PHYSICIAN ASSISTANT
APPLICATION FOR LICENSURE
NEVADA STATE BOARD OF
MEDICAL EXAMINERS
9600 Gateway Drive, Reno, NV 89521
Phone (775) 688-2559

RECEIVED
Date Received by Board
DEC 22 2020
NEVADA STATE BOARD OF
MEDICAL EXAMINERS
(For Board Use Only)

License No._____

File No._____

Identity:

1. Present Legal Name Schmansen (Last) Brycanne (First) Irene (Middle) _____ (Maiden)

List any other name ever used _____

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

2. Public Address 621 E 2nd St (Street) Reno (City) Washoe (County) NV (State) 89502 (Zip)

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

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

4. Telephone Numbers (978) 578-5576 (Office) ( ) _____ (Fax) ( ) _____ (Home) ( ) _____ (Cellular (Optional))

Email address _____

5. Date of Birth 03/1/1986 (Month / Day / Year) Place of Birth _____ MA, USA (City / State / Country) Gender X F ___ M

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

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

Submit a Certified Birth Certificate or original Certificate of Naturalization or current U.S. Passport or copy of the front and back of your Alien Registration card, Employment Authorization card or Visa. Non Citizens (without the foregoing) submit an Original ITIN assignment letter from the IRS. Please note: Copy of the document authorizing your name change (marriage license, divorce decree, etc.) must be included.

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

NRS 630.197(1)(a) An applicant for the issuance of a license to practice medicine shall include the social security number of the applicant in the application submitted to the Board; however, AB275 (2019) provides that an applicant who does not have a social security number must provide an Individual Taxpayer Identification Number (ITIN) when completing an application for licensure.
NRS 630.165(5) The applicant bears the burden of proving and documenting his qualifications for licensure.

Questions:

For the purposes of the following questions, these phrases or words have these meanings:
"Ability to practice as a physician assistant" is to be construed to include all of the following:

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

"Medical condition" includes physiological, mental or psychological condition or disorder.

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

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

8. Do you currently have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? (If "Yes," attach explanation on separate sheet.) ___Yes X No

9. If you currently have a medical condition which in any way impairs or limits your ability to practice medicine, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, the manner in which you have chosen to practice, or by any other reasonable accommodation? ___Yes ___No X N/A
(If "Yes," attach explanation on separate sheet.)

10. If you currently use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety? (If "Yes," attach explanation on separate sheet.) ___Yes ___No X N/A

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

Malpractice Questions:

12. Have you EVER been named as a defendant, or been requested to respond as a defendant, to a legal action involving professional liability, or malpractice, including any military tort claims if applicable?

_____Yes _X_No

12a. Have you EVER had a professional liability, malpractice, claim paid on your behalf, or paid such a claim yourself including any military tort claims if applicable?

_____Yes _X_No

Malpractice Explanation(s):

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

Name of patient involved:

In which state did the action take place?

Case number (if applicable):

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

Current status of claim:

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

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

Amount of judgment or settlement $

Month and year of event precipitating claim:

Month and year of lawsuit or court filing:

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:

Arrest Question:

13. Have you EVER been arrested, investigated for, charged with, convicted of, or pled guilty or nolo contendere to any offense or violation of any federal (including the Uniform Code of Military Justice), state or local law, or the laws of any foreign country, which is a misdemeanor, gross misdemeanor, felony, violation of the Uniform Code of Military Justice, or synonymous thereto in a foreign jurisdiction, excluding any minor traffic offense (driving or being in control of a motor vehicle while under the influence of a chemical substance, including alcohol, is not considered a minor traffic offense), or for any offense which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? *Please note that you MUST disclose ANY investigation or arrest, including those where the final disposition was dismissal, or expungement. ____Yes X No

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

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Nevada License History:

14. Have you previously applied for physician assistant licensure in Nevada? ____Yes X No

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

Physician Assistant Education:

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

15. List all schools attended (including high school), type of degree received and dates of attendance. **Also list your Physician Assistant school information.**

Name	City/State	Type of Degree Received	Dates of Attendance From (Mo./Yr.) To (Mo./Yr.)
Beverly High School	Beverly, MA	HS Diploma	08/2000 - 06/2004
Boston University	Boston, MA	N/A	08/2004 - 12/2004
Univ. of Vermont	Burlington, VT	Bachelor - Science	01/2005 - 06/2008
TMCC	Reno, NV	N/A	09/2015 - 08/2016

16. Physician Assistant Certificate / Degree granted by:

Physician Assistant School	City / State	Exact Date of Issuance (Month/Day/Year)
UC Davis Betty Irene Moore SON	Sacramento, CA	12/18/2020

Activities:

