renewal of license to practice medicine in the State of Nevada; that all statements I have made herein are true; that I am the original and lawful possessor of and person named in the various documents and credentials furnished to the Board in connection with this renewal application.

I HAVE ☒ HAVE NOT ☐ ACTIVELY PRACTICED IN NEVADA WITHIN THE PAST 12 MONTHS. (CHECK ONE)
If you have not practiced medicine in the State of Nevada during the period July 1, 1994, through June 30, 1995, please contact the Board office for further instruction.

(505) 845-8039 — Business Telephone #

4-10-95 — Date

X _____ Signature (SIGNATURE STAMP UNACCEPTABLE)

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

1. Each holder of a license to practice medicine must pay to the secretary-treasurer of the board on or before July 1 of each alternate year the applicable fee for biennial registration. This fee must be collected for the period for which a physician is licensed.

2. When a holder of a license fails to pay the fee for biennial registration after it becomes due, his license to practice medicine in this state is automatically suspended. The holder may, within 2 years after the date his license is suspended, upon payment of twice the amount of the current fee for biennial registration to the secretary-treasurer, and after he is found to be in good standing and qualified under the provisions of this chapter, be reinstated to practice.

3. The board shall notify a licensee:

(a) At least once that his fee for biennial registration is due; and

(b) That his license is suspended for nonpayment of the fee. A copy of this notice must be sent to the Drug Enforcement Administration of the United States Department of Justice or its successor agency.

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

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

1. Any licensee who changes the location of his practice of medicine from this state to another state or country, has never engaged in the practice of medicine in this state after licensure or has ceased to engage in the practice of medicine in this state for 12 consecutive months must be placed on inactive status.

2. Before resuming the practice of medicine in this state, the inactive registrant shall:

(a) Notify the board of his intent to resume the practice of medicine in this state;

(b) File an affidavit with the board describing his activities during the period of his inactive status;

(c) Complete the form for registration for active status;

(d) Pay the applicable fee for biennial registration; and

(e) Satisfy the board of his competence to practice medicine.

3. If the board determines that the conduct or competence of the registrant during the period of inactive status would have warranted denial of an application for a license to practice medicine in this state, the board may refuse to place the registrant on active status.

(Added to NRS by 1985, 2222; A 1987, 195; 1993, 2299)

**630.256 Retired licensees: Duties; requirements for reinstatement.**

1. If a licensee retires from the practice of medicine, he shall notify the board in writing of his intention to retire, and the board shall record the fact of retirement. A licensee who is retired may not engage in the practice of medicine. Any licensee who is retired and desires to return to the practice of medicine, must, before resuming the practice of medicine in this state:

(a) Notify the board of his intent to resume the practice of medicine in this state;

(b) File an affidavit with the board describing his activities during the period of his retired status;

(c) Complete the form for registration for active status;

(d) Pay the applicable fee for biennial registration; and

(e) Satisfy the board of his competence to practice medicine.

2. If the board determines that the conduct or competence of the registrant during the period of retirement would have warranted denial of an application for a license to practice medicine in this state, the board may refuse to place the registrant on active status.

(Added to NRS by 1985, 2222; A 1987, 195)

**630.257 Re-examination of inactive or retired licensee.** If a licensee does not practice allopathic medicine for a period of more than 12 consecutive months, the board may require him to take the same examination to test medical competency as that given to applicants for a license.

(Added to NRS by 1985, 2223; A 1993, 2300)

# APPLICATION FOR REGISTRATION

**NEVADA STATE BOARD OF MEDICAL EXAMINERS**

Post Office Box 7238 Reno, Nevada 89510 Phone (702) 688-2559

Date Received by State Board: JUN 10 1993

This shaded section for BOARD USE ONLY

License No _____

File No _____

New ☐ Renewal ☐

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

| | |
|---|---|
| ☒ ACTIVE STATUS | $320.00 ✓ |
| ☐ INACTIVE STATUS | $150.00 |
| ☐ RETIRED STATUS | $ 50.00 |

NOTE: NO GRACE PERIOD – LICENSED NOT RENEWED BY JULY 1 ARE AUTOMATICALLY SUSPENDED FOR NON PAYMENT.

FINAL NOTICE

Stephanie Ball, MD
PO Box 5800 Div 3320
Albuquerque NM 87185-0000

Make checks payable to:
**BOARD OF MEDICAL EXAMINERS**
(Foreign checks must indicate "U.S. FUNDS")

## INSTRUCTIONS – TYPE OR PRINT LEGIBLY

1. YOUR CURRENT LICENSE EXPIRES ON **JUNE 30, 1993.** This is the notice to renew your M.D. license. You may apply for your license renewal upon receipt of this notice.

2. IN ORDER TO PROVIDE SUFFICIENT TIME FOR PROCESSING, PLEASE RETURN THIS RENEWAL APPLICATION WITH THE CORRECT RENEWAL FEE PRIOR TO **JULY 1, 1993.**

3. Use the enclosed self-addressed envelope to return this renewal notice and registration fee. ACTIVE registration requires submission of proof of 40 hours AMA Category I CME. If you register your license INACTIVE or RETIRED, you may not practice medicine in Nevada, including the writing of prescriptions.

4. All fees are non-refundable. Do not send cash through the mail.

5. If your name and/or address has changed from that printed on this notice, clearly indicate that change in the space provided. A NOTARIZED or CERTIFIED copy of the document authorizing your name change (marriage license, divorce decree, etc.) must be included.

Name Same

Street ~~3704~~ P.O. Box 5800, MEDICAL 7030

City Same County _____ State _____ Zip Code _____

**A LICENSE WILL NOT BE RENEWED WITHOUT THE CORRECT FEE AND SUBMISSION OF THIS PROPERLY COMPLETED FORM.**

**ACTIVE REGISTRANTS MUST SUBMIT PROOF OF 40 HOURS AMA CATEGORY I CONTINUING MEDICAL EDUCATION (CME).**

**PLEASE ALLOW 60 DAYS FOR THE PROCESSING OF YOUR LICENSE RENEWAL. ALL PAGES MUST BE COMPLETED AND RETURNED.**

**ANSWER THE FOLLOWING QUESTIONS AND RETURN IN THE ENCLOSED SELF-ADDRESSED ENVELOPE.**

1. Are you currently active in medicine?
   a. ( ) YES, in training.
   b. (X) YES, working full-time.
   c. ( ) YES, working part-time.
   d. ( ) NO, retired.
   e. ( ) NO, other (specify _____ )

2. Please indicate your primary, secondary and tertiary specialties and percent of time spent in each, using the following codes:

**SPECIALTY CODE:**

1 ADOLESCENT MEDICINE
2 AEROSPACE MEDICINE
3 ALLERGY/IMMUNOLOGY
4 ANESTHESIOLOGY
5 BLOODBANKING
6 BRONCO-ESOPHAGOLOGY
7 CARDIOVASC DISEASES
8 CATSCAN/ULTRASOUND
9 CHILD NEUROLOGY
10 CHILD PSYCHIATRY
11 CLINICAL PHARMACOL
12 CRITICAL CARE
13 DERMATOLOGY
14 EMERGENCY MEDICINE
15 ENDOCRINOLOGY
16 FAMILY PRACTICE
17 GASTROENTEROLOGY
18 GENERAL PRACTICE
19 GERIATRICS
20 GYNECOLOGY
21 HEMATOLOGY
22 HYPNOSIS
23 IMMUNOLOGY
24 INFECTIOUS DISEASES
25 INFERTILITY
26 INTERNAL MEDICINE
27 LARYNGOLOGY
28 LEGAL MEDICINE
29 MATERNAL/FETAL MED
30 NEO/PERINATAL MED
31 NEOPLASTIC DISEASES
32 NEPHROLOGY
33 NEUROLOGY
34 NEUROPATHOLOGY
35 NEURORADIOLOGY
36 NUCLEAR MEDICINE
37 NUTRITION
38 OBSTETRIC/GYNECOLOGY
39 OBSTETRICS
40 OCCUPATIONAL MED
41 ONCOLOGY
42 ONCOLOGY, GYNECOLOGIC
43 ONCOLOGY, HEMATOLOGY
44 ONCOLOGY, RADIATION
45 ONCOLOGY, SURGICAL
46 OPHTHALMOLOGY
47 OTOLARYNGOLOGY
48 OTOLOGY
49 PAIN MANAGEMENT
50 PATHOLOGY
51 PATHOLOGY, ANATOMIC
52 PATHOLOGY, CLINICAL
53 PATHOLOGY, FORENSIC
54 PED, ALLERGY
55 PED, CARDIOLOGY
56 PED, ENDOCRINOLOGY
57 PED, HEMAT/ONCOLOGY
58 PED, INFECTIOUS DIS
59 PED, INTENSIVIST
60 PED, NEPHROLOGY
61 PED, PHYSIATRY
62 PED, RADIOLOGY
63 PED, SURGERY
64 PED, UROLOGY
65 PEDIATRICS
66 PHYSICAL MED/REHAB
67 PREVENTATIVE MED
68 PSYCHIATRY
69 PSYCHOANALYSIS
70 PSYCHOMATIC MEDICINE
71 PUBLIC HEALTH
72 PULMONARY DISEASES
73 RADIOLOGY
74 RADIOLOGY, DIAGNOSTIC
75 RADIOLOGY, NUCLEAR
76 RADIOLOGY, THERAPEUT
77 RHEUMATOLOGY
78 RHINOLOGY
79 SLEEP DISORDERS
80 SURGERY, ABDOMINAL
81 SURGERY, CARDIOVASC
82 SURGERY, COLON/RECTAL
83 SURGERY, GENERAL
84 SURGERY, HAND
85 SURGERY, HEAD/NECK
86 SURGERY, MAXILLOFAC
87 SURGERY, NEUROLOGICAL
88 SURGERY, ORTHOPEDIC
89 SURGERY, PLASTIC
90 SURGERY, THORACIC
91 SURGERY, TRAUMATIC
92 SURGERY, UROLOGIC
93 SURGERY, VASCULAR
94 UROLOGY

| | Code | Percent of Time | Board Certified (Indicate Yes/No) |
|---|---|---|---|
| Primary | 40 | 100 | NO |
| Secondary | 26 | 0 | YES |
| Tertiary | | | |

PLEASE INDICATE AMERICAN BOARD OF MEDICAL SPECIALTIES BOARD CERTIFICATION:

Board Internal Medicine 9/89

Subboard _____

3. How many hours per week do you spend in each of the following activities?
   55 hours Patient care or services
   _____ hours Administration (schools, agencies, association, etc.)
   _____ hours Teaching medical courses
   _____ hours Research
   _____ hours Other (specify _____ )

4. Form of employment is 1006 . (Use the following codes.)

SELF-EMPLOYED
1001 Solo Practice
1002 Partnership or Group Practitioners
SALARIED, EMPLOYED BY
1003 Individual Practitioner
1004 Partnership or Group of Practitioners
1005 Group Health Plan Facility (such as H.M.O.)
(1006) Other Non-Government Employer (hospital, school, etc.)
1007 Federal Government (armed services personnel only)
1008 Federal Government (civilian P.H.S., etc.)
1009 State Government
1010 County Government
1011 Local Government
1012 Other (specify _____ )

All of the following questions refer to the time period of **July 1, 1991, through the present date** only. FOR ALL **YES** RESPONSES, PLEASE EXPLAIN ON A SEPARATE SHEET AND RETURN WITH THE RENEWAL APPLICATION.

