

# Uniform Application for Licensure

Application ID: 276016  
 FID: 215219072

License Requested: MD  
 License Type: Permanent Medical License  
 Submitted to: Nevada State Board of Medical Examiners  
 Submission Date: 04/03/2019

## Practitioner Name

Lin, Jennifer Elaine

## Contact Information

### Address

Public Access	Board Contact	Type	Address
No	Yes	Home	UNITED STATES
Yes	No	Business	1670 East Flamingo Rd Suite C Las Vegas, NV 89119 UNITED STATES

### Phone

Public Access	Board Contact	Type	Phone Number	Phone Extension
Yes	No	Business	(702) 892-0660	
No	Yes	Mobile		

### Email

Public Access	Board Contact	Email
No	Yes	
Yes	No	

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## Identification

USMLE Number	SSN	Birth Date	Birth Place	Gender	NPI	Practitioner Type	US Citizen
		'1981	Houston, TX UNITED STATES	F		MD	Yes

## Medical School

Medical School Name	Address	Start Date	End Date	Graduation Date	Degree Code
Baylor College of Medicine	One Baylor Plaza Houston, TX 77030 UNITED STATES	08/01/2004	05/20/2008	05/20/2008	MD

## Fifth Pathway

None Reported

## ECFMG

Applicant Name: Lin, Jennifer Elaine  
 Application ID: 276016

Certificate Number	Date
None Reported	

**Postgraduate Training**

**Hospital Name:** University of Wisconsin Hospitals and Clinics Program  
Madison, WI UNITED STATES  
**Program Code:** ACGME 2205621306

**Institution:** University of Wisconsin Hospitals and Clinics  
**Attendance Dates:** Start Date: 06/24/2008

**Training Specialty:** Obstetrics & Gynecology  
**End Date:** 07/02/2012

**Program Type:** Residency

**Training Status:** Completed

**Clinical %:** 90  
**Administrative %:** 10

**Examination History**

Exam	State	Last Attempt	Pass/Fail	Number Of Attempts
USMLE Step 1 Examination		01/16/2007	Pass	1
USMLE Step 2 CK Examination		11/01/2007	Pass	1
USMLE Step 2 CS Examination		03/11/2008	Pass	1
USMLE Step 3 Examination		07/27/2009	Pass	1

**State Licensure History**

**MD, DO, PA License History**

License Entity	Licensing State	License Number	Issue Date	Expiration Date	License Type	License Status
Wisconsin Medical Examining Board	WI	53683-20	10/22/2009	10/31/2013		Expired
Oregon Medical Board	OR	MD156662	12/05/2011	12/31/2019	Full	Active

**Physician Reported License History**

Practitioner License Type	Licensing State	License Number	Issue Date	Expiration Date	Type	License Status
None Reported						

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**Chronology of Activity Type**

<b>Practice/Emp/ Desc:</b>	<b>Baylor College of Medicine</b>	<b>Chronology Type:</b>	Medical Education
<b>Address:</b>	Houston, TX US	<b>Attendance Dates:</b>	
<b>Position/Dept:</b>		<b>Start Date:</b>	08/01/2004
<b>Clinical %:</b>		<b>End Date:</b>	05/20/2008
<b>Admin %:</b>			
<b>Employment:</b>	<b>Staff Privileges:</b>	<b>Affiliation:</b>	
<b>Practice/Emp/ Desc:</b>	<b>University of Wisconsin Hospitals and Clinics Program</b>	<b>Chronology Type:</b>	Accredited Training
<b>Address:</b>	Madison, WI US	<b>Attendance Dates:</b>	
<b>Position/Dept:</b>		<b>Start Date:</b>	06/24/2008
<b>Clinical %:</b>	90	<b>End Date:</b>	07/02/2012
<b>Admin %:</b>	10		
<b>Employment:</b>	<b>Staff Privileges:</b>	<b>Affiliation:</b>	
<b>Practice/Emp/ Desc:</b>	<b>Women's Healthcare Associates, LLC</b>	<b>Chronology Type:</b>	Work
<b>Address:</b>	7650 SW Beveland Street Suite 200 Portland, OR 97223 US	<b>Attendance Dates:</b>	
<b>Position/Dept:</b>	physician - ob/gyn	<b>Start Date:</b>	08/27/2012
<b>Clinical %:</b>	100	<b>End Date:</b>	In Progress
<b>Admin %:</b>	0		
<b>Employment:</b>	<b>Staff Privileges:</b>	<b>Affiliation:</b>	

**Malpractice**

None Reported

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**PRACTITIONER PROFILE**

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Prepared for: Uniform Application for Physician State Licensure As of Date: 4/3/2019

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**PRACTITIONER INFORMATION**

Name: Lin, Jennifer Elaine  
DOB: 11/16/1981  
Medical School: Baylor College of Medicine  
Houston, Texas, UNITED STATES  
Year of Grad: 2008  
Degree Type: MD  
NPI: 1043475528

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**BOARD ACTIONS**

To date, there have been no actions reported to the FSMB

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**LICENSE HISTORY**

Jurisdiction	License Number	Issue Date	Expiration Date	Last Updated
OREGON	MD156662	12/05/2011	12/31/2019	03/15/2019
WISCONSIN	53683-20	10/22/2009	10/31/2013	04/01/2019

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**ADDENDUM 1 – RESPONSIBILITY STATEMENT**

**ATTENTION APPLICANT!**

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

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

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

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

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

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

o o o o o

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

Print your name Jennifer Lin

Sign your name \_\_\_\_\_

Date 4-3-2019

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.

