

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

**RECEIVED  
SEP 27 1990**

NEVADA STATE BOARD OF  
MEDICAL EXAMINERS

1. Name LEWY Adam VINCENT  
Last First Middle Maiden

If you have ever used another name, please indicate no

2. Business and/or Mailing Address 554<sup>th</sup> MG / SEMSO, NELLIS AFB, NV 89191  
Street # City State Zip

3. Home Address \_\_\_\_\_  
Street # City State Zip

4. Telephone Number (\_\_\_\_\_) \_\_\_\_\_ 702, 652-3357 (Office)  
Office Home

5. Date of Birth 57 Place of Birth \_\_\_\_\_

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)
Univ of Calif, Santa Cruz	Santa Cruz, Calif	9/75	6/76
" " "	" "	9/77	6/80

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)
Univ. of Southern Calif	2025 Zonal Ave L.A., CA 90033	School of Med.	8/80	5/84

10. Doctor of Medicine Degree granted by:  
 Name of Medical School \_\_\_\_\_ Address of Medical School \_\_\_\_\_ Exact Date of Issuance \_\_\_\_\_

Univer. of Southern Cal. see above 8 May 1984

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))
Los Angeles, CA	I	6/82	PASS 555
" " "	II	4/84	PASS 425
" " "	III	3/85	PASS 450

MAR 28 1989

12. Have you taken any part of the FLEX?  Yes  No If YES, list location, parts taken, date and score(s). Have certificate of scores submitted from FLEX 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.

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)
Univ. of Southern CA L.A. Co. Med Ctr	2025 Zonal Ave Los Angeles, CA 90033	Intern OB/Gyn	6/84	6/85
Valley Med Ctr (UCSF)	445 S. Cedar Ave Fresno CA 93702	OB/Gyn Resid.	6/85	6/89

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: OBSTETRICS / GYNECOLOGY

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

19. Location of medical practice since graduation (Include Military Service)

City/State	From (Mo/Yr)	To (Mo/Yr)
NELLIS AFB LAS VEGAS NV 89191	8/89	Present

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.

Hospital	Complete Mailing Address	Date of Appointment	
		From (Mo/Yr)	To (Mo/Yr)
554 <sup>th</sup> MG. Support Hospitale	554 OSW Hospital NELLIS AFB NV 89191	8/89	Present

21. Have you 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)
CALIFORNIA	G60065	25 June 85	6/84	6/89

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 or FMGEMS, 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?  Yes  No (PLEASE NOTE: THIS REQUIREMENT DOES NOT INCLUDE SUSPENSIONS OR RESTRICTIONS FOR FAILURE TO COMPLETE HOSPITAL MEDICAL RECORDS)

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

- 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 psychological 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 35 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

If YES: Location LAS VEGAS Date ASAP

38. Personal Information

Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Color of Eyes \_\_\_\_\_

Color of Hair \_\_\_\_\_ Social Security Number \_\_\_\_\_

39. I, Adam Vincent Levy, 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.

40. Please check one of the following:

- At the time of oral examination, I wish to be examined in the area of my specialty as indicated in Number 17 of this application.
- At the time of oral examination, I wish to be examined in the area of general medicine.

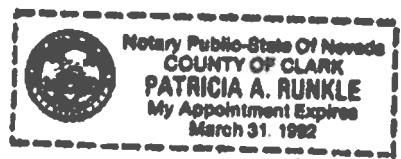
Signature of Applicant \_\_\_\_\_

Subscribed and sworn to before me this 24<sup>TH</sup>

day of SEPTEMBER, 1990

Patricia A. Runkle  
Notary Public for State of NEVADA

(Notary Seal)



My Commission Expires 31 MARCH 1992

Residing at 4535 W. SAHARA AVE.  
LAS VEGAS, NV



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

Signature of Applicant

30 July 90

**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 8, 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**

<p>I verify that all statements made on my application for licensure in the State of Nevada received on _____ <u>09-27-90</u>, are still true and valid on <u>12-01-90</u>, the date of my oral examination</p> <p>Signed: _____</p> <p>Witness: <u>G. Murray</u> (Board Member)</p>
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**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. 6135

File No. \_\_\_\_\_

New  Renewal

This shaded section for BOARD USE ONLY

Apply for certificate of biennial registration and enclose the appropriate fee as indicated below:

- ACTIVE STATUS ~~\$300.00~~ 150.00
- 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

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

**TYPE OR PRINT LEGIBLY**

NAME LEVI Adam Vincent  
Last First Middle

Social Security # \_\_\_\_\_

Business Phone ( ) \_\_\_\_\_

BUSINESS OR MAILING ADDRESS E Mirror Lake Dr, Las Vegas NV 89110  
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 below:

BOARD OF CERTIFICATION

NAME \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_

ADDRESS \_\_\_\_\_ AM. Bld. of \_\_\_\_\_

PHONE # (\_\_\_\_\_) \_\_\_\_\_ 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 I 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. \_\_\_\_\_ 4. \_\_\_\_\_
- 2. \_\_\_\_\_ 5. \_\_\_\_\_
- 3. \_\_\_\_\_ 6. \_\_\_\_\_

I certify that all the above statements are true and that I have not been practicing in Nevada within the past 12 months.

Signature \_\_\_\_\_

(No rubber stamps)

Date 1 Dec 90

**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 29 1991

This shaded section for BOARD USE ONLY

License No.

File No.

Renewal

Renewal

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

- 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

Adam V. Levy, MD  
 E Mirror Lake Dr  
 Las Vegas NV 89110-0000

Make checks payable to  
**BOARD OF MEDICAL EXAMINERS**  
 (Do not check under "Pay to the order of")

NAME LEVY Adam Vincent  
Last First Middle

Social Security # \_\_\_\_\_  
 Business Phone 702 652 3357

BUSINESS OR MAILING ADDRESS E. Mirror Lake Dr Las Vegas NV 89110  
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 N/A  
 ADDRESS \_\_\_\_\_  
 PHONE # (\_\_\_\_) \_\_\_\_\_

BOARD OF CERTIFICATION  
 Yes \_\_\_\_\_ No   
 AM. Bd. of \_\_\_\_\_  
 Date of Certification or Recertification \_\_\_\_\_

Primary Specialty (List only one) OB/Gyn 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: \_\_\_\_\_ Date 5-13-91

- SINCE YOUR LAST REGISTRATION:** (If any question is answered "yes," attach a detailed explanation.)
- 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
  - Have you been arrested, fined (over \$100), charged with or convicted of a crime, indicted, imprisoned or placed on probation? Yes  No
  - Have you been investigated, arrested, charged or convicted for the possession, use of, or illegal sale or dispensing of controlled substances? Yes  No
  - 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
  - Have you had staff privileges in a hospital denied, suspended, limited 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
  - 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)

- N/A; currently @ Nellis AFB Hosp USAF
- Las Vegas NV
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_ state

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

Signature: \_\_\_\_\_ Date 5-13-91  
(No rubber stamps)

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) 688-2559

Date Received  
by State Board

APR 22 1993

License No. 6135

Exp. No.

New

Renewal

This shaded section for BOARD USE ONLY

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.