5. Have you been rejected for membership by any medical society? Yes ☐ No ☒
6. Have you been denied a license to practice medicine? Yes ☐ No ☒
7. Have you been denied staff membership with any licensed hospital, nursing home or other hospital care facility with an organized medical staff? Yes ☐ No ☒
8. Have you been censured, reprimanded, disciplined, had privileges limited, had privileges suspended, been put on probation, or been requested to withdraw from any licensed hospital, nursing home, clinic, or other hospital care facility with an organized medical staff, in which you trained, have been a staff member, have been a partner, or have held hospital privileges? Yes ☐ No ☒
9. Have you lost American Board certification because of disciplinary action? Yes ☐ No ☒
10. Have any U.S. state and/or Canadian provincial licensing or disciplinary agencies limited, restricted, suspended or revoked a license you have held or taken any other disciplinary action against you? Yes ☐ No ☒
11. Have you voluntarily surrendered a license issued to you by any state and/or Canadian provincial licensing agency while an investigation or other disciplinary action was pending? Yes ☐ No ☒
12. Have you been notified of any current/pending charges or complaints filed against you with any state and/or Canadian provincial licensing or disciplinary agency? Yes ☐ No ☒
13. Have you been diagnosed or treated for any physical illness that would serve to hinder your ability to practice medicine? Yes ☐ No ☒
14. Have you been diagnosed or treated for mental illness? Yes ☐ No ☒
15. Have you been chemically dependent? Yes ☐ No ☒
16. Have you interrupted your training because of illness or impairment? Yes ☐ No ☒
17. Have you been unable to practice medicine because of illness or impairment? Yes ☐ No ☒
18. Have you been denied a controlled substances registration certificate by the Drug Enforcement Administration (DEA) or State Board of Pharmacy or other lawful authority concerned with controlled substances or been censured, reprimanded, restricted, voluntarily surrendered, placed on probation or had such authority revoked? Yes ☐ No ☒
19. Have you been indicted, arrested, charged with, convicted, pled guilty or nolo contendere in any criminal prosecution under the laws of any state or of the United States, for any offense reasonably related to the qualifications, functions or duties of a physician, for any offense an essential element of which is fraud, dishonesty or an act of violence, or for any offense involving moral turpitude? Yes ☐ No ☒
20. Have you been a defendant in a legal action involving professional liability (malpractice) or had a professional liability claim paid in your behalf or paid such a claim yourself? Yes ☐ No ☒
21. Have you been denied provider participation in any State Medicaid or Federal Medicare Program? Yes ☐ No ☒
22. Have you been terminated from, sanctioned or penalized by, or had to repay monies to any State Medicaid or Federal Medicare Program as a result of administrative or criminal action? Yes ☐ No ☒

PLEASE LIST CURRENT HOSPITAL AFFILIATION(S): NONE

Name _____ Address _____

Name _____ Address _____

Name _____ Address _____

Name _____ Address _____

## CONTINUING MEDICAL EDUCATION

**630.153 Continuing education: General requirements; exemption; failure to comply.**

1. Except as otherwise provided in subsection 2 and NAC 630.157, each holder of a license to practice medicine shall, at the time of the biennial registration, submit to the board by the final date set by the board for submitting applications for biennial registration evidence, in such form as the board requires, that he has completed 40 full hours of continuing medical education during the preceding 2 years in one or more educational programs. Each educational program must:

(a) Offer, upon successful completion of the program, a certificate of Category 1 credit as recognized by the American Medical Association to the holder of the license;

(b) Be approved by the board; and

(c) Be sponsored in whole or in part by an organization accredited or deemed to be an equivalent organization to offer such programs by the American Medical Association or the Liaison Committee on Continuing Medical Education.

2. Any holder of a license who has completed a full year of residency or fellowship any time during the period for biennial registration immediately preceding the submission of the application for biennial registration is exempt from the requirements set forth in subsection 1.

3. If the holder of a license fails to submit evidence of his completion of continuing medical education within the time and in the manner prescribed by subsection 1, his license will not be renewed. Such a person may not resume the practice of medicine unless, within 2 years after the end of the biennial period of registration, he:

(a) Pays a fee to the board which is twice the fee for biennial registration otherwise prescribed by subsection 1 of NRS 630.290;

(b) Submits to the board, in such form as it requires, evidence that he has completed 40 full hours of continuing medical education in addition to that otherwise required by subsection 1 or NAC 630.157; and

(c) Is found by the board to be otherwise qualified for active status pursuant to the provisions of this chapter and chapter 630 of NRS.

(Added to NAC by Bd. of Medical Exam'rs, 7-31-85, eff. 8-1-85; A 6-23-86; 11-21-88; 9-12-91)

PLEASE CHECK ONE OF THE FOLLOWING:

__X__ 1. I have earned a minimum of 40 hours approved AMA Category I continuing medical education (CME) for the period July 1, 1991, through June 30, 1993.

_____ 2. I am exempt because I have completed a full year of residency or fellowship training during the period for biennial registration immediately preceding the submission of this application.

_____ 3. I am exempt as I am applying for INACTIVE or RETIRED status.

Signature _____
(SIGNATURE STAMP UNACCEPTABLE)

**IMPORTANT: ATTACH COPIES OF CERTIFICATES OF DECLARED CME CREDITS PROOF OF CME CREDITS WILL NOT BE RETURNED.**

Date of Birth: 03/ /52
month/day/year

Social Security Number: _____

DEA Number: _____

Medical School: UNIV. OF NEVADA — RENO (City) — NV (State)

Internship: UNIV OF NEW MEXICO HOSP. — ALBUQUERQUE (City) — NM (State)

Residency: " " " " " " " (City) " (State)

_____ (City) _____ (State)

_____ (City) _____ (State)

Fellowship: _____ (City) _____ (State)

I hereby certify that I am the person named in this application for renewal of license to practice medicine in the state of Nevada; that all statements I have made herein are true; that I am the original and lawful possessor of and person named in the various documents and credentials furnished to the Board in connection with this renewal application.

**I HAVE ☒ HAVE NOT ☐ ACTIVELY PRACTICED IN NEVADA WITHIN THE PAST 12 MONTHS (CHECK ONE)**

(505) 845-8039
Business Telephone #

6/3/93
Date

x _____
Signature (SIGNATURE STAMP UNACCEPTABLE)

**ALL PAGES MUST BE RETURNED OR YOUR LICENSE WILL NOT BE RENEWED.**

# APPLICATION FOR REGISTRATION

## NEVADA STATE BOARD OF MEDICAL EXAMINERS

Post Office Box 7238 Reno, Nevada 89510 Phone (702) 329-2559

Date Received by State Board: MAY 23 1991

MAY 6 1991

License No.

File No.

New ☐ Renewal ☐

This shaded section for BOARD USE ONLY

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

| | |
|---|---|
| X ACTIVE STATUS | $400.00 |
| ☐ INACTIVE STATUS | $150.00 |
| ☐ RETIRED STATUS | $ 50.00 |

NOTE: NO GRACE PERIOD – LICENSES NOT RENEWED BY JULY 1 ARE AUTOMATICALLY SUSPENDED FOR NON PAYMENT.

NRS630 explanation of status on reverse side

Stephanie Ball MD
PO Box 5800 Div 3320
Albuquerque NM 87185-0000

Make checks payable to:
**BOARD OF MEDICAL EXAMINERS**
(Foreign checks must indicate "U.S. FUNDS")

**TYPE OR PRINT LEGIBLY**

NAME BALL (Last) STEPHANIE (First) (Middle)

Social Security #

Business Phone (505) 845-8039

BUSINESS OR MAILING ADDRESS SAME
Street Address or P.O. Box Suite No. City State Zip Code

If you have retired or moved your practice, please indicate the location of former patient's records for the last 5 years below:

NAME

ADDRESS

PHONE # ( )

BOARD OF CERTIFICATION

Yes ✓ No

AM. Bd. of INTERNAL MEDICINE

Date of Certification or Recertification 9/89

Primary Specialty (List only one) Sub-Specialties:

I certify that within the past 24 months, I have completed a minimum of 40 hours of Continuing Medical Education, AMA-Category 1 and that I have in my files documentation of such. I understand that the CME requirement is mandated by NRS 630.253 and NAC 630.153.