**ADDENDUM 3 – ADDITIONAL PHYSICIAN INFORMATION**

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**CITIZENSHIP AND IDENTIFICATION**

U.S. Citizen. Yes  No

Alien Registration # \_\_\_\_\_

Employment Authorization # \_\_\_\_\_

Visa # \_\_\_\_\_

Color of Eyes: \_\_\_\_\_ Color of Hair: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**EXAMINATION SCORES**

List all licensure examinations you have taken, whether U.S. or International, on the Examination History tab of the online Uniform Application. Also list below the score you received on each exam taken. INCLUDE ALL INFORMATION PERTAINING TO ANY AND ALL FAILED ATTEMPTS.

Examination Name	Score Received	Examination Name	Score Received
USMLE Step 1	PASS	_____	_____
USMLE Step 2CK	PASS	_____	_____
USMLE Step 2CS	PASS	_____	_____
USMLE Step 3	PASS	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**SPECIALTY CERTIFICATION**

Scope of Practice/Specialty(ies): OB/GYN

List any and all certifications and re-certifications by a board or sub-board recognized by the American Board of Medical Specialties. INCLUDE ALL INFORMATION PERTAINING TO ANY AND ALL FAILED ATTEMPTS.

Board / Specialty Board	If you are Lifetime Board Certified, indicate "Lifetime"	Certification #	Dates of Certification/ Recertification (MM/YY)
ABOG		9029093	01/15
_____	_____	_____	_____
_____	_____	_____	_____

If you hold "lifetime or historical" ABMS Board certification, please provide a notarized statement agreeing to maintain Board certification for the duration of your licensure in the state of Nevada.

## ADDENDUM 4 – ATTESTATION QUESTIONS

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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 judgment 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 THIS ADDENDUM.**

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? If “Yes,” attach an explanation on a separate sheet. Yes  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? If “Yes,” attach an explanation on a separate sheet. Yes  No
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? If “Yes,” attach an explanation on a separate sheet. Yes  No
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? If “Yes,” attach an explanation on a separate sheet. Yes  No
- 5a. 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? If “Yes,” please describe in the space provided on the Malpractice Liability Claims Information page within the online Uniform Application. Also complete addendum 5. Yes  No
- 5b. 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? If “Yes,” please describe in the space provided on the Malpractice Liability Claims Information page within the online Uniform Application. Also complete addenda 5 and 6. Yes  No
6. 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 an explanation on a separate sheet.

7. Have you previously applied for medical licensure in Nevada (including in a Residency program)? If "Yes," attach an explanation on a separate sheet. Yes  No
8. 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 an explanation on a separate sheet. Yes  No
9. 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 an explanation on a separate sheet. Yes  No
10. 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 an explanation on a separate sheet. Yes  No
11. Have you EVER voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory? If "Yes," attach an explanation on a separate sheet. Yes  No
12. Have you EVER been denied membership, asked to resign, or expelled from a medical society or other professional medical organization? If "Yes," attach an explanation on a separate sheet. Yes  No
13. 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 an explanation on a separate sheet. Yes  No
14. Have you EVER surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? If "Yes," attach an explanation on a separate sheet. Yes  No
15. 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 MM/YY to MM/YY)

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**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.

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

Yes  No  I attest and affirm that I am aware and understand the reporting requirements found in Nevada Revised Statute 432B.220 regarding the abuse or neglect of a child. <http://www.leg.state.nv.us/NRS/NRS-432B.html#NRS432BSec220>

**SAFE INJECTION PRACTICE ATTESTATION**

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

Yes  No  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.  
[http://www.cdc.gov/injectionsafety/IP07\\_standardPrecaution.html](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 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: Jennifer E Lin

Signature of Applicant/Licensee: \_\_\_\_\_ Email Address: \_\_\_\_\_

**MILITARY SERVICE ATTESTATION**

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

Yes  No

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 Chaplain Corps

Police

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- Logistics or Support
- Maintenance
- Medical Services
- Security Forces or Military
- 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

**APPLICATION AFFIRMATION**

I, Jennifer Elaine Lin  
(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

4-12-19  
Date

State of Oregon County of Clackamas

Subscribed and sworn to before me this 12th day of April, 2019

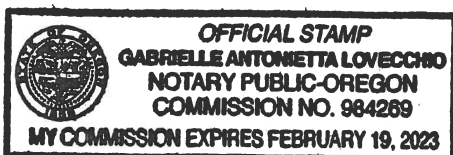
Notary Public for the State of Oregon

My Commission Expires: 02/19/2023

Residing at: Lake Oswego, Oregon  
City State

Jennifer Lin  
Signature of Notary

(NOTARY SEAL)



Applicant's Signature (must be signed in the presence of a notary)

Lin

Applicant's Printed Last Name

Jennifer E.

Applicant's Printed First Name, Middle Initial, and Suffix (e.g., Jr.)

6-3-2019

Date of Signature



NOTARY

Dated June 3, 2019 Signed Ryan J Brandes

State of Oregon County of Clackamas

SUBSCRIBED AND SWORN TO before me this 3rd day of June 2019.

My commission expires: October 19, 2021

(NOTARY PUBLIC SIGNATURE & SEAL)

Applicant Name: Jennifer E Lin

Date: June 3, 2019



OFFICIAL STAMP  
RYAN JOHN BRANDES  
NOTARY PUBLIC-OREGON  
COMMISSION NO. 967390