Adam V. Levy, MD  
2010 Goldring #302  
Las Vegas NV 89106-0000

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 \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_ 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).**

7-1-91  
6-30-93

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

	Code	Percent of Time	Board Certified (Indicate Yes/No)
Primary	<u>38</u>	<u>100%</u>	_____
Secondary	_____	_____	_____
Tertiary	_____	_____	_____

PLEASE INDICATE AMERICAN BOARD OF MEDICAL SPECIALTIES BOARD CERTIFICATION:

Board Amer. Board of Ob/Gyn  
Subboard \_\_\_\_\_

3. How many hours per week do you spend in each of the following activities?

- 28 hours Patient care or services
- 2 hours Administration (schools, agencies, association, etc.)
- 20 hours Teaching medical courses
- 2 hours Research
- \_\_\_\_\_ hours Other (specify \_\_\_\_\_)

4. Form of employment is 1001. (Use the following codes.)

1001 SELF-EMPLOYED Solo Practice	1008 Federal Government (civilian P.H.S., etc.)
1002 Partnership or Group Practitioners	1009 State Government
SALARIED, EMPLOYED BY	1010 County Government
1003 Individual Practitioner	1011 Local Government
1004 Partnership or Group of Practitioners	1012 Other (specify _____)
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)	

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   
 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):

<u>Hennepin</u>	<u>3186 Maryland Pkwy LV, NV 89102</u>
Name	Address
<u>Womens Hospital</u>	<u>7025 E. Sahara Blvd, LV, NV 89116</u>
Name	Address
<u>University Med Ctr</u>	<u>1800 W. Charleston Blvd, LV, NV 89102</u>
Name	Address
<u>Vally Hospital</u>	<u>620 Shadow Lane, LV, NV 89106</u>
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:

- 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.**

*< Transcript from ACOG civil on request >*

Date of Birth:     -57     Social Security Number: \_\_\_\_\_  
month/day/year DEA Number: \_\_\_\_\_

Medical School: Univ of Southern Cal City \_\_\_\_\_ State CA

Internship: Univ of CA SF., Fresno CA City \_\_\_\_\_ State CA

Residency: " City \_\_\_\_\_ State CA

\_\_\_\_\_ 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 1/2 MONTHS. (CHECK ONE)

366 1326 4/19/97 x \_\_\_\_\_  
Business Telephone # Date Signature (SIGNATURE STAMP UNACCEPTABLE)

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

**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 01 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:

- 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.**

Adam V. Levy, MD  
 2010 Goldring #302  
 Las Vegas NV 89106-0000

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. 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 2020 Goldring Ave Ste 404

City Las Vegas County \_\_\_\_\_ State NV Zip Code 89106

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. (  ) 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 | 68 PHYSICIAN ASSISTANT   |
| 5 BLOOD BANKING         | 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 OTOTOLOGY              | 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  | 81 PED, PHYSIATRY         | 89 SURGERY, UROLOGIC     |
| 32 NEPHROLOGY           | 95 PED, PULMONARY         | 90 SURGERY, VASCULAR     |
| 33 NEUROLOGY            | 82 PED, RADIOLOGY         | 94 UROLOGY               |
| 34 NEUROPATHOLOGY       | 83 PED, SURGERY           |                          |

	Code	Percent of Time	Board Certified (Indicate Yes/No)
Primary	<u>38</u>	<u>100</u>	<u>Yes</u>
Secondary	_____	_____	_____
Tertiary	_____	_____	_____

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

	Date of Initial Certification	Date of Last Recertification
Board <u>Amer Board OB/Gyn</u>	<u>12/91</u> (Mo./Yr.)	_____ (Mo./Yr.)
Subboard _____	_____ (Mo./Yr.)	_____ (Mo./Yr.)

3. How many hours per week do you spend in each of the following activities?

- 25 hours Patient care or services
- 5 hours Administration (schools, agencies, associations, etc.)
- 20 hours Teaching medical courses
- \_\_\_\_\_ hours Research
- \_\_\_\_\_ hours Other (specify \_\_\_\_\_)

4. Form of employment is 1001. (Use the following codes.)

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

**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)? *This is a renewal*  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? *please clarify*  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.)

*[Handwritten signature]*

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**

830.183 Continuing education: General requirements; exemption; failure to comply.

1. Except as otherwise provided in subsection 2 and NAC 830.187, 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 Lisison 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:

- 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.

3166-1326      4/20/95      X  
Business Telephone #      Date

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 (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, 2222; A 1993, 2300)



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

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

Date received by Board

MAR 24 1997

License No. 6135

File No. \_\_\_\_\_

(Board Use Only)

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

ACTIVE STATUS \$600.00  
 INACTIVE STATUS \$150.00  
 RETIRED STATUS \$ 50.00  
 P.A. SUPERVISING PHYSICIAN \$200.00

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

Adam V. Levy, MD

Las Vegas, NV

89106

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.**
- 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.
- 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).
- 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 \_\_\_\_\_

**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 medicine?

- a.  YES, in training.      b.  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  | 66 PHYSICIAN ASSISTANT   |
| 5 BLOOD BANKING        | 39 OBSTETRICS            | 67 PREVENTIVE MED        |
| 6 BRONCHO-ESOPHAGOLOGY | 40 OCCUPATIONAL MED      | 68 PSYCHIATRY            |
| 7 CARDIOVASC DISEASES  | 41 ONCOLOGY              | 69 PSYCHOANALYSIS        |
| 8 CATS/CANAL/TRASOUND  | 45 ONCOLOGY, GYNECOLOGIC | 70 PSYCHOMATIC MEDICINE  |
| 9 CHILD NEUROLOGY      | 42 ONCOLOGY, HEMATOLOGY  | 71 PUBLIC HEALTH         |
| 10 CHILD PSYCHIATRY    | 43 ONCOLOGY, RADIATION   | 72 PULMONARY DISEASES    |
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| 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, COLONRECTAL  |
| 22 HYPNOSIS            | 56 PED. CRITICAL CARE    | 82 SURGERY, GENERAL      |
| 23 IMMUNOLOGY          | 57 PED. EMERGENCY MED    | 83 SURGERY, HAND         |
| 24 INFECTIOUS DISEASES | 56 PED. ENDOCRINOLOGY    | 84 SURGERY, HEADNECK     |
| 25 INFERTILITY         | 57 PED. HEMATOLOGY       | 82 SURGERY, MAXILLOFAC   |
| 26 INTERNAL MEDICINE   | 58 PED. INFECTIOUS DIS   | 83 SURGERY, NEUROLOGICAL |
| 27 LARYNGOLOGY         | 59 PED. INTENSIVIST      | 85 SURGERY, ORTHOPEDIC   |
| 28 LEGAL MEDICINE      | 60 PED. NEPHROLOGY       | 86 SURGERY, PLASTIC      |
| 29 MATERNAL/FETAL MED  | 60 PED. NEUROLOGY        | 87 SURGERY, THORACIC     |
| 30 NEOPERNATAL MED     | 101 PED. OPHTHALMOLOGY   | 88 SURGERY, TRAUMATIC    |
| 31 NEOPLASTIC DISEASES | 81 PED. PHYSIATRY        | 89 SURGERY, UROLOGIC     |
| 32 NEPHROLOGY          | 88 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	<u>38</u>	<u>100</u>	<u>Yes</u>
Secondary	_____	_____	_____
Tertiary	_____	_____	_____

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

Board	<u>Amer. Board OB/Gyn</u>	Date of Initial Certification	Date of Last Certification
		<u>12/91</u>	
		(Mo./Yr.)	(Mo./Yr.)
Subboard	_____	(Mo./Yr.)	(Mo./Yr.)

3. Form of employment is 1001 (Use the following codes)

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

**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  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  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  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  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  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  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  No
8. Have you ever had a medical license revoked, suspended, limited, or restricted in any state, country or U.S. territory?  Yes  No
9. Have you ever voluntarily surrendered a license to practice a healing art in any state, country or U.S. territory?  Yes  No
10. Have you ever been denied membership or expelled from a medical society or other professional medical organization?  Yes  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  No
12. Have you ever surrendered your state or federal controlled substance registration or had it revoked or restricted in any way?  Yes  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.)
Valley Hosp	3333 S. Duran Ave.	AL	None
UNIV MED	2001 W. 2nd St	AS	

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.

Signature \_\_\_\_\_

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

I HAVE  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. ALL STATEMENTS I HAVE MADE HEREIN ARE TRUE.

