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Date Received by Board
SEP 01 2017
NEVADA STATE BOARD OF MEDICAL EXAMINERS

PHYSICIAN
APPLICATION FOR ROTATING RESIDENT LIMITED LICENSURE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

License No. _____

File No. _____ (For Board Use Only)

1105 Terminal Way, Ste. 301, Reno, Nevada 89502 Phone (775) 688-2559

Identity:

1. Present Legal Name McColl (Last) Milton (First) Biko (Middle) — (Maiden)

List any other name(s) ever used —

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

2. Public Address 455 O'Connor Drive #100 (Street) San Jose (City) Santa Clara (County) CA (State) 95128 (Zip)

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

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

4. Telephone Numbers (408) 283-7676 (Office) (408) 283-7646 (Fax) (619) 941-3656 (Home) _____ (Cellular (Optional))

Email address _____

5. Date of Birth 1957 (Month / Day / Year) Place of Birth [illegible] (City, State, Country) Gender ___F ✓M

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

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

7. Social Security Number [redacted] Color of Eyes _____ Color of Hair _____ Height ___ Weight _____

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

Questions:

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

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

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

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

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

8. Do you currently have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety?
_____Yes ✓No

9. If you currently have a medical condition which in any way impairs or limits your ability to practice medicine, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, the manner in which you have chosen to practice or by any other reasonable accommodation?
_____Yes _____No ✓N/A

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

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

Malpractice Questions:

12. Have you EVER been named as a defendant, or been requested to respond as a defendant, to a legal action involving professional liability, or malpractice, including any military tort claims if applicable? (IF ANSWER IS "YES", COMPLETE FORM B AND FORM 4 – see Application Checklist. And Guide)

_____Yes ___✓___No

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

_____Yes ___✓___No

Malpractice Explanation(s):

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

Name of patient involved:

In which state did the action take place?

Case number (if applicable):

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

Current status of claim:

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

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

Amount of judgment or settlement $

Month and year of event precipitating claim:

Month and year of lawsuit or court filing:

Insurance carrier at time:

What is/was your status? ☐ Primary defendant ☐ Co-defendant ☐ Other

Please provide specifics in reference to the adverse event including the allegations and your role in the event:

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

14. Have you previously applied for medical licensure in Nevada (including a residency program)? ____Yes ✓No

15. List names and addresses of all medical schools attended. SUBMIT A PHOTOCOPY OF YOUR MEDICAL SCHOOL DIPLOMA.

Medical School Name	City/State/Country	Place Where Instruction Received	Dates of Attendance From (Mo./Yr.) To (Mo./Yr.)
STANFORD UNIV.	STANFORD, SANTA CLARA, CA,	STANFORD, CA.	9/81 – 3/88

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

16. Doctor of Medicine Degree granted by:

Medical School Name	City/State/Country	Exact Date of Issuance
STANFORD UNIV.	STANFORD, CA. SANTA CLARA	3/31/1988

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

Postgraduate Year (e.g. PGY1, PGY2, etc.)	Hospital/ Institution	City/State	Specify (I =Internship or R = Residency) (F = Fellowship)	Type of Specialty	Dates of Attendance From (Mo./Yr.) To (Mo./Yr.)
PGY1	VALLEY MEDICAL CENTER	SAN JOSE, CA.	I,	TRANSITIONAL	4/1/88 - 6/24/8
PGY1	STANFORD/O'CONNOR	SAN JOSE, CA.	I	FAMILY MED	6/13/88 - 6/30/8
PGY2	STANFORD/O'CONNOR	SAN JOSE	R	FAMILY MED	7/1/89 - 6/30/9

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

18. List all non-ACGME approved Fellowship training programs attended in the United States or Canada.

Institution	City/State	Type of Fellowship	Dates of Attendance From (Mo./Yr.) To (Mo./Yr.)

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

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

20. Provide the name of the Nevada facility, school, or hospital in which you **are going to do your rotation.**

Name of Facility / School / Hospital	Complete Mailing Address	Dates of Rotation From (Mo./Yr.) To (Mo./Yr.)
UNIV. OF NEVADA, RENO	See below ↓	2/1/18 - 2/28/18

21. Provide the name of the Physician in Nevada who will supervise you during your rotation.

Name of Supervising Physician	Complete Mailing Address	Phone Number
ARTHUR ISLAS M.D.	UNC FAM. MED. BELLAGIO AVE. #36 RENO, NV 89557	775-682-8648

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

23. USMLE (United States Medical Licensing Examination): (ALSO INCLUDE ALL INFORMATION PERTAINING TO ANY AND ALL FAILED EXAMINATIONS.)