Signature: (No rubber stamps) Date 4/15/91

**SINCE YOUR LAST REGISTRATION:** (If any question is answered "yes," attach a detailed explanation.)

1. Have you been investigated by, or charged or convicted of unprofessional conduct, professional incompetence or gross or repeated malpractice by any medical licensing board or other agency, hospital or medical society? Yes ☐ No X

2. Have you been arrested, fined (over $100), charged with or convicted of a crime, indicted, imprisoned or placed on probation? Yes ☐ No X

3. Have you been investigated, arrested, charged or convicted for the possession, use of, or illegal sale or dispensing of controlled substances? Yes ☐ No X

4. Have you been denied a medical license or surrendered your license to practice in another jurisdiction or had your medical license or right to practice medicine revoked, suspended or limited in another jurisdiction. Yes ☐ No X

5. Have you had staff privileges in a hospital denied, suspended, limited, revoked or not renewed, or have you resigned from a medical staff in lieu of disciplinary or administrative action, excluding failure to complete medical records? Yes ☐ No X

6. Have any malpractice settlements, awards or judgments been made against you in any jurisdiction? Yes ☐ No X

STAFF PRIVILEGES: List all Nevada Hospitals in which you have any staff privileges: (Name and Location)

1. N/A
2.
3.
4.
5.
6.

I certify that all my statements in this application are true. I have X have not ☐ actively practiced in Nevada within the past 12 months. (Check one)

Signature: (No rubber stamps) Date 4/15/91

NOTE: Have you signed both "signature" lines.

# APPLICATION FOR REGISTRATION

## NEVADA STATE BOARD OF MEDICAL EXAMINERS

Post Office Box 7238 Reno, Nevada 89510 Phone (702) 329-2559

Date Received by State Board: 12/1/90

License No. 6164

File No. ____

New ☑ Renewal ☐

This shaded section for BOARD USE ONLY

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

| | | |
|---|---|---|
| ☒ ACTIVE STATUS | ~~$300.00~~ 150.00 | NOTE: NO GRACE PERIOD – LICENSES NOT RENEWED BY JULY 1 ARE AUTOMATICALLY SUSPENDED FOR NON PAYMENT. |
| ☐ INACTIVE STATUS | $150.00 | |
| ☐ RETIRED STATUS | $ 50.00 | |

NRS630 explanation of status on reverse side

Make checks payable to:
**BOARD OF MEDICAL EXAMINERS**
(Foreign checks must indicate "U.S. FUNDS")

**TYPE OR PRINT LEGIBLY**

NAME Ball (Last) Stephanie (First) ____ (Middle)

Social Security # –

Business Phone (505) 845-8039

BUSINESS OR MAILING ADDRESS Division 3320 P.O. Box 5800 (Street Address or P.O. Box) Albuquerque (City) NM (State) 87185 (Zip Code)

If you have retired or moved your practice, please indicate the location of former patient's records below:

NAME ____

ADDRESS ____

PHONE # (____) ____

BOARD OF CERTIFICATION

Yes ____ No ____

AM. Bd. of ____

Date of Certification or Recertification ____

Primary Specialty (List only one) ____ Sub-Specialties: ____

I certify that within the past 24 months, I have completed a minimum of 40 hours of Continuing Medical Education, AMA-Category 1 and that I have in my files documentation of such. I understand that the CME requirement is mandated by NRS 630.253 and NAC 630.153.

Signed: ____ Date ____

(No rubber stamps)

**SINCE YOUR LAST REGISTRATION:** (If any question is answered "yes," attach a detailed explanation.)

1. Have you been investigated, charged or convicted of unprofessional conduct, professional incompetence or gross or repeated malpractice by any medical licensing board or other agency, hospital or medical society? Yes ☐ No ☐

2. Have you been arrested, fined (over $100), charged with or convicted of a crime, indicted, imprisoned or placed on probation? Yes ☐ No ☐

3. Have you been investigated, arrested, charged or convicted for the possession, use of, or illegal sale or dispensing of controlled substances? Yes ☐ No ☐

4. Have you been denied a medical license or surrendered your license to practice in another jurisdiction or had your medical license revoked, suspended or limited in another jurisdiction. Yes ☐ No ☐

5. Have you had staff privileges in a hospital denied, suspended, limited, revoked or not renewed, or have you resigned from a medical staff in lieu of disciplinary or administrative action, excluding failure to complete medical records? Yes ☐ No ☐

6. Have any malpractice settlements, awards or judgments been made against you in any jurisdiction? Yes ☐ No ☐

STAFF PRIVILEGES: List all Nevada Hospitals in which you have any staff privileges: (Name and Location)

1. none
2. ____
3. ____
4. ____
5. ____
6. ____

I certify that all the above statements are true ~~and that I have actively practiced in Nevada within the past 12 months.~~

Signature ____ Date 12-1-90

(No rubber stamps)

PHYSICIA

**APPLICATION FOR STATUS CHANGE TO ACTIVE STATUS REGISTRATION FORM FOR THE BIENNIAL PERIOD 2019 - 2021**
**NEVADA STATE BOARD OF MEDICAL EXAMINERS**
9600 Gateway Drive, Reno, NV 89521
Phone (775) 688-2559

RECEIVED — Date Received by Board
HAND-DELIVERED
MAY 24 2019
NEVADA STATE BOARD OF MEDICAL EXAMINERS

License No. 01604
File No. _____
(Board Use Only)

I hereby apply for status change to active status, and enclose the appropriate fee as indicated below:

| | | | |
|---|---|---|---|
| ✓ | CHANGE FROM INACTIVE TO ACTIVE STATUS | between 7/1/2019 - 6/30/2021 | **$ 750.00** |

**You may pay by cashier's check or money order payable to "NEVADA STATE BOARD OF MEDICAL EXAMINERS," or by credit card. If paying by credit card, please complete the Credit Card Autho[illegible] application. A two percent (2%) service fee will be assessed for payment by cr[illegible]**

[redacted]

Licens[illegible]

*PLEA[illegible]*

**NRS 63[illegible]: reinstatement.**

4. Befo[illegible]cine in this State, the inactive registrant must:
[illegible] his or her intent to resume the practice of medicine in this State;
[illegible]rd describing the activities of the registrant during the period of inactive status;
[illegible]ration for active status;
(d) Pay the applicable fee for biennial registration; and
(e) Satisfy the Board of his or her competence to practice medicine.

5. If the Board determines that the conduct or competence of the registrant during the period of inactive status would have warranted denial of an application for a license to practice medicine in this State, the Board may refuse to place the registrant on active status.

- Your Status Will Not Be Changed Unless You Answer All Questions On This *Application For Status Change To Active Status Registration* Form.
- You Must Provide Written Explanations For All Questions Answered "Yes."
- All Information You Provide On This Application Is Public Information.

## PLEASE TYPE OR PRINT LEG[illegible]

1. Active status registration requires the submission of proof of completion of **AMA C[illegible]** (CME), **completed during the preceding 24-month time period of the date of you[illegible]** proof of completion of CME with your completed ***APPLICATION FOR STA[illegible]TATUS REGISTRATION*** form. A detailed description of the number of continuing medical ed[illegible] status can be found on page 8 of this application.

[illegible]ucation [illegible]nit your [illegible]ange of

2. If your name and/or address have changed, indicate the change in the space provided below. Please be advised, the address you provide below is viewable on the NSBME website and will become your public address. Also, please indicate your current public telephone and fax numbers. Please note: if your name has changed, a copy of the document authorizing your name change (marriage license, divorce decree, etc.) must be included.

Name Stephanie Ball

Street PO Box 9869

City Reno County Washoe State NV Zip 89507

Public Phone Number _____ Public Fax Number _____

Cellular Phone: 925-337-1076 Private ✓ Public ☐

Email address sball3550@yahoo.com

Questions:

## All of the following questions refer to the time period since your last renewal

**In the event that your status was not changed to Inactive during a renewal, all questions refer to the time period within the last 24 months prior to your submission of this form.**

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HAND-DELIVERED
MAY 24 2019
NEVADA STATE BOARD OF MEDICAL EXAMINERS

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 your completed *Application for Status Change to Active Status Registration* 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 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

3. **IF YOU HAVE RETIRED OR MOVED YOUR PRACTICE,** indicate the location of patient records below:

Name Sandia National Labs Medical Clinic

Street 7011 East Avenue Mailstop 9112

City Livermore County Alameda State CA Zip 94550

Phone Number 925-294-3000

RECEIVED
HAND-DELIVERED
MAY 24 2019
NEVADA STATE BOARD OF
MEDICAL EXAMINERS

4. **INDICATE BELOW YOUR PRIMARY AND SECONDARY SCOPES OF PRACTICE** using the following codes:

