

APPLICATION – UNLIMITED LICENSE #26477

Benedict Stefan Landgren Mills

Benedict Stefan LANDGREN MILLS

File Number

Nevada Business License
Number

Date of Birth

/1989

Public Address

Street

7155 E 38th Sr.

Address Line 2

None

City

Denver

State

Colorado

Postal Code

80207

Mailing Address

Street

Address Line 2

Employer Addresses

No active employers.

Licensure

License Type: Medical Doctor

License Number: 26477

Status: Active

License Type: Resident - Rotating

License Number: LL2908

Status: Expired

City

State

Postal Code

Telephone

E-mail Address

Demographic Details

First Name

Benedict

Middle Name

Stefan

Last Name *

LANDGREN MILLS

Previous Name(s)

Social Security Number

Tax Identification Number

Height

Hair Color

Is this person deceased?

Yes No

Date Deceased

Do you have a Nevada Business License in your individual name?

Yes No

Nevada BIN

Historical File Number

Gender

Male

Date of Birth

1989

Name Suffix

City of Birth

Place of Birth

Weight (in lbs)

Eye Color

Comments (non-public information)

Public Information

Military Detail

Have you ever served in the United States Military (to include National Guard or Reserves)?

Yes No

Discipline / SPL


Disciplinary Action?

Yes No

SPL?

Yes No

Date of SPL Issuance



Contact Information

Primary Phone

Primary Phone Extension

Primary E-mail Address



Cell Phone

Secondary Phone

Secondary Phone Extension

Mail should be directed to

Fax

Public Address

Street Address

Address Line 2

City

County

ZIP / Postal Code

State / Province

Country

Is your physical address different from your mailing address?

Yes No

Public Phone

Mailing Address

Street Address

Address Line 2

ZIP / Postal Code (Mailing)

City (Mailing)

State / Province (Mailing)


County (Mailing)



County (Mailing)

Application Status

Applicant *

Application Number

License Issued?

Yes No

Application Status

Assigned To

Manual Paper Application?

Yes No

License ID Card Conditions (max 120 characters)

License Details (Pre-Approval)

License Category

Obtained By

Expected Issue Date

Credentials / Degree Suffix (Enter before approval!)

Expected Expiration Date

Application Details

Application Type

Application Date *

Submitted Date

Application Step

Have you ever served in the United States Military (to include National Guard or Reserves)?

Yes No

Reviewed Date

Decision Date

Approved Date

Expiration Date

Is Simultaneous Application

Yes No

Are you the spouse of an active duty member or surviving spouse of a veteran?

Yes No

Invoices

Application Invoice

- Paid in Full 

Licensure Invoice

- Paid in Full 

Application Payment Date



Licensure Payment Date



Attestations

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.

Yes No

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.

Yes No

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.

Yes No

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

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

Yes No

Child Support Attestation Type

Not subject to a court order 

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

Yes No

In consideration for processing my application I, the undersigned, whose name and signature voluntarily appears below; do hereby and irrevocably agree to the Civil Applicant Waiver.

Yes No

Activities

| Licensee / Applicant | Name of Organization / Institution | Start Date ↑ | End Date | Percent Clinical |
|---------------------------------|---|--------------|-------------|------------------|
| LANDGREN MILLS, Benedict Stefan | Montefiore Medical Center | Jun-16-2014 | Jun-18-2014 | 100 |
| LANDGREN MILLS, Benedict Stefan | Harbor-UCLA | Jul-01-2015 | Jul-30-2015 | 100 |
| LANDGREN MILLS, Benedict Stefan | Boulder Abortion Clinic | Jul-23-2018 | Sep-12-2022 | 100 |
| LANDGREN MILLS, Benedict Stefan | Planned Parenthood of the Rocky Mountains | Jan-01-2022 | Mar-06-2025 | 100 |
| LANDGREN MILLS, Benedict Stefan | Partners in Abortion Care | Oct-10-2022 | Dec-15-2023 | 100 |
| LANDGREN MILLS, Benedict Stefan | Healthy Futures | Nov-17-2022 | Feb-06-2024 | 100 |