Step Taken	Date (Mo./Yr.)	Results (Three Digit Scores)	Number of Attempts
NBME PART 1	6/84	445	1
NBME PART 2	4/87	405	1
NBME Part 3	5/89	410	1

24. State your scope of practice / specialty(ies) FAMILY MEDICINE

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

Board	Specialty Board	Certification #	Date of Certification (Mo./Yr.)
~~0~~			

26. Account for, **In chronological order**, all activities since graduation from medical school. ALL PERIODS OF TIME MUST BE ACCOUNTED FOR. (Curriculum Vitae cannot be submitted in lieu of your answer to this question.)

Activities	Location (City/State/Country)	From (Mo./Yr.)	To (Mo./Yr.)	Percent Clinical (%)
INTERNSHIP	VMC, SAN JOSE, CA.	4/88	6/89	100%
SAN FRANCISCO 49ERS / LA RAIDERS SR/LA		4/88	7/89	~~0~~
MEDICAL DEVICE COMPANIES, SAN FRANCISCO BAY AREA		7/89	6/16	~~0~~
CLINIC By the BAY	SAN FRANCISCO, CA	6/14 → 6/16		100% - 50%

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

27. List any and all licenses (including training licenses and permits) **YOU HOLD OR HAVE HELD** to practice medicine in any state, territory or country.

State/Territory Country	License #	Date of Issuance (Mo./Yr.)	Status
CA.	G068043	2/13/90 → CURRENT	ACTIVE

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

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

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

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

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

32. Have you EVER been: a) asked to respond to an investigation, b) notified that you were under investigation for; c) investigated for; d) charged with; or e) convicted of any violation of a statute, rule or regulation governing your practice as a physician by any medical licensing board, hospital, medical society, governmental entity or agency other than the Nevada State Board of Medical Examiners? (If "Yes," attach explanation on separate sheet.) ____Yes ✓ No

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

34: 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.)

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CHILD SUPPORT STATEMENT

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

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

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

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

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

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

I attest and affirm that I am aware of and understand the reporting requirements found in Nevada Revised Statute 432B.220 regarding the abuse or neglect of a child.

✓ Yes _____ No

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

SAFE INJECTION PRACTICE ATTESTATION

ATTESTATION TO KNOWLEDGE OF AND COMPLIANCE WITH THE GUIDELINES OF THE CENTERS FOR DISEASE CONTROL AND PREVENTION FOR APPLICANT LIMITED LICENSE AND/OR ROTATING RESIDENTS

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.

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

Signature of Applicant: _____ Date: 8/18/17

COMMUNICATIONS AFFIRMATION

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

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

Printed Name of Applicant/Licensee: MILTON BIRD McCALL, M.D.

Signature of Applicant/Licensee: _____

Electronic Mail Address: _____ Date: 8/18/17

MILITARY SERVICE ATTESTATION

Have you ever served in the United States Military (to include National Guard or Reserves)? ____Yes ✓ No

If your answer is "No", you do not have to complete the remaining questions for the Military Service Attestation.

If yes, which branch of service did you serve?

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

N/A

Military occupation specialty or specialties?

N/A

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

Dates of service in the Military:

N/A

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

APPLICANT PHOTOGRAPH

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

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

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

_____ Signature of applicant _____ 8/18/17. Date

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NEVADA STATE BOARD OF
MEDICAL EXAMINERS

NEVADA STATE BOARD OF MEDICAL EXAMINERS LICENSURE APPLICATION ATTESTATION

I, Milton B McCall MD,
(Print your full name)

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

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

_____ 9/15/17
Signature of applicant — Date

ANITHA RAMASAMY
COMM. #2189340
NOTARY PUBLIC - CALIFORNIA
SANTA CLARA COUNTY
My Comm. Exp. April 1, 2021

(NOTARY SEAL)

State of California County of Santa clara
Subscribed and sworn to before me this 15th day of
Sep., 2017.
Notary Public for the State of California
My Commission Expires: April 1, 2021
Residing at: Los Altos (City) California (State)

Anitha. R
Signature of Notary

END OF APPLICATION

ATTENTION APPLICANT!

RESPONSIBILITY STATEMENT

Please sign and return this statement with your application for licensure to:
The Nevada State Board of Medical Examiners,
1105 Terminal Way, Ste 301
Reno, NV 89502

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

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

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

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

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

o o o o o

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

Print your name MILTON B. McCall M.D.

Sign your name _____

Date 8/18/17

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