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

RECEIVED
Date Received by Board
SEP 25 2017
NEVADA STATE BOARD OF MEDICAL EXAMINERS
For Board Use Only

License No. _____

File No. _____

Identity:

1. Present Legal Name ROSS (Last) ANDREW (First) JORDAN (Middle) _____ (Maiden)

List any other name(s) ever used _____

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

2. Public Address 886 S. GILPIN ST (Street) DENVER (City) _____ (County) CO (State) 80209 (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 303 788-8808 (Office) 303 788-6656 (Fax) _____ (Home) _____ (Cellular (Optional))

Email address _____

5. Date of Birth 6/16/64 (Month / Day / Year) Place of Birth NY, 10025 (City, State, Country) Gender ___F X M

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

Submit a Certified Birth Certificate or original Certificate of Naturalization or current U.S. Passport or copy of the front and back of your Alien Registration card, Employment Authorization card or Visa. Please note: Copy of the document authorizing your name change (marriage license, divorce decree, etc.) must be included.

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

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

Questions:

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

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

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

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

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

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

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

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

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

Malpractice Questions:

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

X Yes _____No

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

X Yes _____No

Arrest Question:

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

Nevada License History:

14. Have you previously applied for medical licensure in Nevada (including in a Residency program)? ____Yes X No
(If "Yes," attach explanation on separate sheet.)

Medical School and Postgraduate Training History:

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

Medical School Name	City/State/Country	Place Where Instruction Received	Dates of Attendance From (Mo./Yr.)	To (Mo./Yr.)
ALBERT EINSTEIN COLLEGE OF MEDICINE	BRONX, NY, USA	BRONX NY	8/92	6/96

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

16. Doctor of Medicine Degree granted by:

Medical School Name	City/State/Country	Exact Date of Issuance (Month/Day/Year)
ALBERT EINSTEIN COLLEGE OF MEDICINE	BRONX, NY, USA	6/6/1996

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

Postgraduate Year (e.g. PGY1, PGY2, etc.)	Hospital/ Institution	City/State	Specify (I =Internship or R = Residency) (F = Fellowship)	Type of Specialty	Dates of Attendance From (Mo./Yr.)	To (Mo./Yr.)
PGY1-4	THOMAS JEFFERSON UNIVERSITY HOSPITAL	PHILADELPHIA PA	R	OB/GYN	6/96	6/00

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

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

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

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

19. Have you EVER been the subject of an investigation (including matters that resulted in no adverse action or outcome to you), have you resigned, been dismissed, or have any actions, restrictions, limitations, probations, terminations or any other disciplinary actions ever been imposed on you while participating in any type of training program? (If "Yes," attach explanation on separate sheet.) ____Yes X No

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

Nevada State Board of Medical Examiners

MD License Application

Andrew J. Ross MD FACOG

3/19/18

May it please the board,

Please addend my application as follows:

1) Medical school attendance at the Albert Einstein College of Medicine from 8/92 to 5/96

2)Post-graduate education as Thomas Jefferson University Hospital, PGY-1 Internship and PGY2-4 Residency in Obstetrics and Gynecology

Thank you,

Andrew J. Ross MD FACOG

Examinations:

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

21a. STATE Written Examination:

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

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

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

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

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

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

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

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

Step Taken	Number of Attempts	Date (Mo./Yr.)	Results (Three Digit Scores)
1	1	6/94	218
2	1	3/96	223
3	1	5/97	209

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

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

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

21f. SPEX (Special Purpose Examination):

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

Specialty:

ALSO INTERIM MED. DIRECTOR - ADMIN - 1 STRATIVE PP ROCK MTNS - NV

22. State your scope of practice / specialty (ies) OB/GYN - CLINICAL PRACTICE

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

ABMS Primary Board	Specialty Board	If you are Lifetime Board Certified, indicate "Lifetime"	Certification #	Dates of Certification and Recertification (Mo./Yr.)
ABOG			90040066	11/02 - 12/17

Nevada State Board of Medical Examiners

MD License Application

Andrew J. Ross MD FACOG

3/20/18

May it please the board,

Please update my application to note that I am up to date with my ABOG Maintenance of Certification which currently expires 12/31/18.

Thank you,

Andrew J. Ross MD FACOG

Activities:

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

Activities	Location (City/State/Country)	From (Mo./Yr.) To (Mo./Yr.)	Percent Clinical (%)
RESIDENCY	PHILADELPHIA PA USA	6/96 - 6/00	100
PRIVATE PRACTICE	ENGLEWOOD CO USA	8/00 - 9/17	99
INTERIM MEDICAL DIRECTOR PLANNED PARENTHOOD OF THE ROCKY MTNS (CO, NM, MT)	DENVER CO USA	6/17 - 9/17	0

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

25. List below the requested information for all hospitals or surgery centers in which you **ARE, OR HAVE EVER BEEN** a staff member at any level during the last ten years. If none, please indicate. Do not list internship, residency or fellowship affiliation.