366-1326  
Business Telephone #  
(702)

3-15-97  
Date

\_\_\_\_\_  
Signature (SIGNATURE STAMP UNACCEPTABLE)

PHYSICIAN  
APPLICATION FOR RENEWAL REGISTRATION  
NEVADA STATE BOARD OF  
MEDICAL EXAMINERS

Date Received by Board

License No. 6135

APR 29 1999

File No. \_\_\_\_\_

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

(Board Use Only)

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

- ACTIVE STATUS  \$600.00  
 INACTIVE STATUS \$200.00  
 RETIRED STATUS \$ 50.00  
 SUPERVISING/COLLABORATING PHYSICIAN ~~\$200.00~~

*emer* *MB*

Adam V. Levy, MD

Las Vegas NV 89106

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.
- c.  YES, working part-time
- e.  NO, other (specify \_\_\_\_\_)

- b.  YES, working full-time
- d.  NO, retired.

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**

- |  |  |  |
|--|--|--|
| <ul style="list-style-type: none"> <li>102 ADDICTION MEDICINE</li> <li>1 ADOLESCENT MEDICINE</li> <li>2 AEROSPACE MEDICINE</li> <li>3 ALLERGY/IMMUNOLOGY</li> <li>104 ALTERNATIVE MEDICINE</li> <li>4 ANESTHESIOLOGY</li> <li>5 BLOODBANKING</li> <li>6 BRONCO-ESOPHAGOLOGY</li> <li>7 CARDIOVASCULAR DISEASES</li> <li>8 CATSCAN/ULTRASOUND</li> <li>9 CHILD NEUROLOGY</li> <li>10 CHILD PSYCHIATRY</li> <li>11 CLINICAL PHARMACOLOGY</li> <li>12 CRITICAL CARE</li> <li>13 DERMATOLOGY</li> <li>14 EMERGENCY MEDICINE</li> <li>15 ENDOCRINOLOGY</li> <li>16 FAMILY PRACTICE</li> <li>17 GASTROENTEROLOGY</li> <li>18 GENERAL PRACTICE</li> <li>19 GERIATRICS</li> <li>20 GYNECOLOGY</li> <li>21 HEMATOLOGY</li> <li>105 HOMEOPATHY</li> <li>22 HYPNOSIS</li> <li>23 IMMUNOLOGY</li> <li>24 INFECTIOUS DISEASES</li> <li>25 INFERTILITY</li> <li>26 INTERNAL MEDICINE</li> <li>27 LARYNGOLOGY</li> <li>28 LEGAL MEDICINE</li> <li>29 MATERNAL/FETAL MEDICINE</li> <li>106 MEDICAL ACUPUNCTURE</li> <li>107 MEDICAL ETHICS</li> <li>30 NEO/PERINATAL MEDICINE</li> </ul> | <ul style="list-style-type: none"> <li>31 NEOPLASTIC DISEASES</li> <li>32 NEPHROLOGY</li> <li>33 NEUROLOGY</li> <li>34 NEUROPATHOLOGY</li> <li>35 NEURORADIOLOGY</li> <li>36 NUCLEAR MEDICINE</li> <li>37 NUTRITION</li> <li><u>38 OBSTETRICS/GYNECOLOGY</u></li> <li>39 OBSTETRICS</li> <li>40 OCCUPATIONAL MEDICINE</li> <li>41 ONCOLOGY</li> <li>45 ONCOLOGY, GYNECOLOGICAL</li> <li>42 ONCOLOGY, HEMATOLOGY</li> <li>43 ONCOLOGY, RADIATION</li> <li>44 ONCOLOGY, SURGICAL</li> <li>46 OPHTHALMOLOGY</li> <li>47 OTOLARYNGOLOGY</li> <li>48 OTOLOGY</li> <li>49 PAIN MANAGEMENT</li> <li>50 PATHOLOGY</li> <li>51 PATHOLOGY, ANATOMIC</li> <li>52 PATHOLOGY, CLINICAL</li> <li>53 PATHOLOGY, FORENSIC</li> <li>54 PEDIATRIC, ALLERGY</li> <li>55 PEDIATRIC, CARDIOLOGY</li> <li>99 PEDIATRIC, CRITICAL CARE</li> <li>97 PEDIATRIC, EMERGENCY MEDICINE</li> <li>56 PEDIATRIC, ENDOCRINOLOGY</li> <li>57 PEDIATRIC, HEMATOLOGY/ONCOLOGY</li> <li>58 PEDIATRIC, INFECTIOUS DISEASES</li> <li>59 PEDIATRIC, INTENSIVIST</li> <li>60 PEDIATRIC, NEPHROLOGY</li> <li>98 PEDIATRIC, NEUROLOGY</li> <li>101 PEDIATRIC, OPHTHALMOLOGY</li> <li>61 PEDIATRIC, PHYSIATRY</li> <li>95. PEDIATRIC, PULMONARY</li> </ul> | <ul style="list-style-type: none"> <li>62 PEDIATRIC, RADIOLOGY</li> <li>63 PEDIATRIC, SURGERY</li> <li>64 PEDIATRIC, UROLOGY</li> <li>65 PEDIATRICS</li> <li>66 PHYSICAL MEDICINE/REHABILITATION</li> <li>67 PREVENTIVE MEDICINE</li> <li>68 PSYCHIATRY</li> <li>69 PSYCHOANALYSIS</li> <li>70 PSYCHOMATIC MEDICINE</li> <li>71 PUBLIC HEALTH</li> <li>72 PULMONARY DISEASES</li> <li>73 RADIOLOGY</li> <li>74 RADIOLOGY, DIAGNOSTIC</li> <li>75 RADIOLOGY, NUCLEAR</li> <li>76 RADIOLOGY, THERAPEUTIC</li> <li>77 RHEUMATOLOGY</li> <li>78 RHINOLOGY</li> <li>79 SLEEP DISORDERS</li> <li>100 SPORTS MEDICINE</li> <li>80 SURGERY, ABDOMINAL</li> <li>103 SURGERY, CARDIOTHORACIC</li> <li>81 SURGERY, CARDIOVASCULAR</li> <li>91 SURGERY, COLON/RECTAL</li> <li>82 SURGERY, GENERAL</li> <li>83 SURGERY, HAND</li> <li>84 SURGERY, HEAD/NECK</li> <li>92 SURGERY, MAXILLOFACIAL</li> <li>93 SURGERY, NEUROLOGICAL</li> <li>85 SURGERY, ORTHOPEDIC</li> <li>88 SURGERY, PLASTIC</li> <li>87 SURGERY, THORACIC</li> <li>88 SURGERY, TRAUMATIC</li> <li>89 SURGERY, UROLOGIC</li> <li>90 SURGERY, VASCULAR</li> <li>94 UROLOGY</li> </ul> |
|--|--|--|

	Code	Percent of Time	Board Certified (Indicate Yes/No)
Primary	<u>38</u>	<u>100</u>	<u>Yes</u>
Secondary	_____	_____	_____
Tertiary	_____	_____	_____

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

	Date of Initial Certification	Date of Last Certification
Board <u>ABOG</u>	<u>12/91</u> (Mo./Yr.)	_____ (Mo./Yr.)
Subboard _____	_____ (Mo./Yr.)	_____ (Mo./Yr.)
Board _____	_____ (Mo./Yr.)	_____ (Mo./Yr.)
Subboard _____	_____ (Mo./Yr.)	_____ (Mo./Yr.)