Application Activity Details

Licensee / Applicant

LANDGREN MILLS, Benedict Stefan



Name of Organization / Institution

Montefiore Medical Center

Start Date

Jun-16-2014



End Date

Jun-18-2014



Percent Clinical *

100

Position

Application

Application - LANDGREN MILLS, Benedict Stefan



Activity Type

Postgraduate Training



Location Details

Street Address 1

Country

United States



City

Bronx

State / Province

New York

Zip / Postal Code

10467

Application Activity Details

Licensee / Applicant

LANDGREN MILLS, Benedict Stefan



Name of Organization / Institution

Harbor-UCLA

Start Date

Jul-01-2015



End Date

Jul-30-2015



Percent Clinical *

100

Position

Application

Application - LANDGREN MILLS, Benedict Stefan



Activity Type

Postgraduate Training



Location Details

Street Address 1

Country

United States



City

Torrance

State / Province

California

Zip / Postal Code

90502

Application Activity Details

Licensee / Applicant

LANDGREN MILLS, Benedict Stefan



Name of Organization / Institution

Boulder Abortion Clinic

Start Date

Jul-23-2018



End Date

Sep-12-2022



Percent Clinical *

100

Position

Application

Application - LANDGREN MILLS, Benedict Stefan

Activity Type

Medical Practice/Physician



Location Details

Street Address 1

Country

United States



City

Boulder

State / Province

Colorado

Zip / Postal Code

80304

Application Activity Details

Licensee / Applicant

LANDGREN MILLS, Benedict Stefan



Name of Organization / Institution

Planned Parenthood of the Rocky Mountains

Start Date

Jan-01-2022



End Date

Mar-06-2025



Percent Clinical *

100

Position

Application

Application - - LANDGREN MILLS, Benedict Stefan

Activity Type

Medical Practice/Physician



Location Details

Street Address 1

Country

United States



City

Denver

State / Province

Colorado

Zip / Postal Code

80207

Application Activity Details

Licensee / Applicant

LANDGREN MILLS, Benedict Stefan



Name of Organization / Institution

Partners in Abortion Care

Start Date

Oct-10-2022



End Date

Dec-15-2023



Percent Clinical *

100

Position

Application

Application - - LANDGREN MILLS, Benedict Stefa



Activity Type

Medical Practice/Physician



Location Details

Street Address 1

Country

United States



City

College Park

State / Province

Maryland

Zip / Postal Code

20740

Application Activity Details

Licensee / Applicant

LANDGREN MILLS, Benedict Stefan



Name of Organization / Institution

Healthy Futures

Start Date

Nov-17-2022



End Date

Feb-06-2024



Percent Clinical *

100

Position

Application

Application - LANDGREN MILLS, Benedict Stefan



Activity Type

Medical Practice/Physician



Location Details

Street Address 1

Country

United States



City

Denver

State / Province

Colorado

Zip / Postal Code

80218

Declarations

| Ordinal ↑ | Licensee/Applicant | Declaration Question | Answer |
|-----------|---------------------------------|---|--------|
| 1 | LANDGREN MILLS, Benedict Stefan | MD, PA – Q1 – Medical Condition Impair Safe Practice | No |
| 2 | LANDGREN MILLS, Benedict Stefan | MD, PA – Q2 – Medical Condition Field of Practice | No |
| 3 | LANDGREN MILLS, Benedict Stefan | MD, PA – Q3 – Chemical Substances Impair Safe Practice | No |
| 4 | LANDGREN MILLS, Benedict Stefan | MD, PA, LL – Q4 – Performance of Public Service Requirement | No |
| 5 | LANDGREN MILLS, Benedict Stefan | ALL – Q5 – Named Defendant Respond to Legal Action | No |
| 6 | LANDGREN MILLS, Benedict Stefan | ALL – Q6 – Malpractice Claim Paid | No |
| 7 | LANDGREN MILLS, Benedict Stefan | ALL – Q7 – Arrest Question | No |
| 8 | LANDGREN MILLS, Benedict Stefan | MD, Previously applied for licensure in Nevada. | Yes |
| 9 | LANDGREN MILLS, Benedict Stefan | MD – Investigation Disciplinary during Training Program | No |
| 10 | LANDGREN MILLS, Benedict Stefan | MD – Q8 – Denied License / Permission to Practice Medicine | No |
| 11 | LANDGREN MILLS, Benedict Stefan | MD – Q9 – Medical License Revoked | No |
| 12 | LANDGREN MILLS, Benedict Stefan | MD – Q11 – Voluntarily Surrendered a License | No |
| 13 | LANDGREN MILLS, Benedict Stefan | MD – Q12 – Denied Membership | No |
| 14 | LANDGREN MILLS, Benedict Stefan | MD – Q13 – Investigation – Respond To/Notify Of | No |
| 15 | LANDGREN MILLS, Benedict Stefan | MD, PA – Q10 – Controlled Substance Registration | No |
| 16 | LANDGREN MILLS, Benedict Stefan | MD, PA, CCP, Hospital Privileges Denied, Suspended | No |

Declaration

Licensee/Applicant

LANDGREN MILLS, Benedict Stefan  

Declaration Question

MD, Previously applied for licensure in Nevada.  