**SCOPES OF PRACTICE CODES**

| | | | | | |
|---|---|---|---|---|---|
| 1 | ADDICTION MEDICINE | 41 | NEOPLASTIC DISEASES | 81 | PEDIATRIC, RHEUMATOLOGY |
| 2 | ADOLESCENT MEDICINE | 42 | NEPHROLOGY | 82 | PEDIATRIC, SURGERY |
| 3 | AEROSPACE MEDICINE | 43 | NEUROLOGY | 83 | PEDIATRIC, UROLOGY |
| 4 | ALLERGY | 44 | NEURO-OPHTHALMOLOGY | 84 | PEDIATRICS |
| 5 | ALLERGY/IMMUNOLOGY | 45 | NEUROPATHOLOGY | 85 | PHYSICAL MEDICINE/REHABILITATION |
| 6 | AMBULATORY MEDICINE | 46 | NEURORADIOLOGY | 86 | PREVENTIVE MEDICINE |
| 7 | ANESTHESIOLOGY | 47 | NON-CONVENTIONAL MEDICINE | 87 | PSYCHIATRY |
| 8 | BLOODBANKING | 48 | NUCLEAR MEDICINE | 88 | PSYCHOANALYSIS |
| 9 | BRONCO-ESOPHAGOLOGY | 49 | NUTRITION | 89 | PUBLIC HEALTH |
| 10 | CARDIOVASCULAR DISEASES | 50 | OBSTETRICS | 90 | PSYCHOMATIC MEDICINE |
| 11 | CATSCAN/ULTRASOUND | 51 | OBSTETRICS/GYNECOLOGY | 91 | PULMONARY DISEASES |
| 12 | CHILD NEUROLOGY | 52 | OCCUPATIONAL MEDICINE | 92 | RADIOLOGY |
| 13 | CHILD PSYCHIATRY | 53 | ONCOLOGY | 93 | RADIOLOGY, DIAGNOSTIC |
| 14 | CLINICAL PHARMACOLOGY | 54 | ONCOLOGY, GYNECOLOGICAL | 94 | RADIOLOGY, INTERVENTIONAL |
| 15 | CRITICAL CARE | 55 | ONCOLOGY, HEMATOLOGY | 95 | RADIOLOGY, NUCLEAR |
| 16 | DERMATOLOGY | 56 | ONCOLOGY, RADIATION | 96 | RADIOLOGY, THERAPEUTIC |
| 17 | DERMATOPATHOLOGY | 57 | ONCOLOGY, SURGICAL | 97 | RADIOLOGY, VASCULAR |
| 18 | EMERGENCY MEDICINE | 58 | OPHTHALMOLOGY | 98 | RHEUMATOLOGY |
| 19 | ENDOCRINOLOGY | 59 | OTOLARYNGOLOGY | 99 | RHINOLOGY |
| 20 | FAMILY PRACTICE | 60 | OTOLOGY | 100 | SLEEP DISORDERS |
| 21 | GASTROENTEROLOGY | 61 | PAIN MANAGEMENT | 101 | SPORTS MEDICINE |
| 22 | GENERAL PRACTICE | 62 | PATHOLOGY | 102 | SURGERY, ABDOMINAL |
| 23 | GERIATRIC PSYCHIATRY | 63 | PATHOLOGY, ANATOMIC | 103 | SURGERY, CARDIOTHORACIC |
| 24 | GERIATRICS | 64 | PATHOLOGY, CLINICAL | 104 | SURGERY, CARDIOVASCULAR |
| 25 | GYNECOLOGY | 65 | PATHOLOGY, FORENSIC | 105 | SURGERY, COLON/RECTAL |
| 26 | HAIR TRANSPLANTATION | 66 | PEDIATRIC, ALLERGY | 106 | SURGERY, GENERAL |
| 27 | HEMATOLOGY | 67 | PEDIATRIC, CARDIOLOGY | 107 | SURGERY, HAND |
| 28 | HOMEOPATHY | 68 | PEDIATRIC, CRITICAL CARE | 108 | SURGERY, HEAD/NECK |
| 29 | HYPNOSIS | 69 | PEDIATRIC, EMERGENCY MEDICINE | 109 | SURGERY, MAXILLOFACIAL |
| 30 | IMMUNOLOGY | 70 | PEDIATRIC, ENDOCRINOLOGY | 110 | SURGERY, NEUROLOGICAL |
| 31 | INFECTIOUS DISEASES | 71 | PEDIATRIC, GASTROENTEROLOGY | 111 | SURGERY, ORTHOPEDIC |
| 32 | INFERTILITY | 72 | PEDIATRIC, HEMATOLOGY/ONCOLOGY | 112 | SURGERY, PLASTIC |
| 33 | INTERNAL MEDICINE | 73 | PEDIATRIC, INFECTIOUS DISEASES | 113 | SURGERY, THORACIC |
| 34 | LARYNGOLOGY | 74 | PEDIATRIC, INTENSIVIST | 114 | SURGERY, TRANSPLANT |
| 35 | LEGAL MEDICINE | 75 | PEDIATRIC, NEPHROLOGY | 115 | SURGERY, TRAUMATIC |
| 36 | MATERNAL/FETAL MEDICINE | 76 | PEDIATRIC, NEUROLOGY | 116 | SURGERY, UROLOGIC |
| 37 | MEDICAL ACUPUNCTURE | 77 | PEDIATRIC, OPHTHALMOLOGY | 117 | SURGERY, VASCULAR |
| 38 | MEDICAL ETHICS | 78 | PEDIATRIC, PHYSIATRY | 118 | TOXICOLOGY |
| 39 | MEDICAL GENETICS | 79 | PEDIATRIC, PULMONARY | 119 | URGENT CARE |
| 40 | NEO/PERINATAL MEDICINE | 80 | PEDIATRIC, RADIOLOGY | 120 | UROLOGY |

**Code** **Code**

**Primary Scope of Practice** 33 **Secondary Scope of Practice** _____

## Other States of Current or Previous Licensure:

List state licenses YOU HOLD OR HAVE HELD to practice medicine in any state, territory or country with the exception of training licenses. (Current direct source verification of these licenses must be received by the Board prior to any status change.)

| State/Territory/Country | License # | Date of Issuance | Dates of Practice From (Mo./Yr.) To (Mo./Yr.) |
|---|---|---|---|
| ~~California~~ | ~~G85528~~ | ~~11/24/1999~~ | ~~06/00 to 03/19~~ |
| ~~New Mexico~~ | ~~86-368~~ | ~~11/17/1986~~ | ~~11/86 to 07/2014~~ |

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

Questions (continued): **The following questions refer to the time period since your last renewal OR within the last 24 months prior to your submission of this form.**

## Malpractice Questions:

5. 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

6. 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

## 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 have not answered "yes" to questions #5 and/or #6 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.)

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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/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:

Questions (continued): **The following questions refer to the time period since your last renewal OR within the last 24 months prior to your submission of this form.**

7. 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

8. 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? _____Yes X No

9. 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?

_____Yes X No

10. Have you ever voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory?

_____Yes X No

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

_____Yes X No

12. 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?

_____Yes X No

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

_____Yes X No

14. 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.) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

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

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Attestations/Affirmations:

## CHILD SUPPORT STATEMENT

I UNDERSTAND THAT THIS *APPLICATION FOR STATUS CHANGE TO ACTIVE STATUS REGISTRATION* WILL BE DENIED IF I HAVE NOT PLACED A CHECK MARK NEXT TO (a), (b), OR (c) UNDER THE CHILD SUPPORT STATEMENT SECTION.

**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

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## 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: Stephanie Ball

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

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## APPLICATION AFFIRMATION

I, Stephanie Ball,
(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 _____ 24/May 2019 Date

(NOTARY SEAL)

MARIA FELISE
Notary Public, State of Nevada
Appointment No. 17-1599-2
My Appt. Expires Mar 15, 2021

State of NEVADA County of WASHOE
Subscribed and sworn to before me this 24 day of MAY, 2019
Notary Public for the State of NEVADA
My Commission Expires: MAR. 15, 2021
Residing at: RENO (City) NV (State)

Maria Felise
Signature of Notary

Continuing Education:

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## CONTINUING MEDICAL EDUCATION (CME) STATEMENT:

***Note:*** *If you have previously submitted proof of 4 hours AMA Category 1 continuing medical education regarding bioterrorism or relating to medical consequences of act of terrorism involving use of weapon of mass destruction, you will not be responsible to do so again. For your information, this requirement became effective October 2003.*

**Please place a check mark next to one of the following statements:**

X (a) I was initially licensed in Nevada prior to or during the time period July 1, 2019 through December 31, 2019 and completed a minimum of 44 hours of AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics or pain management and/or addiction care, 20 hours of which were in my scope of practice or specialty and 4 of which were in bio-terrorism/weapons of mass destruction *(if applicable)*;

_____(b) I was initially licensed in Nevada during the time period January 1, 2020 through June 30, 2020, the second six months of the past biennial period, and completed a minimum of 34 hours of AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics or pain management and/or addiction care, 20 hours of which were in my scope of practice or specialty and 4 of which were in bio-terrorism/weapons of mass destruction *(if applicable)*;

_____(c) I was initially licensed in Nevada during the time period July 1, 2020 through December 31, 2020, the third six months of the past biennial period, and completed a minimum of 24 hours of AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics or pain management and/or addiction care, 18 hours of which were in my scope of practice or specialty and 4 of which were in bio-terrorism/weapons of mass destruction *(if applicable)*;

_____(d) I was initially licensed in Nevada during the time period January 1, 2021 through June 30, 2021, the fourth six months of the past biennial period, and completed a minimum of 14 hours of AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics or pain management and/or addiction care, 8 hours of which were in my scope of practice or specialty and 4 of which were in bio-terrorism/weapons of mass destruction *(if applicable)*, OR

_____(e) I am exempt from submitting proof of completion of continuing medical education (CME) because I have completed a full year of residency or fellowship training during the biennial period July 1, 2019 through June 30, 2021.

**Attach copies of proof of your completion of continuing medical education (CME) hours**
**or**
Proof of completion of 1 year of residency or fellowship training obtained during the biennial.

Your copies of proof of CME or training completion will not be returned to you.

END OF STATUS CHANGE APPLICATION

System Automation
Enabling Responsive Government
MyLicense Transaction Reports

Reports Home Page Back

**Renewal Questions for License Number 6164**

Powered by MyLicense

| Licensee | Question | Answer | Date |
|---|---|---|---|
| BALL, Stephanie | 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 | 4/19/2019 |
| BALL, Stephanie | **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 explana[illegible] information may be faxed to 775-688-2551 [illegible] to elicensensbme@medboard.nv.gov.** | | |
| BALL, Stephanie | If you have a medical condition which in any way [illegible] ability to practice medicine, is that impairment o[illegible] ameliorated because of the field of practice, the [illegible] which you have chosen to practice, or by any ot[illegible] accommodation? **If you do not have a medical condition, sel[illegible]** | [illegible] | 4/19/2019 |
| BALL, Stephanie | **Explanation 2: For the above question if yo[illegible] 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.** | | |
| BALL, Stephanie | 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 | 4/19/2019 |
| BALL, Stephanie | **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.** | | |
| BALL, Stephanie | 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?<br><br>Please include: who, what, where (provide state) and when in the text box directly below this question. | N | 4/19/2019 |
| BALL, Stephanie | **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.** | | |
| BALL, Stephanie | 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? | N | 4/19/2019 |

| | | | |
|---|---|---|---|
| | **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.** | | |
| BALL, Stephanie | Have you actively practiced medicine in Nevada within the past 24 months? | N | 4/19/2019 |
| BALL, Stephanie | **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.** | | 4/19/2019 |
| BALL, Stephanie | OPTION TO CHANGE LICENSE STATUS FROM ACTIVE TO INACTIVE:<br><br>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."<br><br>I hereby request my license to be placed on Inactive status, which means I will not physically practice in the state of Nevada.<br><br>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 | 4/19/2019 |
| BALL, Stephanie | **If you believe that you are in compliance with the Centers for Disease Control safe injection practices, your answer should be "YES".**<br><br>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.<br><br>**http://www.cdc.gov/injectionsafety/IP07_standardPrecaution.html** | Y | 4/19/2019 |
| BALL, Stephanie | 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.<br><br>**(If you have performed no such surgeries or procedures, then your answer should be "YES.")**<br><br>**Instructions for in-office surgery/procedure reporting can be located on the Board's website at: medboard.nv.gov/forms/in-** | Y | 4/19/2019 |

| | | | |
|---|---|---|---|
| | **office surgery.** | | |
| BALL, Stephanie | Are you out of compliance with court ordered child support? **If this does not apply to you, please answer "no."**<br><br>If "Yes" during the time period July 1, 2017 - July 1, 2019 type an explanation in the text box directly below this question. | N | 4/19/2019 |
| BALL, Stephanie | **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.** | | |
| BALL, Stephanie | 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.<br><br>**http://www.leg.state.nv.us/NRS/NRS-432B.html#NRS432BSec220**<br><br>**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 | 4/19/2019 |
| BALL, Stephanie | **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.** | | |
| BALL, Stephanie | 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<br><br>http://medboard.nv.gov/licensees/ce/)<br><br>**If renewing to an Inactive status, CME is not required and "No" can be selected.** | Y | 4/19/2019 |
| BALL, Stephanie | 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 | 4/19/2019 |
| BALL, Stephanie | 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 | 4/19/2019 |