9. Form of employment is 1001. (Use one of the following codes.)

- |  |   |
|--|---|
| <p><b>SELF-EMPLOYED:</b></p> <ul style="list-style-type: none"> <li>1001 Solo Practice</li> <li>1002 Partnership or Group Practitioners</li> </ul> <p><b>SALARIED, EMPLOYED BY:</b></p> <ul style="list-style-type: none"> <li>1003 Individual Practitioner</li> <li>1004 Partnership or Group of Practitioners</li> <li>1005 Group Health Plan Facility (such as H.M.O.)</li> </ul> | <p><b>SALARIED, EMPLOYED BY: (continued)</b></p> <ul style="list-style-type: none"> <li>1006 Other Non-Government Employer (hospital, school, etc.)</li> <li>1007 Federal Government (armed services personnel only)</li> <li>1008 Federal Government (civilian, P.H.S., etc.)</li> <li>1009 State Government</li> <li>1010 County Government</li> <li>1011 Local Government</li> </ul> |
|--|---|

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  No

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  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 \_\_\_\_\_ 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 \_\_\_\_\_ 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 \_\_\_\_\_ 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 \_\_\_\_\_ 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  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  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  No

10. Have you ever been denied membership or expelled from a medical society or other professional medical organization? \_\_\_\_\_ Yes  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  No

12. Have you ever surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? Yes  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.)
	(None)		

(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.
- 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:**

- 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  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.**

702 366 1326      4/6/99      Signature (SIGNATURE STAMP UNACCEPTABLE)  
Business Telephone #      Date

PHYSICIAN  
APPLICATION FOR REGISTRATION RENEWAL  
FOR THE BIENNIAL REGISTRATION PERIOD 2001- 2003  
NEVADA STATE BOARD OF MEDICAL EXAMINERS

Date Received by Board

*AM*  
License No. 6135

APR 06 2001

File No. \_\_\_\_\_

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

(For Board Use Only)

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

<input checked="" type="checkbox"/> ACTIVE STATUS	\$600.00	
<input type="checkbox"/> INACTIVE STATUS	\$200.00	(RETIRED STATUS REQUIRES THAT THE
<input type="checkbox"/> RETIRED STATUS	\$ 50.00	APPLICANT NOT PRACTICE MEDICINE
<input checked="" type="checkbox"/> SUPERVISING/COLLABORATING PHYSICIAN	\$200.00	ANYWHERE)

Adam V LEVY  
2501 W Charleston Blvd  
Las Vegas NV 89102

M.D.

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 \_\_\_\_\_  
Street \_\_\_\_\_  
City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

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 Southern California 5-8-1984  
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	40 NEUROLOGY	79 PEDIATRIC, UROLOGY
2 ADOLESCENT MEDICINE	41 NEURO-OPHTHALMOLOGY	80 PEDIATRICS
3 AEROSPACE MEDICINE	42 NEUROPATHOLOGY	81 PHYSICAL MEDICINE/REHABILITATION
4 ALLERGY	43 NEURORADIOLOGY	82 PREVENTIVE MEDICINE
5 ALLERGY/IMMUNOLOGY	44 NON-CONVENTIONAL MEDICINE	83 PSYCHIATRY
6 ANESTHESIOLOGY	45 NUCLEAR MEDICINE	84 PSYCHOANALYSIS
7 BLOODBANKING	46 NUTRITION	85 PSYCHOMATIC MEDICINE
8 BRONCO-ESOPHAGOLOGY	47 OBSTETRICS	86 PUBLIC HEALTH
9 CARDIOVASCULAR DISEASES	48 OBSTETRICS/GYNECOLOGY	87 PULMONARY DISEASES
10 CATSCAN/ULTRASOUND	49 OCCUPATIONAL MEDICINE	88 RADIOLOGY
11 CHILD NEUROLOGY	50 ONCOLOGY	89 RADIOLOGY, DIAGNOSTIC
12 CHILD PSYCHIATRY	51 ONCOLOGY, GYNECOLOGICAL	90 RADIOLOGY, INTERVENTIONAL
13 CLINICAL PHARMACOLOGY	52 ONCOLOGY, HEMATOLOGY	91 RADIOLOGY, NUCLEAR
14 CRITICAL CARE	53 ONCOLOGY, RADIATION	92 RADIOLOGY, THERAPEUTIC
15 DERMATOLOGY	54 ONCOLOGY, SURGICAL	93 RADIOLOGY, VASCULAR
16 DERMATOPATHOLOGY	55 OPHTHALMOLOGY	94 RHEUMATOLOGY
17 EMERGENCY MEDICINE	56 OTOLARYNGOLOGY	95 RHINOLOGY
18 ENDOCRINOLOGY	57 OTOTOLOGY	96 SLEEP DISORDERS
19 FAMILY PRACTICE	58 PAIN MANAGEMENT	97 SPORTS MEDICINE
20 GASTROENTEROLOGY	59 PATHOLOGY	98 SURGERY, ABDOMINAL
21 GENERAL PRACTICE	60 PATHOLOGY, ANATOMIC	99 SURGERY, CARDIOTHORACIC
22 GERIATRICS	61 PATHOLOGY, CLINICAL	100 SURGERY, CARDIOVASCULAR
23 GYNECOLOGY	62 PATHOLOGY, FORENSIC	101 SURGERY, COLON/RECTAL
24 HEMATOLOGY	63 PEDIATRIC, ALLERGY	102 SURGERY, GENERAL
25 HOMEOPATHY	64 PEDIATRIC, CARDIOLOGY	103 SURGERY, HAND
26 HYPNOSIS	65 PEDIATRIC, CRITICAL CARE	104 SURGERY, HEAD/NECK
27 IMMUNOLOGY	66 PEDIATRIC, EMERGENCY MEDICINE	105 SURGERY, MAXILLOFACIAL
28 INFECTIOUS DISEASES	67 PEDIATRIC, ENDOCRINOLOGY	106 SURGERY, NEUROLOGICAL
29 INFERTILITY	68 PEDIATRIC, GASTROENTEROLOGY	107 SURGERY, ORTHOPEDIC
30 INTERNAL MEDICINE	69 PEDIATRIC, HEMATOLOGY/ONCOLOGY	108 SURGERY, PLASTIC
31 LARYNGOLOGY	70 PEDIATRIC, INFECTIOUS DISEASES	109 SURGERY, THORACIC
32 LEGAL MEDICINE	71 PEDIATRIC, INTENSIVIST	110 SURGERY, TRANSPLANT
33 MATERNAL/FETAL MEDICINE	72 PEDIATRIC, NEPHROLOGY	111 SURGERY, TRAUMATIC
34 MEDICAL ACUPUNCTURE	73 PEDIATRIC, NEUROLOGY	112 SURGERY, UROLOGIC
35 MEDICAL ETHICS	74 PEDIATRIC, OPHTHALMOLOGY	113 SURGERY, VASCULAR
36 MEDICAL GENETICS	75 PEDIATRIC, PHYSIATRY	114 URGENT CARE
37 NEO/PERINATAL MEDICINE	76 PEDIATRIC, PULMONARY	115 UROLOGY
38 NEOPLASTIC DISEASES	77 PEDIATRIC, RADIOLOGY	
39 NEPHROLOGY	78 PEDIATRIC, SURGERY	

Primary Specialty Code 48      Secondary Specialty \_\_\_\_\_      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  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  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  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  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 \_\_\_\_\_ 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 \_\_\_\_\_ 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  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  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  No

10. Have you ever been denied membership or expelled from a medical society or other professional medical organization? \_\_\_\_\_ Yes \_\_\_\_\_ 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  No

12. Have you ever surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? \_\_\_\_\_ Yes  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.)
<i>None</i>			

**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, 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  HAVE NOT \_\_\_\_\_ (CHECK ONE) ACTIVELY PRACTICED MEDICINE IN NEVADA WITHIN THE PAST 12 MONTHS.

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

- 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;
- 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
- 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).

3/30/2001  
Date \_\_\_\_\_ Signature (SIGNATURE STAMP UNACCEPTABLE)

PHYSICIAN

Date Received by Board

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

License No. 6135 File No.

MAR 10 2003 FEB 21 2003 (For Board Use Only)

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

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

File no. License no: 6135

Adam V LEVY 1670 E Flamingo Rd # C Las Vegas NV 89119

M.D.