Hospital	Complete Mailing Address	Dates of Appointment From (Mo./Yr.) To (Mo./Yr.)
SWEDISH MEDICAL CENTER	501 E HAMPDEN ENGLEWOOD CO 80113	8/00 → PRESENT

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

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

State/Territory Country	License #	Date of Issuance (Mo./Yr.)	Status
CO	38983	8/00	ACTIVE
PA	MT-039150-T	6/96	EXPIRED - TRAINING LICENSE

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

Disciplinary Questions:

27. Have you EVER been denied a license, permission to practice medicine or any other healing art, or permission to take an examination to practice medicine or any other healing art in any state, country or U.S. territory? (If "Yes," attach explanation on separate sheet.) ____Yes X No

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28. Have you EVER had a medical license or license to practice any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory? (If "Yes," attach explanation on separate sheet.) ____Yes X No

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

30. Have you EVER been denied membership, asked to resign, or expelled from a medical society or other professional medical organization? (If "Yes," attach explanation on separate sheet.) ____Yes X No

31. Have you EVER been: a) asked to respond to an investigation; b) notified that you were under investigation for; c) investigated for; d) charged with; or e) convicted of any violation of a statute, rule or regulation governing your practice as a physician by any medical licensing board, hospital, medical society, governmental entity or agency other than the Nevada State Board of Medical Examiners? (If "Yes," attach explanation on separate sheet.) X Yes ____No

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

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

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

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

Attestations/Affirmations:

CHILD SUPPORT STATEMENT

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

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

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

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

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

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

I attest and affirm that I am aware of and understand the reporting requirements found in Nevada Revised Statute 432B.220 regarding the abuse or neglect of a child. __X__ Yes _____ No

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

SAFE INJECTION PRACTICE ATTESTATION

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

I hereby attest to knowledge of and compliance with the guidelines of the Centers for Disease Control and Prevention concerning the prevention of transmission of infectious agents through safe and appropriate injection practices. I also attest that any person who is currently, or will be under my control as their supervising physician in the future, and who is not licensed pursuant to Chapter 630 of the Nevada Revised Statutes and whose duties involve injection practices, has knowledge of and is in compliance with the guidelines of the Centers for Disease Control and Prevention concerning the prevention of transmission of infectious agents through safe and appropriate injection practices. __X__ Yes _____ No

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

COMMUNICATIONS AFFIRMATION

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

I am willing to accept Board communications to me, to include service of process as defined under Nevada Revised Statute (NRS) 630.344, via electronic mail (more commonly known as e-mail). Further, should the electronic mail address provided below change for any reason, I agree to apprise the Board in writing of my new electronic mail address within 30 days after the change.

Printed Name of Applicant/Licensee: Andrew J. Ross

Signature of Applicant/Licensee: _____

Electronic Mail Address: [redacted]

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, which branch of service did you serve?

- ☐ Air Force
- ☐ Army
- ☐ Navy
- ☐ Marine Corp
- ☐ Coast Guard

Military occupation specialty or specialties?

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

Dates of service in the Military:

From: ____/ ____/ ____ **To:** ____/ ____/ ____
DD MM YYYY DD MM YYYY

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.

[illegible] 9/4/17
gnature of applicant Date

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APPLICATION AFFIRMATION

I, Andrew J. Ross
(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] / **Signature of applicant** — 9/7/2017 **Date**

(NOTARY SEAL)
RHONDA D WEBSTER
NOTARY PUBLIC - STATE OF COLORADO
Notary ID 20174031878
My Commission Expires 7/31/2021

State of Colorado County of Jefferson
Subscribed and sworn to before me this 7th day of September, 2017
Notary Public for the State of Colorado
My Commission Expires: 7/31/2021
Residing at: Littleton (City) Colorado (State)
[signature]
Signature of Notary

END OF APPLICATION

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FORM B

LIST OF MALPRACTICE INSURANCE CARRIERS

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

Name of Insured: ANDREW J. ROSS MD

Insurance Company: HCI - INSURED SINCE 3/1/06
Address: PO 555 W/ANNUAL RENEWAL
NASHVILLE TN 37202-0555

Phone Number:
Fax Number:
Policy Number:
Dates: 1/1/17 - 1/1/18

Insurance Company: MARSH USA INC
Address: 1166 AVE OF THE AMERICAS
NYC NY 10036

Phone Number: healthcare.accounts@MARSH.COM
Fax Number:
Policy Number:
Dates: 6/30/17 - 1/1/18

Insurance Company: COPIC
Address: 7351 LOWRY BLVD
DENVER CO 80230

Phone Number: 800-421-1834
Fax Number:
Policy Number:
Dates: 8/00 → 3/1/06

Insurance Company: THE MIIX GROUP OF COMPANIES
Address: DEFUNCT

Phone Number:
Fax Number:
Policy Number:
Dates: 6/96 - 6/00

Insurance Company:
Address:

Phone Number:
Fax Number:
Policy Number:
Dates:

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

Ross, A. MD