RENEWED
7/1/17 - 6/30/19
BIENNIAL

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# PHYSICIAN APPLICATION FOR REGISTRATION RENEWAL FOR THE BIENNIAL REGISTRATION PERIOD 2017 – 2019 NEVADA STATE BOARD OF MEDICAL EXAMINERS

Phone (775) 688-2559
Physical Address: 1105 Terminal Way, Suite 301 Reno, Nevada 89502

Date Received by Board _____ License No. 6164

File No. _____ (For Board Use Only)

I hereby apply for renewal [illegible] the appropriate fee(s) as indicated below:

☐ ACTIVE STATUS –

☒ INACTIVE STATUS

SAVE $20 by renewing

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 FOL[illegible]CTIONS REGARDING YOUR APPLICATION:**

- Your current physicia[illegible] 2017. If this form is not received by the Nevada State Board of Medic[illegible] July 1, 2017 at 5:00 p.m., 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 [illegible] written explanation(s) for any/all question(s) answered "yes."
- Your license will not be renewed until the Board [illegible] *stration Renewal* form. **A faxed copy is not acceptable.**
- Your license will not be renewed unless it is acc[illegible] it card authorization.
- You may have been selected in a random contin[illegible] es. If you were randomly selected, you will be contacte[illegible] e will not be renewed if you do not have proof of the re[illegible] CME requirement. Please retain proof of your CME as th[illegible]
- All information provided on this application is PUBL[illegible]
- If you select "INACTIVE STATUS," you are prohibite[illegible] ting prescriptions in the state of Nevada. Inactive license[illegible]
- PLEASE TYPE OR PRINT LEGIBLY.

Inactive MD

Please print your name and address clearly in the space pro[illegible] address you provide below is viewable on the Board website and is listed as the pu[illegible]ess. 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 STEPHANIE BALL, M.D.
Street P.O. Box 9869
City RENO County WASHOE State NV
Zip 89507
Phone Number 925-294-2112 Cell Phone Number _____
Fax Number N/A E-mail address _____

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

| | Date of Initial Certification (Mo./Yr.) | Date of Last Recertification (Mo./Yr.) |
|---|---|---|
| Board: | American Board of Internal Medicine | 1988 |
| Subboard: | none | |

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 <u>July 1, 2015 – June 30, 2017,</u> <u>or since your last renewal</u>.**

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

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

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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

*Pursuant to NRS 630.253: If you are a medical doctor whose specialty is psychiatry, a continuing medical education course of instruction that provides at least 2 hours of instruction on clinically-based suicide prevention and awareness and have completed prior to the renewal of your license.*

15. I am medical doctor **whose specialty is Psychiatry** and I am in compliance with NRS 630.253, as I have completed at minimum 2 hours of continuing medical education in the area of clinically-based suicide prevention and awareness. ***Note: If you are not a Psychiatrist or hold Inactive status licensure (or choose to change to Inactive status during your renewal) your answer should be "No."***
_____Yes _X_No

16. Have you actively practiced medicine in Nevada within the past 24 months?
_X_Yes _~~X~~_No

## ATTESTATIONS / AFFIRMATION

## CHILD SUPPORT STATEMENT

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

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## 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

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.*

If yes, in which branch of service did you serve?

- ☐ Air Force
- ☐ Army
- ☐ Navy
- ☐ Marine Corps
- ☐ 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
- ☐ Medical Services
- ☐ Security Forces or Military Police
- ☐ Other

Dates of service in the Military:

From: ____/____/____ (MM / DD / YYYY) To: ____/____/____ (MM / DD / YYYY)

## 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

Nevada Revised Statutes (NRS) require the Nevada State Board of Medical Examiners to obtain from each applicant who seeks renewal of his or her license to practice medicine, a report stating the number and type of surgeries requiring conscious sedation, deep sedation or general anesthesia performed by the holder of the license at his or her office or any other facility, excluding any surgical care performed at a medical facility as defined in NRS 449.0151, or outside the state of Nevada.

**I hereby attest that I am in compliance with the reporting requirements of NRS 630.30665. 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.**

****** I HAVE SUBMITTED MY A OR B REPORT TO THE BOARD:*** X Yes _____ No

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

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MEDICAL EXAMINERS

## 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: STEPHANIE BALLA M.D.

Signature of Applicant/Licensee: _____

Electronic Mail Address: _____

## CONTINUING EDUCATION

**ALL CONTINUING MEDICAL EDUCATION MUST HAVE BEEN COMPLETED DURING THE PERIOD OF JULY 1, 2015 THROUGH JUNE 30, 2017.** Please place a check mark next to the statement that applies to you.

__X__ I was initially licensed in Nevada prior to July 1, 2015 or during the first 6 months of the biennial period of registration (July 1, 2015 through December 31, 2015) 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 addition care, or instruction on clinically-based suicide prevention and awareness, and twenty (20) hours of which were in my scope of practice or specialty.

_____ I was initially licensed in Nevada during the second 6 months of the biennial period of registration (January 1, 2016 through June 30, 2016) 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 addition care, or instruction on clinically-based suicide prevention and awareness, and fifteen (15) hours of which were in my scope of practice or specialty.

_____ I was initially licensed in Nevada during the third 6 months of the biennial period of registration (July 1, 2016 through December 31, 2016) 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 addition care, or instruction on clinically-based suicide prevention and awareness, and ten (10) hours of which were in my scope of practice or specialty.

_____ I was initially licensed in Nevada during the fourth 6 months of the biennial period of registration (January 1, 2017 through June 30, 2017) 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 addition care, or instruction on clinically-based suicide prevention and awareness, and five (5) hours of which were in my scope of practice or specialty.

_____ 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, 2015 through June 30, 2017. ***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.**

Signature *(Stamp Unacceptable)* Date 5/15/2017

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**Renewal Questions for License Number 6164**

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| Licensee | Question | Answer | Date |
|---|---|---|---|
| Stephanie BALL | 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 | 5/13/2015 |
| Stephanie BALL | **Explanation 1: For the above question if your answer is "Yes" for the time period July 1, 2013 – June 30, 2015, or since your last renewal, please type your brief explanation in this text box (Fields are space limited to 256 characters). Lengthy explanations or additional information may be faxed to 775-688-2551 or scanned and Email to elicensensbme@medboard.nv.gov!.** | | |
| Stephanie BALL | 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 | 5/13/2015 |
| Stephanie BALL | **Explanation 2: For the above question if your answer is "Yes" for the time period July 1, 2013 - June 30, 2015, or since your last renewal, please type your brief explanation in this text box (Fields are space limited to 256 characters). Lengthy explanations or additional information may be faxed to 775-688-2551 or scanned and Email to elicensensbme@medboard.nv.gov!.** | | |
| Stephanie BALL | 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 | 5/13/2015 |
| Stephanie BALL | **Explanation 3: For the above question if your answer is "Yes" for the time period July 1, 2013 - June 30, 2015, or since your last renewal, please type your brief explanation in this text box (Fields are space limited to 256 characters).Lengthy explanations or additional information may be faxed to 775-688-2551 or scanned and Email to elicensensbme@medboard.nv.gov!.** | | |
| Stephanie BALL | 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?<br><br>Please include: who, what, where (provide state), and when in the textbox directly below this question. | N | 5/13/2015 |
| Stephanie BALL | **Explanation 4: For the above question if your answer is "Yes" for the time period July 1, 2013 - June 30, 2015, or since your last renewal, please type your explanation in this text box.**<br>Please fax a copy of the Complaint, Settlement and/or Dismissal, civil or otherwise to 775-688-2551 or email to elicensensbme@medboard.nv.gov. | | |
| | | N | 5/13/2015 |