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 Street City County State Zip Phone Number Fax Number

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	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 OTOTOLOGY	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  
 Primary Scope of Practice 25

Code  
 Secondary Scope of Practice 50

**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
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**“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  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  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  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  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  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  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  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  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  No
10. Have you ever been denied membership or expelled from a medical society or other professional medical organization? \_\_\_\_\_ Yes  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  No
12. Have you ever surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? \_\_\_\_\_ Yes  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.)
(None)			

**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).

2-7-03  
Date

Signature (SIGNATURE STAMP INACCEPTABLE)

**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 28 2005**  
**APR 15 2005**

License No. 6135  
 File No. \_\_\_\_\_

(For Board Use Only)

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

**ACTIVE STATUS** \$600.00 *hi*  
 **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)

**Fee No.** License No. **6135**

Adam Vincent LEVY M.D. **NEVADA STATE BOARD OF MEDICAL EXAMINERS**  
 1670 E Flamingo Rd # C (Foreign checks must indicate "U.S. FUNDS")  
 Las Vegas NV 89119-

**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 \_\_\_\_\_ Fax Number \_\_\_\_\_



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

Primary Scope of Practice 26

Secondary Scope of Practice \_\_\_\_\_

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

Board OB/Gyn Date of Initial Certification 12/31/91 Date of Last Recertification 9/30/05  
 (Mo./Yr.) (Mo./Yr.) (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  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  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 \_\_\_\_\_ 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 \_\_\_\_\_ 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  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  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  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  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  No

10. Have you ever been denied membership or expelled from a medical society or other professional medical organization? \_\_\_\_\_ Yes  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  No

12. Have you ever surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? \_\_\_\_\_ Yes  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.)
<u>None</u>			

**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 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  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).

2/3/05

Date

Signature (SIGNATURE STAMP UNACCEPTABLE)

License Number	Licensee Name	Question Text	Answer	Date Answered
6135	LEVY, Adam Vincent	Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety?	N	3/29/2007
6135	LEVY, Adam Vincent	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?	N	3/29/2007
6135	LEVY, Adam Vincent	If you use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety?	N	3/29/2007
6135	LEVY, Adam Vincent	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	3/29/2007
6135	LEVY, Adam Vincent	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 claim paid on your behalf, or paid such a claim yourself?	N	3/29/2007

6135	LEVY, Adam Vincent	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.	N	3/29/2007
6135	LEVY, Adam Vincent	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	3/29/2007
6135	LEVY, Adam Vincent	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	3/29/2007
6135	LEVY, Adam Vincent	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	3/29/2007
6135	LEVY, Adam Vincent	Have you been denied membership or expelled from a medical society or other professional medical organization?	N	3/29/2007

6135	LEVY, Adam Vincent	Have you 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 agency other than the Nevada State Board of Medical Examiners?	N	3/29/2007
6135	LEVY, Adam Vincent	Have you surrendered your state or federal controlled substance registration or had it revoked or restricted in any way ?	N	3/29/2007
6135	LEVY, Adam Vincent	Have you had hospital staff privileges denied, suspended, limited, revoked or not renewed by the hospital? 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 <a href="mailto:ellicensensbme@medboard.nv.gov">ellicensensbme@medboard.nv.gov</a> (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	3/29/2007
6135	LEVY, Adam Vincent	Is your license currently contingent upon compliance with the Diversion program also known as the Nevada Health Professionals Assistance Foundation?	N	3/29/2007
6135	LEVY, Adam Vincent	Is your license currently contingent upon maintaining certification by the American Board of Medical Specialties in the specialty of Family Practice, Emergency Medicine or Preventative medicine?	N	3/29/2007

6135	LEVY, Adam Vincent	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?	N	3/29/2007
6135	LEVY, Adam Vincent	Are you out of compliance with court ordered child support? If this does not apply to you please answer "no".	N	3/29/2007
6135	LEVY, Adam Vincent	Do you want to change your scope of practice or specialty? If you answer "Yes" please email your request to elicensesbme@medboard.nv.gov	N	3/29/2007
6135	LEVY, Adam Vincent	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 elicensesbme@medboard.nv.gov	Y	3/29/2007
6135	LEVY, Adam Vincent	I have completed the required amount of AMA Category 1 CME within the current biennial. (Review CME information online at www.medboard.nv.gov) 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	3/29/2007
6135	LEVY, Adam Vincent	I have actively practiced medicine in Nevada within the past 12 months.	Y	3/29/2007
6135	LEVY, Adam Vincent	I hereby request my license to be placed on Inactive status. I will not physically practice in the state of Nevada.	N	3/29/2007
6135	LEVY, Adam Vincent	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	3/29/2007

6135	LEVY, Adam Vincent	Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety?	N	5/7/2009
6135	LEVY, Adam Vincent	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?	N	5/7/2009
6135	LEVY, Adam Vincent	If you use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety?	N	5/7/2009
6135	LEVY, Adam Vincent	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)? Please include: who, what, where (provide state), and when in the textbox directly below this question.	Y	5/7/2009



6135

LEVY, Adam Vincent

For the above question if your answer is "Yes" for the time period July 1, 2007 - June 30, 2009, please type your explanation in this text box.

5/7/2009

6135	LEVY, Adam Vincent	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)? Please include: who, what, where (provide state), when and case number in the textbox directly below this question. Please fax a copy of the complaint, civil or otherwise to 775-688-2551.	N	5/7/2009
6135	LEVY, Adam Vincent	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 where the final disposition was dismissal, sealing of a record, or expungement.	N	5/7/2009
6135	LEVY, Adam Vincent	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	5/7/2009
6135	LEVY, Adam Vincent	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	5/7/2009
6135	LEVY, Adam Vincent	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	5/7/2009

6135	LEVY, Adam Vincent	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	5/7/2009
6135	LEVY, Adam Vincent	Have you been denied membership, been asked to resign or expelled from a medical society or other professional medical organization (including the ABMS)?	N	5/7/2009
6135	LEVY, Adam Vincent	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: (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?	N	5/7/2009
6135	LEVY, Adam Vincent	Have you surrendered your state or federal controlled substance registration or had it revoked or restricted in any way?	N	5/7/2009
6135	LEVY, Adam Vincent	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? 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. (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	5/7/2009

6135	LEVY, Adam Vincent	Are you out of compliance with court ordered child support? If this does not apply to you, please answer "no". If "Yes" during the time period July 1, 2007 - June 30, 2009 type an explanation in the textbox directly below this question.	N	5/7/2009
6135	LEVY, Adam Vincent	I hereby request my license to be placed on Inactive status, which means I will not physically practice in the state of Nevada.	N	5/7/2009
6135	LEVY, Adam Vincent	Do you want to change your scope of practice or specialty? If you answer "Yes" type your current scope of practice or specialty in the textbox directly below this question.	N	5/7/2009
6135	LEVY, Adam Vincent	I have completed the required amount of AMA Category 1 CME within the current biennial. (Review CME information online at <a href="http://www.medboard.nv.gov">www.medboard.nv.gov</a> ) 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.	Y	5/7/2009
6135	LEVY, Adam Vincent	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	5/7/2009

2011 Renewal

System Automation  
Enabling Responsible Government

MyLicense Transaction Reports

[Reports Home Page](#)

## Renewal Questions for License Number 6135



Licensee	Question	Answer	Date
LEVY, Adam Vincent	Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? <b>If you do not have a medical condition, select No.</b>	N	4/7/2011
LEVY, Adam Vincent	<b>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.</b>		
LEVY, Adam Vincent	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? <b>If you do not have a medical condition, select No.</b>	N	4/7/2011
LEVY, Adam Vincent	<b>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.</b>		
LEVY, Adam Vincent	If you use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety? <b>If you do not use chemical substances, select No.</b>	N	4/7/2011
LEVY, Adam Vincent	<b>Explanation 3: 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.</b>		
LEVY, Adam Vincent	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? <b>Please include: who, what, where (provide state), and when in the textbox directly below this question.</b>	Y	4/7/2011