17. Account for, in chronological order, all activities since graduation from Physician Assistant School. Activities include working as a Physician Assistant and also non-medical activities (seeking employment, moving, job search, applying for a license, vacation etc.) **ALL PERIODS OF TIME MUST BE ACCOUNTED FOR.**

Activities	City / State (and Country if other than U.S.)	From (Mo./Yr.) To (Mo./Yr.)	Percent Clinical (%)

Addendum #2

Question 17: Activities since graduation (12/18/20)

Activities	City/State	From (mo/yr) to (mo/yr)	% Clinical
NV Medical Board Application preparation	Sacramento, CA	December 2020 to January 2021	0
PANCE Board Preparation	Sacramento, CA	December 2020 to January 2021	0
New Hire Paperwork	Reno, NV	January 2021 to January 2021	0
Pack and Relocate to Reno, NV	Sacramento, CA to Reno, NV	January 5, 2021 to January 2021	0

Signature

1/19/21
Date

Addendum #1

Question 15: Physician Assistant Education

School Name: UC Davis Betty Irene Moore School of Nursing
City/State: Sacramento, CA
Type of Degree Received: Master of Health Services
Major: Physician Assistant Studies SS
Dates of attendance: July 2018 to December 18, 2020

Signature

1/19/21
Date

State licenses:

18. List any and all licenses (including training licenses and permits) YOU HOLD OR HAVE HELD to practice as a physician assistant in any state, territory or country. Note: You will not be required to verify your training licenses by direct source.

State/Territory	License #	Date of Issuance (Mo./Yr.)	Status

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Examination:

19. Are you currently certified by the National Commission for the Certification of Physician Assistants? ____Yes __X__No

If "Yes:" certification number _____ certification expires _____

If "No:" date scheduled to sit for the examination January 4, 2021 *

* Note: You must be scheduled to sit for the examination if not certified when submitting your application.

Disciplinary Questions:

20. Have you ever been denied a license or certificate to practice as a physician assistant, or in any other healing art, or permission to take an examination to practice as a physician assistant or in any other healing art(s) in any state, country or U.S. territory? ____Yes __X__No
(If "Yes," attach explanation on separate sheet.)

21. Have you ever had a physician assistant license or certificate, or license or certificate to practice in any other healing art, revoked, suspended, limited, or restricted in any state, country or U.S. territory? (If "Yes," attach explanation on separate sheet.) ____Yes __X__No

22. Have you ever voluntarily surrendered a license or certificate to practice as a physician assistant, or in any other healing art, in any state, country or U.S. territory? (If "Yes," attach explanation on separate sheet.) ____Yes __X__No

23. Have you ever failed the NCCPA examination, or any state or other jurisdiction examination for certification as a physician assistant? (If "Yes," attach explanation on separate sheet.) ____Yes __X__No

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

25. Have you ever surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? (If "Yes," attach explanation on separate sheet.) ____Yes __X__No

26. 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, please attach separate sheet)

Addendum #3

Question 19: Examination

Are you currently certified by the National Commission for the Certification of Physician Assistants? Yes

NCCPA Certification Number: 1179834

Expiration: 12/31/2023

Signature

1/19/21
Date

Attestations/Affirmations:

CHILD SUPPORT STATEMENT

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

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

__✓__ (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. ✓ Yes ____ No

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

SAFE INJECTION PRACTICE ATTESTATION

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

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 supervision 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. ✓ 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: Bryanne Salmansen

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.

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

3-Military occupation specialty or specialties?
- ☐ Administration or Personnel
- ☐ Aviation
- ☐ Civil Engineering
- ☐ Communications
- ☐ 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 _X_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 _X_No

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

10-If 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 _X_N/A

APPLICANT PHOTOGRAPH

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

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

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

_____ _____
Signature of applicant — Date 12/21/20

APPLICATION AFFIRMATION

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I, Bryanne Salmanson
(Print your full name)

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

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

Signature of applicant — Date: 12/21/20

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

State of California County of Sacramento

Subscribed and sworn to before me this 21st day of December, 2020

Notary Public for the State of California

My Commission Expires: 03/25/2022

Residing at: Sacramento (City) CA (State)

Signature of Notary

(NOTARY SEAL)

HIVAYAT ALI
COMM. #2235698
NOTARY PUBLIC-CALIFORNIA
COUNTY OF PLACER
My Comm. Expires MARCH 25, 2022

END OF APPLICATION

ATTENTION APPLICANT!

RESPONSIBILITY STATEMENT

Please sign and return this statement with your application for licensure to:
The Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521

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

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

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

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

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

o o o o o

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

Print your name Bryanne Salmonsen

Sign your name _____

Date 12/21/20

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