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| Stephanie BALL | 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?<br><br>If "Yes" during the time period July 1, 2013 - June 30, 2015 type an explanation in the textbox directly below this question. | | |
| Stephanie BALL | **Explanation 5: For the above question if your answer is "Yes" for the time period July 1, 2013 - June 30, 2015, or since your last renewal, please type your explanation in this text box.**<br>Please fax a copy of the Complaint, Settlement and/or Dismissal, civil or otherwise to 775-688-2551 or email to elicensensbme@medboard.nv.gov. | | |
| Stephanie BALL | Have you been arrested, investigated for, charged with, convicted of, or pled guilty or nolo contendere to any offense or violation of any federal (including the Uniform Code of Military Justice), state or local law, or the laws of any foreign country, which is a misdemeanor, gross misdemeanor, felony, violation of the Uniform Code of Military Justice, or synonymous thereto in a foreign jurisdiction, excluding any minor traffic offense (driving or being in control of a motor vehicle while under the influence of a chemical substance, including alcohol, is not considered a minor traffic offense), or for any offense which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? **Please note that you MUST disclose ANY investigation or arrest, including those where the final disposition was dismissal, or expungement.** | N | 5/13/2015 |
| Stephanie BALL | **Explanation 6: For the above question if your answer is "Yes" for the time period July 1, 2013 - June 30, 2015, or since your last renewal, please type your brief explanation in this text box (Fields are space limited to 256 characters).Lengthy explanations or additional information may be faxed to 775-688-2551 or scanned and Email to elicensensbme@medboard.nv.gov!.** | | |
| Stephanie BALL | 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 | 5/13/2015 |
| Stephanie BALL | **Explanation 7: For the above question if your answer is "Yes" for the time period July 1, 2013 - June 30, 2015, or since your last renewal, please type your brief explanation in this text box (Fields are space limited to 256 characters).Lengthy explanations or additional information may be faxed to 775-688-2551 or scanned and Email to elicensensbme@medboard.nv.gov!.** | | |
| Stephanie BALL | 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 | 5/13/2015 |
| Stephanie BALL | **Explanation 8: For the above question if your answer is "Yes" for the time period July 1, 2013 - June 30, 2015, or since your last renewal, please type your brief explanation in this text box (Fields are space limited to 256 characters).Lengthy explanations or additional information may be faxed to 775-688-2551 or scanned and Email to elicensensbme@medboard.nv.gov!.** | | |
| Stephanie BALL | 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 | 5/13/2015 |
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| Stephanie BALL | **Explanation 9: For the above question if your answer is "Yes" for the time period July 1, 2013 - June 30, 2015, or since your last renewal, please type your brief explanation in this text box (Fields are space limited to 256 characters).Lengthy explanations or additional information may be faxed to 775-688-2551 or scanned and Email to elicensensbme@medboard.nv.gov!.** | | |
| Stephanie BALL | Have you failed to initiate the performance of public service within one year after the date the public service is required to begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local government for your medical education? | N | 5/13/2015 |
| Stephanie BALL | **Explanation 10: For the above question if your answer is "Yes" for the time period July 1, 2013 – June 30, 2015, or since your last renewal, please type your brief explanation in this text box (Fields are space limited to 256 characters). Lengthy explanations or additional information may be faxed to 775-688-2551 or scanned and Email to elicensensbme@medboard.nv.gov!.** | | |
| Stephanie BALL | 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 | 5/13/2015 |
| Stephanie BALL | **Explanation 11: For the above question if your answer is "Yes" for the time period July 1, 2013 – June 30, 2015, or since your last renewal, please type your brief explanation in this text box (Fields are space limited to 256 characters). Lengthy explanations or additional information may be faxed to 775-688-2551 or scanned and Email to elicensensbme@medboard.nv.gov!.** | | |
| Stephanie BALL | Have you surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? | N | 5/13/2015 |
| Stephanie BALL | **Explanation 12: For the above question if your answer is "Yes" for the time period July 1, 2013 – June 30, 2015, or since your last renewal, please type your brief explanation in this text box (Fields are space limited to 256 characters). Lengthy explanations or additional information may be faxed to 775-688-2551 or scanned and Email to elicensensbme@medboard.nv.gov!.** | | |
| Stephanie BALL | Have you had hospital staff privileges denied, suspended, limited, revoked or not renewed by the hospital, including any and all resignations from any medical staff in lieu of disciplinary or administrative action?<br><br>If the answer is "Yes," type the name of the hospital, the hospital's mailing address, the type of action taken, and the date or dates of the actions taken in the textbox directly below this question.<br><br>**(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 | 5/13/2015 |
| Stephanie BALL | **Explanation 13: For the above question if your answer is "Yes" for the time period July 1, 2013 – June 30, 2015, or since your last renewal, please type your brief explanation in this text box (Fields are space limited to 256 characters). Lengthy explanations or additional information may be faxed to 775-688-2551 or scanned and Email to elicensensbme@medboard.nv.gov!.** | | |

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| Stephanie BALL | Have you actively practiced medicine in Nevada within the past 12 months? | Y | 5/13/2015 |
| Stephanie BALL | **Explanation 14: For the above question if your answer is "No" for the time period July 1, 2013 – June 30, 2015, or since your last renewal, please type your brief explanation in this text box (Fields are space limited to 256 characters).Lengthy explanations or additional information may be faxed to 775-688-2551 or scanned and Email to elicensensbme@medboard.nv.gov!.** | | |
| Stephanie BALL | OPTION TO CHANGE LICENSE STATUS FROM ACTIVE TO INACTIVE:<br><br>NOTE: If you choose to drop to Inactive status during this renewal, your status will be changed to "Inactive" **as of the date of your renewal.** If you do NOT wish to change your status to "Inactive" as of today, DO NOT COMPLETE YOUR RENEWAL UNTIL SUCH TIME AS YOU ARE PREPARED TO HAVE YOUR STATUS CHANGED (prior to JULY 1ST). For your information, your answers to the questions that you've already completed will remain, but you should not complete the renewal and pay until such time as you are prepared to change your status to "Inactive."<br><br>I hereby request my license to be placed on Inactive status, which means I will not physically practice in the state of Nevada.<br><br>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 | 5/13/2015 |
| Stephanie BALL | **If you believe that you are in compliance with the Centers for Disease Control safe injection practices, your answer should be "YES".**<br><br>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.<br><br>**http://www.cdc.gov/injectionsafety/IP07_standardPrecaution.html** | Y | 5/13/2015 |
| Stephanie BALL | 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.<br><br>I HAVE SUBMITTED A "FORM A" OR "FORM B" REPORT TO THE BOARD.<br><br>Instructions and Forms A and B for in-office surgery/procedure reporting can be located on the Board's website by clicking the red "In-Office Surgery Reporting" link on the home page of the Board's website: www.medboard.nv.gov.<br><br>**If you have submitted your in-office surgery/procedure reporting forms (A/B Forms) to the Board and are in compliance with NRS 630.30665, your answer should be "YES."** | Y | 5/13/2015 |
| Stephanie BALL | Are you out of compliance with court ordered child support? **If this does not apply to you, please answer "no".** | N | 5/13/2015 |

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| | If "Yes" during the time period July 1, 2013 - June 30, 2015 type an explanation in the textbox directly below this question. | | |
| Stephanie BALL | **Explanation 15: For the above question, if your answer is "Yes" for the biennial July 1, 2013 – June 30, 2015, please type your brief explanation in this text box (Fields are space limited to 256 characters). Lengthy explanations or additional information may be faxed to 775-688-2551 or scanned and Email to elicensensbme@medboard.nv.gov!.** | | |
| Stephanie BALL | 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".<br><br>**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.**<br><br>**www.leg.state.nv.us/NRS/NRS-432B.html#NRS432BSec220** | Y | 5/13/2015 |
| Stephanie BALL | **Explanation 16: For the above question if your answer is "No" for the time period July 1, 2013 - June 30, 2015, or since your last renewal, please type your explanation in this text box.** | | |
| Stephanie BALL | Have you ever served in the United States Military (to include National Guard or Reserves)? | N | 5/13/2015 |
| Stephanie BALL | **Explanation 17: If your answer is "No", you do not have to provide information in the text box for the remaining questions regarding the Military Service Attestation.**<br><br>1. If yes, in which branch of service did you serve?<br>2. What was your Military occupation specialty or specialties?<br>3. Provide your dates of service in the Military. | | |
| Stephanie BALL | Do you hold a Nevada state business license issued in your individual name? | N | 5/13/2015 |
| Stephanie BALL | **Explanation 18: If yes, provide the business license number:** | | |
| Stephanie BALL | I have completed the required amount of AMA Category 1 CME within the current biennial. I understand that I may be included in a random audit. I agree to retain CME's taken between July 1, 2013 and June 30, 2015. (Review CME information online at www.medboard.nv.gov)<br><br>If renewing to an Inactive status, CME is not required and "No" can be selected. | Y | 5/13/2015 |
| Stephanie BALL | 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 | 5/13/2015 |

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**Renewal Questions for License Number 6164**

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| Licensee | Question | Answer | Date |
|---|---|---|---|
| Stephanie BALL | 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 | 5/12/2013 |
| Stephanie BALL | If you have a medical condition which in any way impairs or limits your ability to practice medicine, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? **If you do not have a medical condition, select No.** | N | 5/12/2013 |
| Stephanie BALL | 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 | 5/12/2013 |
| Stephanie BALL | 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?<br><br>Please include: who, what, where (provide state), and when in the textbox directly below this question. | N | 5/12/2013 |
| Stephanie BALL | 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?<br><br>If "Yes" during the time period July 1, 2011 - June 30, 2013 type an explanation in the textbox directly below this question. | N | 5/12/2013 |
| Stephanie BALL | Have you been arrested, investigated for, charged with, convicted of, or pled guilty or nolo contendere to any offense or violation of any federal (including the Uniform Code of Military Justice), state or local law, or the laws of any foreign country, which is a misdemeanor, gross misdemeanor, felony, violation of the Uniform Code of Military Justice, or synonymous thereto in a foreign jurisdiction, excluding any minor traffic offense (driving or being in control of a motor vehicle while under the influence of a chemical substance, including alcohol, is not considered a minor traffic offense), or for any offense which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? **Please note that you MUST disclose ANY investigation or arrest, including those where the final disposition was dismissal, or expungement.** | N | 5/12/2013 |
| Stephanie BALL | 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 | 5/12/2013 |
| Stephanie BALL | 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 | 5/12/2013 |
| Stephanie BALL | 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 | N | 5/12/2013 |

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|---|---|---|---|
| | action? | | |
| Stephanie BALL | Have you failed to initiate the performance of public service within one year after the date the public service is required to begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local government for your medical education? | N | 5/12/2013 |
| Stephanie BALL | 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 | 5/12/2013 |
| Stephanie BALL | **If you believe that you are in compliance with the Centers for Disease Control safe injection practices, your answer should be "YES".**<br><br>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.<br><br>**http://www.cdc.gov/hicpac/2007IP/2007isolationPrecautions.html** | Y | 5/12/2013 |
| Stephanie BALL | Have you surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? | N | 5/12/2013 |
| Stephanie BALL | Have you had hospital staff privileges denied, suspended, limited, revoked or not renewed by the hospital, including any and all resignations from any medical staff in lieu of disciplinary or administrative action?<br><br>If the answer is " Yes," type the name of the hospital, the hospital`s mailing address, the type of action taken, and the date or dates of the actions taken in the textbox directly below this question.<br><br>**(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 | 5/12/2013 |
| Stephanie BALL | Have you actively practiced medicine in Nevada within the past 12 months? | Y | 5/12/2013 |
| Stephanie BALL | I hereby request my license to be placed on Inactive status, which means I will not physically practice in the state of Nevada.<br><br>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 | 5/12/2013 |
| Stephanie BALL | **The submission of the in-office surgery/procedure forms is required for all medical doctors, whether in state, out of state, active or inactive status! THIS IS NOT OPTIONAL. DO NOT answer this attestation until you have completed the requisite form. Once you have completed this action, you may proceed in answering the renewal attestations and questions. The online renewal site will retain your previous responses.** | Y | 5/12/2013 |