**Explanation 4: For the above question if your**

LEVY, Adam Vincent	<b>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.</b>		4/7/2011
LEVY, Adam Vincent	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?	Y	4/7/2011
	If "Yes" during the time period July 1, 2009 - June 30, 2011 type an explanation in the textbox directly below this question.		
LEVY, Adam Vincent	<b>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.</b>		4/7/2011
	Please fax a copy of the complaint, civil or otherwise to 775-688-2551.		
LEVY, Adam Vincent	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?	N	4/7/2011
	<b>Please note that you MUST disclose ANY investigation or arrest, including those where the final disposition was dismissal, or expungement.</b>		
LEVY, Adam Vincent	<b>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.</b>		
LEVY, Adam Vincent	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	4/7/2011
LEVY, Adam Vincent	<b>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.</b>		

LEVY, Adam Vincent	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	4/7/2011
LEVY, Adam Vincent	<b>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.</b>		
LEVY, Adam Vincent	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	4/7/2011
LEVY, Adam Vincent	<b>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.</b>		
LEVY, Adam Vincent	Have you been denied membership, been asked to resign or expelled from a medical society or other professional medical organization (including the ABMS)?	N	4/7/2011
LEVY, Adam Vincent	<b>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.</b>		
LEVY, Adam Vincent	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 <u>other than</u> the Nevada State Board of Medical Examiners?	N	4/7/2011
LEVY, Adam Vincent	<b>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.</b>		
LEVY, Adam Vincent	Have you surrendered your state or federal controlled substance registration or had it revoked or restricted in any way?	N	4/7/2011
LEVY, Adam Vincent	<b>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.</b>		
	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?

LEVY,  
Adam  
Vincent

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.

N

4/7/2011

**(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.)

LEVY,  
Adam  
Vincent

**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.**

Are you out of compliance with court ordered child support? **If this does not apply to you, please answer "no".**

LEVY,  
Adam  
Vincent

If "Yes" during the time period July 1, 2009 - June 30, 2011 type an explanation in the textbox directly below this question.

N

4/7/2011

LEVY,  
Adam  
Vincent

**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.**

I hereby request my license to be placed on Inactive status, which means I will not physically practice in the state of Nevada.

LEVY,  
Adam  
Vincent

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

4/7/2011

LEVY,  
Adam  
Vincent

**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.**

LEVY,  
Adam  
Vincent

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

4/7/2011

LEVY,  
Adam

**Explanation 16: For the above question if your answer is "YES" , please type your new scope of**



Vincent	<b>practice or specialty in this text box.</b>		
	Do you want to change your scope of practice or specialty?		
LEVY, Adam Vincent	If you answer "Yes" type your current scope of practice or specialty in the textbox directly below this question.	N	4/7/2011
	<b>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.</b>		
LEVY, Adam Vincent	I have completed the required amount of AMA Category 1 CME within the current biennial. (Review CME information online at <a href="http://www.medboard.nv.gov">www.medboard.nv.gov</a> )		
LEVY, Adam Vincent	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.	Y	4/7/2011
	If renewing to an <u>Inactive</u> status, CME is not required and "No" can be selected.		
LEVY, Adam Vincent	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	4/7/2011

# Nevada State Board of Medical Examiners

## Renewal Responses Report



License Number	Licensee	License Type	Answer	Date
6135	Adam Vincent LEVY	Medical Doctor		

**Question**  
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  
05/08/2013

**Question**  
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  
05/08/2013

**Question**  
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  
05/08/2013

### NSBME Renewal Responses Report

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? Please include: who, what, where (provide state), and when in the textbox directly below this question.

N

05/08/2013

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?  
If "Yes" during the time period July 1, 2011 - June 30, 2013 type an explanation in the textbox directly below this question.

N

05/08/2013

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

05/08/2013

**NSBME Renewal Responses Report**

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

05/08/2013

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

05/08/2013

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

05/08/2013

**NSBME Renewal Responses Report**

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

05/08/2013

**If you believe that you are in compliance with the Centers for Disease Control safe injection practices, your answer should be "YES". 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/hicpac/2007IP/2007isolationPrecautions.html>**

Y

05/08/2013

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

N

05/08/2013

**NSBME Renewal Responses Report**

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?  
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.  
**(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

05/08/2013

Have you actively practiced medicine in Nevada within the past 12 months?

Y

05/08/2013

I hereby request my license to be placed on Inactive status, which means I will not physically practice in the state of Nevada.  
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

05/08/2013

## NSBME Renewal Responses Report

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. Please go to the website, click on the following link for instructions and complete the required form. Click on the following link for the instructions and forms:

[http://medboard.nv.gov/New\\_In\\_Office\\_Surgery\\_Forms.htm](http://medboard.nv.gov/New_In_Office_Surgery_Forms.htm)

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". Nevada Revised Statutes (NRS) require the Nevada State Board of Medical Examiners to

Are you out of compliance with court ordered child support? If this does not apply to you, please answer "no".

If "Yes" during the time period July 1, 2011 - June 30, 2013 type an explanation in the textbox directly below this question.

Y 05/08/2013

N 05/08/2013

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](http://www.medboard.nv.gov))

If renewing to an inactive status, CME is not required and "No" can be selected.

Y 05/08/2013

**NSBME Renewal Responses Report**

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

05/08/2013



**Renewal Questions for License Number 6135**

Licensee	Question	Answer	Date
<b>LEVY, Adam Vincent</b>			

LEVY, Adam Vincent	Have you ever served in the United States Military (to include National Guard or Reserves)?	Y	5/11/2015
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**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.**

LEVY, Adam Vincent	1. If yes, in which branch of service did you serve?	Airforce, OB/GYN	
	2. What was your Military occupation specialty or specialties?	physician, 1998-2001	5/11/2015
	3. Provide your dates of service in the Military.		

**RENEWED  
7/1/15 - 6/30/17  
BIENNIAL**

Renewal	Ordinal	Question Text	Answer Text
6135-2015-03-31	1	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
6135-2015-03-31	2	<b>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)</b> 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 If you do not have a medical condition, select No.	N
6135-2015-03-31	3	<b>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)</b> 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
6135-2015-03-31	4	<b>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)</b> 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? Please include who, what, where (provide state), and when in the textbox directly below this question.	N
6135-2015-03-31	5	<b>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 brief explanation in this text box.</b> 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
6135-2015-03-31	6	<b>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 brief explanation in this text box.</b> 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
6135-2015-03-31	7	<b>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)</b> 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	N
6135-2015-03-31	8	<b>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)</b> 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

6185-2015-03-31 16 **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 character**

6185-2015-03-31 17 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

6185-2015-03-31 18 **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 character**

6185-2015-03-31 19 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

6185-2015-03-31 20 **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 character**

6185-2015-03-31 25 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 l

6185-2015-03-31 30 **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 charac**

6185-2015-03-31 35 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 phy

6185-2015-03-31 40 **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 charact**

6185-2015-03-31 45 Have you surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? N

6185-2015-03-31 50 **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 charac**

6185-2015-03-31 60 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?  
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. N  
**(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.)**

6185-2015-03-31 61 **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 charac**

6185-2015-03-31 64 Have you actively practiced medicine in Nevada within the past 12 months? Y

6185-2015-03-31 67 **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 character**

6185-2015-03-31 68 **OPTION TO CHANGE LICENSE STATUS FROM ACTIVE TO INACTIVE:**  
**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  
I hereby request my license to be placed on Inactive status, which means I will not physically practice in the state of Nevada. N  
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