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| | Please go to the website, click on the following link for instructions and complete the required form.<br>Click on the following link for the instructions and forms:<br>http://medboard.nv.gov/New_In_Office_Surgery_Forms.htm<br><br>**If you have submitted your In-Office Surgery/Procedure Reporting Forms (A/B forms) to the Board and are in compliance with NRS 630.30665, your answer should be "YES".**<br><br>Nevada Revised Statutes (NRS) require the Nevada State Board of Medical Examiners to obtain from each applicant who seeks renewal of his or her license to practice medicine, a report stating the number and type of surgeries requiring conscious sedation, deep sedation or general anesthesia performed by the holder of the license at his or her office or any other facility, excluding any surgical care performed at a medical facility as defined in NRS 449.0151, or outside the state of Nevada.<br><br>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. | | |
| Stephanie BALL | Are you out of compliance with court ordered child support? **If this does not apply to you, please answer "no".**<br><br>If "Yes" during the time period July 1, 2011 - June 30, 2013 type an explanation in the textbox directly below this question. | N | 5/12/2013 |
| Stephanie BALL | I have completed the required amount of AMA Category 1 CME within the current biennial. I understand that I may be included in a random audit. I agree to retain CME's taken between July 1, 2011 and June 30, 2013. (Review CME information online at www.medboard.nv.gov)<br><br>If renewing to an Inactive status, CME is not required and "No" can be selected. | Y | 5/12/2013 |
| Stephanie BALL | 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 | 5/12/2013 |

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## Renewal Questions for License Number 6164

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| Licensee | Question | Answer | Date |
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| Stephanie BALL | 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 | 4/19/2011 |
| Stephanie BALL | **Explanation 1: For the above question if your answer is "Yes" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box.** | | |
| Stephanie BALL | If you have a medical condition which in any way impairs or limits your ability to practice medicine, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? **If you do not have a medical condition, select No.** | N | 4/19/2011 |
| Stephanie BALL | **Explanation 2: For the above question if your answer is "Yes" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box.** | | |
| Stephanie BALL | 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 | 4/19/2011 |
| Stephanie BALL | **Explanation 3: For the above question if your answer is "Yes" for the time period** | | |

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| | **July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box.** | | |
| Stephanie BALL | 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?<br><br>Please include: who, what, where (provide state), and when in the textbox directly below this question. | N | 4/19/2011 |
| Stephanie BALL | **Explanation 4: For the above question if your answer is "Yes" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box.** | | |
| Stephanie BALL | 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?<br><br>If "Yes" during the time period July 1, 2009 - June 30, 2011 type an explanation in the textbox directly below this question. | N | 4/19/2011 |
| Stephanie BALL | **Explanation 5: For the above question if your answer is "Yes" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box.**<br>Please fax a copy of the complaint, civil or otherwise to 775-688-2551. | | |
| Stephanie BALL | 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 | N | 4/19/2011 |

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| | 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.** | | |
| Stephanie BALL | **Explanation 6: For the above question if your answer is "Yes" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box.** | | |
| Stephanie BALL | 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 | 4/19/2011 |
| Stephanie BALL | **Explanation 7: For the above question if your answer is "Yes" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box.** | | |
| Stephanie BALL | 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 | 4/19/2011 |
| Stephanie BALL | **Explanation 8: For the above question if your answer is "Yes" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box.** | | |
| Stephanie BALL | 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 | 4/19/2011 |

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| Stephanie BALL | **Explanation 9: For the above question if your answer is "Yes" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box.** | | |
| Stephanie BALL | Have you been denied membership, been asked to resign or expelled from a medical society or other professional medical organization (including the ABMS)? | N | 4/19/2011 |
| Stephanie BALL | **Explanation 10: For the above question if your answer is "Yes" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box.** | | |
| Stephanie BALL | 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 | 4/19/2011 |
| Stephanie BALL | **Explanation 11: For the above question if your answer is "Yes" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box.** | | |
| Stephanie BALL | Have you surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? | N | 4/19/2011 |
| Stephanie BALL | **Explanation 12: For the above question if your answer is "Yes" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box.** | | |
| Stephanie BALL | Have you had hospital staff privileges denied, suspended, limited, revoked or not renewed by | N | 4/19/2011 |

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| | the hospital, including any and all resignations from any medical staff in lieu of disciplinary or administrative action?<br><br>If the answer is " Yes," type the name of the hospital, the hospital's mailing address, the type of action taken, and the date or dates of the actions taken in the textbox directly below this question.<br><br>**(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.)** | | |
| Stephanie BALL | **Explanation 13: For the above question if your answer is "Yes" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box.** | | |
| Stephanie BALL | Are you out of compliance with court ordered child support? **If this does not apply to you, please answer "no".**<br><br>If "Yes" during the time period July 1, 2009 - June 30, 2011 type an explanation in the textbox directly below this question. | N | 4/19/2011 |
| Stephanie BALL | **Explanation 14: For the above question if your answer is "YES" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box.** | | |
| Stephanie BALL | I hereby request my license to be placed on Inactive status, which means I will not physically practice in the state of Nevada.<br><br>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 | 4/19/2011 |

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| Stephanie BALL | **Explanation 15: For the above question, if your answer is "Yes" and you want to change to Inactive status for the next biennial July 1, 2011 – June 30, 2013, please provide a brief explanation in this text box.** | | |
| Stephanie BALL | Is your license contingent upon maintaining certification with the American Board of Medical Specialties (ABMS) in the specialty of Family Practice, Emergency Medicine, or Preventative Medicine? | N | 4/19/2011 |
| Stephanie BALL | **Explanation 16: For the above question if your answer is "YES" , please type your new scope of practice or specialty in this text box.** | | |
| Stephanie BALL | Do you want to change your scope of practice or specialty?<br><br>If you answer "Yes" type your current scope of practice or specialty in the textbox directly below this question. | N | 4/19/2011 |
| Stephanie BALL | **Explanation 17: For the above question if your answer is "Yes" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box.** | | |
| Stephanie BALL | I have completed the required amount of AMA Category 1 CME within the current biennial. (Review CME information online at www.medboard.nv.gov)<br><br>I understand that I may be included in a random audit following the July 1st, 2011 renewal. I agree to retain CME's taken between July 1, 2009 and June 30, 2011.<br><br>If renewing to an Inactive status, CME is not required and "No" can be selected. | Y | 4/19/2011 |
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| Stephanie BALL | 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. |

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## Renewal Questions for License Number 6164

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| Licensee | Question | Answer | Date |
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| Stephanie BALL | Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? **If you do not have a medical condition, select No.** | N | 6/3/2009 |
| Stephanie BALL | **Explanation 1: For the above question if your answer is "Yes" for the time period July 1, 2007 - June 30, 2009, or since your last renewal, please type your explanation in this text box.** | | |
| Stephanie BALL | If you have a medical condition which in any way impairs or limits your ability to practice medicine, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? **If you do not have a medical condition, select No.** | N | 6/3/2009 |
| Stephanie BALL | **Explanation 2: For the above question if your answer is "Yes" for the time period July 1, 2007 - June 30, 2009, or since your last renewal, please type your explanation in this text box.** | | |
| Stephanie BALL | If you use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety? **If you do not use chemical substances, select No.** | N | 6/3/2009 |
| Stephanie BALL | **Explanation 3: For the above question if your answer is "Yes" for the time period July 1, 2007 - June 30, 2009, or since your** | | |

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| | **last renewal, please type your explanation in this text box.** | | |
| Stephanie BALL | Have you been named as a defendant, or been requested to respond as a defendant or potential defendant, to a legal action involving professional liability (malpractice)?<br><br>Please include: who, what, where (provide state), and when in the textbox directly below this question. | N | 6/3/2009 |
| Stephanie BALL | **Explanation 4: For the above question if your answer is "Yes" for the time period July 1, 2007 - June 30, 2009, or since your last renewal, please type your explanation in this text box.** | | |
| Stephanie BALL | 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)?<br><br>Please include: who, what, where (provide state), when and case number in the textbox directly below this question.<br><br>Please fax a copy of the complaint, civil or otherwise to 775-688-2551. | N | 6/3/2009 |
| Stephanie BALL | **Explanation 5: For the above question if your answer is "Yes" for the time period July 1, 2007 - June 30, 2009, or since your last renewal, please type your explanation in this text box.**<br>Please fax a copy of the complaint, civil or otherwise to 775-688-2551. | | |
| Stephanie BALL | Have you been arrested, investigated for, charged with, convicted of, or pled guilty or nolo contendere to any criminal offense related to the manufacture, distribution, prescribing, or dispensing of controlled substances? **Please note that you MUST disclose ANY investigation or arrest, including those** | N | 6/3/2009 |

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| | **where the final disposition was dismissal, sealing of a record, or expungement.** | | |
| Stephanie BALL | **Explanation 6: For the above question if your answer is "Yes" for the time period July 1, 2007 - June 30, 2009, or since your last renewal, please type your explanation in this text box.** | | |
| Stephanie BALL | Have you been arrested, investigated for, charged with, convicted of, or pled guilty or nolo contendere to any criminal offense other than a criminal offense listed in Question #6? **Please note that you MUST disclose ANY investigation or arrest, including those where the final disposition was dismissal, sealing of a record, or expungement.** | N | 6/3/2009 |
| Stephanie BALL | **Explanation 7: For the above question if your answer is "Yes" for the time period July 1, 2007 - June 30, 2009, or since your last renewal, please type your explanation in this text box.** | | |
| Stephanie BALL | Have you been denied a license, permission to practice medicine or any other healing art, or permission to take an examination to practice medicine or any other healing art in any state, country or U.S. territory? | N | 6/3/2009 |
| Stephanie BALL | **Explanation 8: For the above question if your answer is "Yes" for the time period July 1, 2007 - June 30, 2009, or since your last renewal, please type your explanation in this text box.** | | |
| Stephanie BALL | Have you had a medical license or license to practice any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory? | N | 6/3/2009 |
| Stephanie BALL | **Explanation 9: For the above question if your answer is "Yes" for the time period July 1, 2007 - June 30, 2009, or since your last renewal, please type your explanation** | | |

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| | **in this text box.** | | |
| Stephanie BALL | Have you voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory in lieu of any disciplinary action? | N | 6/3/2009 |
| Stephanie BALL | **Explanation 10: For the above question if your answer is "Yes" for the time period July 1, 2007 - June 30, 2009, or since your last renewal, please type your explanation in this text box.** | | |
| Stephanie BALL | Have you been denied membership, been asked to resign or expelled from a medical society or other professional medical organization (including the ABMS)? | N | 6/3/2009 |
| Stephanie BALL | **Explanation 11: For the above question if your answer is "Yes" for the time period July 1, 2007 - June 30, 2009, or since your last renewal, please type your explanation in this text box.** | | |
| Stephanie BALL | Regarding any medical licensing board, hospital medical society, or other governmental entity or agency (other than the Nevada State Board of Medical Examiners), have you been:<br>(a) Asked to respond to an investigation;<br>(b) Notified that you were under investigation for;<br>(c) Investigated for;<br>(d) Charged with; or<br>(e) Convicted of<br>any violation of a statute, rule or regulation governing your practice as a physician? | N | 6/3/2009 |
| Stephanie BALL | **Explanation 12: For the above question if your answer is "Yes" for the time period July 1, 2007 - June 30, 2009, or since your last renewal, please type your explanation in this text box.** | | |
| Stephanie BALL | Have you surrendered your state or federal controlled substance registration or had it | N | 6/3/2009 |

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| | revoked or restricted in any way? | | |
| Stephanie BALL | **Explanation 13: For the above question if your answer is "Yes" for the time period July 1, 2007 - June 30, 2009, or since your last renewal, please type your explanation in this text box.** | | |
| Stephanie BALL | Have you had hospital staff privileges denied, suspended, limited, revoked or not renewed by the hospital, including any and all resignations from any medical staff in lieu of disciplinary or administrative action?<br><br>If the answer is " Yes," type the name of the hospital, the hospital's mailing address, the type of action taken, and the date or dates of the actions taken in the textbox directly below this question.<br><br>**(<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.)** | N | 6/3/2009 |
| Stephanie BALL | **Explanation 14: For the above question if your answer is "Yes" for the time period July 1, 2007 - June 30, 2009, or since your last renewal, please type your explanation in this text box.** | | |
| Stephanie BALL | Are you out of compliance with court ordered child support? **If this does not apply to you, please answer "no".**<br><br>If "Yes" during the time period July 1, 2007-June 30, 2009 type an explanation in the textbox directly below this question. | N | 6/3/2009 |
| Stephanie BALL | **Explanation 15: For the above question if your answer is "YES" for the time period July 1, 2007 - June 30, 2009, or since your last renewal, please type your explanation in this text box.** | | |

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| Stephanie BALL | I hereby request my license to be placed on Inactive status, which means I will <u>not</u> physically practice in the state of Nevada.<br><br>If you choose to place your license on Inactive status, make certain to select "Yes" to this question **AND** choose the Inactive status in the dropdown box located at the end of the questions. | N | 6/3/2009 |
| Stephanie BALL | **Explanation 16: For the above question, if your answer is "Yes" and you want to change to Inactive status for the next biennial July 1, 2009 – June 30, 2011, please provide a brief explanation in this text box.** | | |
| Stephanie BALL | Do you want to change your scope of practice or specialty?<br><br>If you answer "Yes" type your current scope of practice or specialty in the textbox directly below this question. | N | 6/3/2009 |
| Stephanie BALL | **Explanation 17: For the above question if your answer is "YES" , please type your new scope of practice or specialty in this text box.** | | |
| Stephanie BALL | I have completed the required amount of AMA Category 1 CME within the current biennial. (Review CME information online at <u>www.medboard.nv.gov</u>)<br><br>I understand that I may be included in a random audit following the July 1st, 2009 renewal. I agree to retain CME's taken between July 1, 2007 and June 30, 2009.<br><br>If renewing to an <u>Inactive</u> status, CME is not required and "No" can be selected. | Y | 6/3/2009 |
| Stephanie BALL | I SWEAR OR AFFIRM UNDER THE PENALTY OF PERJURY THAT I PERSONALLY ANSWERED ALL | Y | 6/3/2009 |

OF THE QUESTIONS IN THIS APPLICATION AND THAT THE ANSWERS I HAVE PROVIDED ARE TRUE AND CORRECT.

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## Renewal Questions for License Number 6164

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| Licensee | Question | Answer | Date |
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| Stephanie BALL | Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety?<br><br>If you answer "Yes" during the time period July 1, 2005 - June 30, 2007 email to elicensensbme@medboard.nv.gov | N | 4/13/2007 |
| Stephanie BALL | If you have a medical condition which in any way impairs or limits your ability to practice medicine, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice?<br><br>If you answer "Yes" during the time period July 1, 2005 - June 30, 2007 email to elicensensbme@medboard.nv.gov | N | 4/13/2007 |
| Stephanie BALL | If you use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety?<br><br>If you answer "Yes" during the time period July 1, 2005 - June 30, 2007 email to elicensensbme@medboard.nv.gov | N | 4/13/2007 |
| Stephanie BALL | Have you failed to initiate the performance of public service within one year after the date the public service is required to begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local government for your medical education? | N | 4/13/2007 |
| Stephanie BALL | Have you been named as a defendant, or been requested to respond as a defendant, to a legal action involving professional liability (malpractice), or had a professional liability | N | 4/13/2007 |

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| | claim paid on your behalf, or paid such a claim yourself? | | |
| Stephanie BALL | Have you been investigated for, arrested for, charged with, convicted of, or plead guilty or nolo contendere to any offense or violation of any federal (including the U.S. Military), state or local law, including any foreign country, which is in a foreign jurisdiction equivalent to, a misdemeanor, gross misdemeanor, court martial, or felony, excluding any minor traffic offense (driving or being in control of a motor vehicle while under the influence of any chemical substance and/or including alcohol, is not considered a minor traffic offense), or for any offense which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? Please note that you MUST disclose ANY investigation or arrest, even if the ultimate disposition was dismissal or expungement.<br><br>If you answer "Yes" during the time period July 1, 2005 - June 30, 2007 email to elicensensbme@medboard.nv.gov | N | 4/13/2007 |
| Stephanie BALL | 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?<br><br>If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov. | N | 4/13/2007 |
| Stephanie BALL | 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?<br><br>If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov. | N | 4/13/2007 |
| Stephanie BALL | Have you voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory by the direct request of a medical board? | N | 4/13/2007 |

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| | If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov. | | |
| Stephanie BALL | Have you been denied membership or expelled from a medical society or other professional medical organization?<br><br>If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov. | N | 4/13/2007 |
| Stephanie BALL | Have you been:<br>a) notified that you were under investigation for;<br>b) investigated for;<br>c) charged with; or<br>d) convicted of<br>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?<br><br>If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov. | N | 4/13/2007 |
| Stephanie BALL | Have you surrendered your state or federal controlled substance registration or had it revoked or restricted in any way?<br><br>If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov. | N | 4/13/2007 |
| Stephanie BALL | Have you had hospital staff privileges denied, suspended, limited, revoked or not renewed by the hospital?<br><br>*If you have answered "Yes" you will be required to submit a list of any and all resignations from any medical staff in lieu of disciplinary or administrative action via email to elicensensbme@medboard.nv.gov (Please Note: Do not include suspensions or restrictions for failure to complete hospital medical records,* | N | 4/13/2007 |

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| | *attend hospital department or staff meetings, or maintain required malpractice insurance.)*<br><br>If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov. | | |
| Stephanie BALL | Is your license currently contingent upon compliance with the Diversion program also known as the Nevada Health Professionals Assistance Foundation?<br><br>If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov. | N | 4/13/2007 |
| Stephanie BALL | Was your license issued contingent upon maintaining certification by the American Board of Medical Specialties in the specialty of Family Practice, Emergency Medicine or Preventative medicine?<br><br>If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov. | N | 4/13/2007 |
| Stephanie BALL | Are you a foreign medical doctor, who holds a Conditional Resident Alien Card, Employment Authorization Card, or Visa with the Department of Homeland Security, Immigration and Naturalization Services?<br><br>If "yes" please fax a copy of proof to (775) 688-2551 ATTN:Online License Renewal. | N | 4/13/2007 |
| Stephanie BALL | Are you out of compliance with court ordered child support? **If this does not apply to you please answer "no".**<br><br>If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov. | N | 4/13/2007 |
| Stephanie BALL | Do you want to change your scope of practice or specialty?<br><br>If you answer "Yes" during the time period July 1, 2005 - June 30, 2007 email to elicensensbme@medboard.nv.gov | N | 4/13/2007 |
| | | N | 4/13/2007 |

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| Stephanie BALL | Are you currently supervising a Physician Assistant or an Advanced Practitioner of Nursing? If you answer "Yes" please email a list of names of those you are supervising to elicensensbme@medboard.nv.gov | | |
| Stephanie BALL | I have completed the required amount of AMA Category 1 CME within the current biennial. (Review CME information online at www.medboard.nv.gov)<br><br>I understand that I may be included in a random audit following July 1st 2007 renewal. I agree to retain CME's taken between July 1, 2005 and June 30, 2007. | Y | 4/13/2007 |
| Stephanie BALL | I have actively practiced medicine in Nevada within the past 24 months. | Y | 4/13/2007 |
| Stephanie BALL | I hereby request my license to be placed on Inactive status. I will not physically practice in the state of Nevada. | N | 4/13/2007 |
| Stephanie BALL | I HEREBY SWEAR OR AFFIRM UNDER THE PENALTIES OF PERJURY THAT I AM IN FULL COMPLIANCE WITH ANY AND ALL OBLIGATIONS, TERMS OR CONDITIONS OF MY NEVADA MEDICAL LICENSE SPECIFIED BY THE BOARD. | Y | 4/13/2007 |