6135-2015-03-31	70	<p>If you believe that you are in compliance with the Centers for Disease Control safe injection practices, your answer should be "YES".</p> <p>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 understand that 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.</p> <p>I HAVE SUBMITTED A "FORM A" OR "FORM B" REPORT TO THE BOARD.</p> <p>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: <a href="http://www.medboard.nv.gov">www.medboard.nv.gov</a>.</p> <p>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."</p> <p>Are you out of compliance with court-ordered child support? If this does not apply to you, please answer "no".</p> <p>If "Yes" during the time period July 1, 2013 - June 30, 2015 type an explanation in the textbox directly below this question.</p> <p><b>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</b></p> <p>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".</p> <p>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.</p> <p><a href="http://www.leg.state.nv.us/NRS/NRS-432B.html#NRS432BSec220">www.leg.state.nv.us/NRS/NRS-432B.html#NRS432BSec220</a></p>	Y
6135-2015-03-31	71		
6135-2015-03-31	80		N
6135-2015-03-31	85		
6135-2015-03-31	87		Y
6135-2015-03-31	88	<p><b>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.</b></p>	
6135-2015-03-31	90	<p>Have you ever served in the United States Military (to include National Guard or Reserves)?</p> <p><b>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.</b></p> <ol style="list-style-type: none"> <li>If yes, in which branch of service did you serve?</li> <li>What was your Military occupation specialty or specialties?</li> <li>Provide your dates of service in the Military.</li> </ol>	Y
6135-2015-03-31	91		
6135-2015-03-31	93	<p>Do you hold a Nevada state business license issued in your individual name?</p> <p><b>Explanation 18: If yes, provide the business license number.</b></p>	N
6135-2015-03-31	94		
6135-2015-03-31	100	<p>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 <a href="http://www.medboard.nv.gov">www.medboard.nv.gov</a>)</p> <p>If renewing to an inactive status, CME is not required and "No" can be selected.</p>	Y
6135-2015-03-31	105	<p>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.</p>	

# 2017 Renewal

Renewal	Ordinal	Question Text	Answer Text
6135-2017-04-07	1	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
6135-2017-04-07	2	<b>Explanation 1: For the above question if your answer is "Yes" for the time period July 1, 2015 - June 30, 2017, or since your last renewal, please type your brief explanation in this text box (Fields are space limited to 256 characters). Lengthy</b>	
6135-2017-04-07	3	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 If you do not have a medical condition, select No.	N
6135-2017-04-07	4	<b>Explanation 2: For the above question if your answer is "Yes" for the time period July 1, 2015 - June 30, 2017, or since your last renewal, please type your brief explanation in this text box (Fields are space limited to 256 characters). Lengthy</b>	
6135-2017-04-07	5	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
6135-2017-04-07	6	<b>Explanation 3: For the above question if your answer is "Yes" for the time period July 1, 2015 - June 30, 2017, or since your last renewal, please type your brief explanation in this text box (Fields are space limited to 256 characters). Lengthy</b>	
6135-2017-04-07	7	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? Please include who, what, where (provide state) and when in the text box directly below this question.	N
6135-2017-04-07	8	<b>Explanation 4: For the above question if your answer is "Yes" for the time period July 1, 2015 - June 30, 2017, 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 elicensensome@medboard.nv.gov.</b>	
6135-2017-04-07	9	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? If "Yes" during the time period July 1, 2015 - June 30, 2017 type an explanation in the text box directly below this question.	N
6135-2017-04-07	10	<b>Explanation 5: For the above question if your answer is "Yes" for the time period July 1, 2015 - June 30, 2017, 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 elicensensome@medboard.nv.gov.</b>	
6135-2017-04-07	11	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, with	N
6135-2017-04-07	12	<b>Explanation 6: For the above question if your answer is "Yes" for the time period July 1, 2015 - June 30, 2017, or since your last renewal, please type your brief explanation in this text box (Fields are space limited to 256 characters). Lengthy</b>	
6135-2017-04-07	15	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

6195-2017-04-07	16	<b>Explanation 7:</b> For the above question if your answer is "Yes" for the time period July 1, 2015 - June 30, 2017, or since your last renewal, please type your <u>brief</u> explanation in this text box (Fields are space limited to 256 characters). Length	
6195-2017-04-07	17	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
6195-2017-04-07	18	<b>Explanation 8:</b> For the above question if your answer is "Yes" for the time period July 1, 2015 - June 30, 2017, or since your last renewal, please type your <u>brief</u> explanation in this text box (Fields are space limited to 256 characters). Length	
6195-2017-04-07	19	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
6195-2017-04-07	20	<b>Explanation 9:</b> For the above question if your answer is "Yes" for the time period July 1, 2015 - June 30, 2017, or since your last renewal, please type your <u>brief</u> explanation in this text box (Fields are space limited to 256 characters). Length	
6195-2017-04-07	25	Have you failed to initiate the performance of public service within one year after the date the public service was required to begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local government?	
6195-2017-04-07	30	<b>Explanation 10:</b> For the above question if your answer is "Yes" for the time period July 1, 2015 - June 30, 2017, or since your last renewal, please type your <u>brief</u> explanation in this text box (Fields are space limited to 256 characters). Length	
6195-2017-04-07	35	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 an	
6195-2017-04-07	40	<b>Explanation 11:</b> For the above question if your answer is "Yes" for the time period July 1, 2015 - June 30, 2017, or since your last renewal, please type your <u>brief</u> explanation in this text box (Fields are space limited to 256 characters). Length	
6195-2017-04-07	45	Have you surrendered your state or federal controlled substance registration or had it revoked or restricted in any way?	N
6195-2017-04-07	50	<b>Explanation 12:</b> For the above question if your answer is "Yes" for the time period July 1, 2015 - June 30, 2017, or since your last renewal, please type your <u>brief</u> explanation in this text box (Fields are space limited to 256 characters). Length	
6195-2017-04-07	60	Have you had hospital 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," type the name of the hospital, the hospital's mailing address, the type of action taken, and the date(s) of the actions taken in the text box directly below this question. <u>(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.)</u>	N
6195-2017-04-07	61	<b>Explanation 13:</b> For the above question if your answer is "Yes" for the time period July 1, 2015 - June 30, 2017, or since your last renewal, please type your <u>brief</u> explanation in this text box (Fields are space limited to 256 characters). Length	
6195-2017-04-07	62	Have you been denied membership, been asked to resign or expelled from a medical society or other professional medical organization?	N
6195-2017-04-07	63	<b>Explanation 14:</b> For the above question if your answer is "Yes" for the time period July 1, 2015 - June 30, 2017, or since your last renewal, please type your <u>brief</u> explanation in this text box (Fields are space limited to 256 characters). Length	
6195-2017-04-07	64	Have you actively practiced medicine in Nevada within the past 24 months?	Y
6195-2017-04-07	67	<b>Explanation 15:</b> For the above question if your answer is "No" for the time period July 1, 2015 - June 30, 2017, or since your last renewal, please type your <u>brief</u> explanation in this text box (Fields are space limited to 256 characters). Length	

6135-2017-04-07	68	<p>OPTION TO CHANGE LICENSE STATUS FROM ACTIVE TO INACTIVE:</p> <p>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 COMPLY</p> <p>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. N</p> <p>If you choose to place your license on Inactive status, make certain to select "Yes" to this question <u>AND</u> choose the inactive status in the dropdown box located at the end of the questions.</p> <p>If you believe that you are in compliance with the Centers for Disease Control safe injection practices, your answer should be "YES".</p> <p>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 <u>Y</u>  <a href="http://www.cdc.gov/injectionsafety/IP07_standardPrecaution.html">http://www.cdc.gov/injectionsafety/IP07_standardPrecaution.html</a></p> <p>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.</p> <p>I HAVE SUBMITTED A "FORM A" OR "FORM B" REPORT TO THE BOARD Y</p> <p>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: <a href="http://medboard.nv.gov/forms/in-office_surge">medboard.nv.gov/forms/in-office_surge</a></p> <p>If you have submitted your in-office surgery/procedure reporting form ("A" OR "B" FORM) to the Board and are in compliance with NRS 630.30665, your answer should be "YES."</p> <p>Are you out of compliance with court ordered child support? If this does not apply to you, please answer "no." N</p> <p>If "Yes" during the time period July 1, 2015 - June 30, 2017 type an explanation in the text box directly below this question.</p> <p><b>Explanation 16: For the above question, if your answer is "Yes" for the biennial July 1, 2015 - June 30, 2017, please type your brief explanation in this text box (fields are space limited to 256 characters). Lengthy explanations or additional in</b></p> <p>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.  <a href="http://www.leg.state.nv.us/NRS/NRS-432B.html#NRS432BSec220">http://www.leg.state.nv.us/NRS/NRS-432B.html#NRS432BSec220</a></p> <p>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</p> <p><b>Explanation 17: For the above question if your answer is "No" for the time period July 1, 2015 - June 30, 2017, or since your last renewal, please type your explanation in this text box.</b></p> <p>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, 2015 and June 30, 2017.  (Review CME information online at <a href="http://medboard.nv.gov/licenses/ce/">http://medboard.nv.gov/licenses/ce/</a>) Y</p> <p>If renewing to an Inactive status, CME is not required and "No" can be selected.</p> <p>I am a medical doctor whose specialty is psychiatry and I am in compliance with NRS 630.253, as I have completed a minimum of 2 hours of continuing medical education in the area of suicide prevention and awareness. <b>Note: If you are not a PSY</b></p> <p>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</p>
6135-2017-04-07	70	
6135-2017-04-07	71	
6135-2017-04-07	80	
6135-2017-04-07	85	
6135-2017-04-07	87	
6135-2017-04-07	88	
6135-2017-04-07	100	
6135-2017-04-07	102	
6135-2017-04-07	105	

## 2019 Renewal

Renewal	Ordinal #	Question Text	Answer Text
6135-2019-04-05	1	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
6135-2019-04-05	2	<b>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 expl</b>	
6135-2019-04-05	3	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 if you do not have a medical condition, select No.	N
6135-2019-04-05	4	<b>Explanation 2: 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 expla</b>	
6135-2019-04-05	5	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
6135-2019-04-05	6	<b>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 expla</b>	
6135-2019-04-05	7	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? Please include: who, what, where (provide state) and when in the text box directly below this question.	N
6135-2019-04-05	8	<b>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.</b>	
6135-2019-04-05	9	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? If "Yes" during the time period July 1, 2017 - July 1, 2019 type an explanation in the text box directly below this question.	N
6135-2019-04-05	10	<b>Explanation 5: 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.</b>	
6135-2019-04-05	11	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	N
6135-2019-04-05	12	<b>Explanation 6: 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 expla</b>	
6135-2019-04-05	15	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



6/35-2019-04-05	16	<b>Explanation 7: 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 expla</b>	
6/35-2019-04-05	17	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
6/35-2019-04-05	18	<b>Explanation 8: 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 expla</b>	
6/35-2019-04-05	19	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
6/35-2019-04-05	20	<b>Explanation 9: 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 expla</b>	
6/35-2019-04-05	25	Have you failed to initiate the performance of public service within one year after the date the public service was required to begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local governm	
6/35-2019-04-05	30	<b>Explanation 10: 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 exp</b>	
6/35-2019-04-05	35	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 m	
6/35-2019-04-05	40	<b>Explanation 11: 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 expli</b>	
6/35-2019-04-05	45	Have you surrendered your state or federal controlled substance registration or had it revoked or restricted in any way?	N
6/35-2019-04-05	50	<b>Explanation 12: 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 exp</b>	
6/35-2019-04-05	60	Have you had hospital 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," type the name of the hospital, the hospital's mailing address, the type of action taken, and the date(s) of the actions taken in the text box directly below this question. <b>(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.)</b>	N
6/35-2019-04-05	61	<b>Explanation 13: 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 exp</b>	
6/35-2019-04-05	62	Have you been denied membership, been asked to resign or expelled from a medical society or other professional medical organization?	N
6/35-2019-04-05	63	<b>Explanation 14: 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 exp</b>	
6/35-2019-04-05	64	Have you actively practiced medicine in Nevada within the past 24 months?	Y
6/35-2019-04-05	67	<b>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 expl</b>	

OPTION TO CHANGE LICENSE STATUS FROM ACTIVE TO INACTIVE

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

N

6/35-2019-04-05 68

I hereby request my license to be placed on Inactive status, which means I will not physically practice in the state of Nevada.

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.

If you believe that you are in compliance with the Centers for Disease Control safe injection practices, your answer should be "YES".

6/35-2019-04-05 70

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 an

[http://www.cdc.gov/injectionsafety/IP07\\_standardPrecaution.html](http://www.cdc.gov/injectionsafety/IP07_standardPrecaution.html)

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 utilize

(If you have performed no such surgeries or procedures, then your answer should be "YES.")

Y

6/35-2019-04-05 71

Instructions for in-office surgery/procedure reporting can be located on the Board's website at: [medboard.nv.gov/forms/in-office\\_surgery](http://medboard.nv.gov/forms/in-office_surgery).

Are you out of compliance with court ordered child support? If this does not apply to you, please answer "no."

N

6/35-2019-04-05 80

If "Yes" during the time period July 1, 2017 - July 1, 2019 type an explanation in the text box directly below this question.

**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 inform**

6/35-2019-04-05 85

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

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

6/35-2019-04-05 87

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

**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.**

6/35-2019-04-05 88

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

<http://medboard.nv.gov/licenses/ce/>)

6/35-2019-04-05 100

If renewing to an Inactive status, CME is not required and "No" can be selected.

Y

I hereby 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.

6/35-2019-04-05 102

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.

6/35-2019-04-05 105

Y

## 2021 Renewal

Ordinal †	Licensee/Applicant	Declaration Question	Answer
N/A	Adam LEVY	Malpractice Claim Paid	No
N/A	Adam LEVY	Failed Public Service	No
N/A	Adam LEVY	Voluntarily Surrendered a License	No
N/A	Adam LEVY	Denied Membership	No
N/A	Adam LEVY	Drop to Inactive Status	No
N/A	Adam LEVY	MD - Swear and Affirm	Yes
N/A	Adam LEVY	Hospital Privileges Issues	No
N/A	Adam LEVY	Medical License Revoked	No
N/A	Adam LEVY	Arrest Question	No
N/A	Adam LEVY	Denied License / Permission to Practice Medicine	No
N/A	Adam LEVY	Conscious Sedation Attestation	Yes
N/A	Adam LEVY	CME Affirmation	Yes
N/A	Adam LEVY	Medical Condition Field of Practice	No
N/A	Adam LEVY	Named Defendant Respond to Legal Action	No
N/A	Adam LEVY	Chemical Substances Impair Safe Practice	No
N/A	Adam LEVY	Medical Condition Impair Safe Practice	No
N/A	Adam LEVY	Suicide CME Attestation	Yes
N/A	Adam LEVY	Investigation – Respond To/Notify Of	No
N/A	Adam LEVY	MD Actively Practiced	Yes
N/A	Adam LEVY	Controlled Substance Registration	No

## 2023 Renewal

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Ordinal ↑	Licensee/Applicant	Declaration Question	Answer
1	Adam LEVY	Medical Condition Impair Safe Practice	No
2	Adam LEVY	Medical Condition Field of Practice	No
3	Adam LEVY	Chemical Substances Impair Safe Practice	No
4	Adam LEVY	Named Defendant Respond to Legal Action	No
5	Adam LEVY	Malpractice Claim Paid	No
6	Adam LEVY	Arrest Question	No
7	Adam LEVY	Denied License / Permission to Practice Medicine	No
8	Adam LEVY	Medical License Revoked	No
9	Adam LEVY	Voluntarily Surrendered a License	No
10	Adam LEVY	Failed Public Service	No
11	Adam LEVY	Investigation – Respond To/Notify Of	No
12	Adam LEVY	Controlled Substance Registration	No
13	Adam LEVY	Hospital Privileges Issues	No
14	Adam LEVY	Denied Membership	No
15	Adam LEVY	MD Actively Practiced	Yes
16	Adam LEVY	Drop to Inactive Status	No
17	Adam LEVY	Conscious Sedation Attestation	Yes
18	Adam LEVY	CME Affirmation	Yes
19	Adam LEVY	Suicide CME Attestation	Yes
20	Adam LEVY	MD - Swear and Affirm	Yes
45	Adam LEVY	Emotional Trauma Treatment Training	No
46	Adam LEVY	Willingness to Provide Emotional Trauma Treatment	No
N/A	Adam LEVY	Is your specialty psychiatry?	No

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