Answer

Yes No

Answer Details

Ordinal

8

Declaration Text

Have you previously applied for medical licensure in Nevada, including in a Residency program? (If "Yes," please explain)

Related To

Application

Application - - LANDGREN MILLS, Benedict Stefan 

Renewal

Education

| Licensee/Applicant | Education Type | Name of School | Degree Attained | Date From | Date To | Graduation Date |
|---------------------------------|--------------------|--|-----------------------|-------------|-------------|-----------------|
| LANDGREN MILLS, Benedict Stefan | College/University | Brown University | Bachelor of Science | Sep-01-2006 | May-30-2010 | May-30-2010 |
| LANDGREN MILLS, Benedict Stefan | Medical School | Warren Alpert Medical School of Brown University | Medical Doctor Degree | Aug-01-2010 | May-25-2014 | May-25-2014 |

Education Details

Licensee/Applicant *

LANDGREN MILLS, Benedict Stefan 

Address

City

Providence

State / Province

Rhode Island

Zip / Postal Code

Country

United States 

Application

Application - - LANDGREN MILLS, Benedict Stefan 

Specialty Type



Name of School

Brown University

Education Type

College/University 

Degree Attained

Bachelor of Science 

Date From

Sep-01-2006 

Date To

May-30-2010 

Did you graduate from the program?

Yes No

Graduation Date

May-30-2010 

Major Program

Education Details

Licensee/Applicant *

LANDGREN MILLS, Benedict Stefan



Address

City

Providence

State / Province

Rhode Island

Zip / Postal Code

Country

United States



Application

Application - LANDGREN MILLS, Benedict Stefan



Specialty Type



Name of School

Warren Alpert Medical School of Brown Univer

Education Type

Medical School



Degree Attained

Medical Doctor Degree



Date From

Aug-01-2010



Date To

May-25-2014



Did you graduate from the program?

Yes No

Graduation Date

May-25-2014



Major Program

Examinations

| Licensee / Applicant | Examination Type | Attended Date ↑ |
|---------------------------------|---|-----------------|
| LANDGREN MILLS, Benedict Stefan | United States Medical Licensing Examination (USMLE) | Jun-14-2012 |
| LANDGREN MILLS, Benedict Stefan | United States Medical Licensing Examination (USMLE) | Oct-28-2013 |
| LANDGREN MILLS, Benedict Stefan | United States Medical Licensing Examination (USMLE) | Nov-05-2013 |
| LANDGREN MILLS, Benedict Stefan | United States Medical Licensing Examination (USMLE) | May-27-2015 |

Examination Details

Licensee / Applicant *

LANDGREN MILLS, Benedict Stefan



Attended Date

Jun-14-2012



Number of Attempts

1

Application

Application - LANDGREN MILLS, Benedict Stefan



Location

Result

202

Examination Type

United States Medical Licensing Examination (USMLE)



Other Exam

Are you currently certified?

Yes No

Steps

Step 1

Certificate Number

Exam Date



Expiration Date



Examination Details

Licensee / Applicant *

LANDGREN MILLS, Benedict Stefan 

Attended Date

Oct-28-2013 

Number of Attempts

1

Application


Application - LANDGREN MILLS, Benedict Stefan 

Location

Result

234

Examination Type

United States Medical Licensing Examination (USMLE) 

Other Exam

Are you currently certified?

Yes No

Steps

Step 2 (CK)

Certificate Number

Exam Date



Expiration Date



Examination Details

Licensee / Applicant *

LANDGREN MILLS, Benedict Stefan



Attended Date

Nov-05-2013



Number of Attempts

1

Application

Application - LANDGREN MILLS, Benedict Stefan

Location

Result

Pass

Examination Type

United States Medical Licensing Examination (USMLE)



Other Exam

Are you currently certified?

Yes No

Steps

Step 2 (CS)

Certificate Number

Exam Date



Expiration Date



Examination Details

Licensee / Applicant *

LANDGREN MILLS, Benedict Stefan



Attended Date

May-27-2015



Number of Attempts

1

Application

Application - LANDGREN MILLS, Benedict Stefan

Location

Result

219

Examination Type

United States Medical Licensing Examination (USMLE)



Other Exam

Are you currently certified?

Yes No

Steps

Step 3

Certificate Number

Exam Date



Expiration Date



Other Licenses

| Licensee/Applicant | License Number | License Type | Issue Date | Expiration Date | State / Province |
|---------------------------------|----------------|--------------|-------------|-----------------|------------------|
| LANDGREN MILLS, Benedict Stefan | A-140251 | N/A | Jan-13-2016 | Apr-30-2019 | California |
| LANDGREN MILLS, Benedict Stefan | DR0060865 | N/A | Jun-28-2018 | Apr-30-2025 | Colorado |
| LANDGREN MILLS, Benedict Stefan | D95831 | N/A | Oct-27-2022 | Sep-30-2024 | Maryland |
| LANDGREN MILLS, Benedict Stefan | LL2908 | N/A | Oct-16-2017 | Nov-19-2017 | Nevada |

Other License Details

Licensee/Applicant

Licensing Board or Regulatory Authority

License Number

State / Province

Country

Application

License Type

License Status

Issue Date

Expiration Date

Notes

Other License Details

Licensee/Applicant

LANDGREN MILLS, Benedict Stefan



Licensing Board or Regulatory Authority

Colorado

License Number

DR0060865

State / Province

Colorado

Country

United States



Application

Application - - LANDGREN MILLS, Benedict Stefan

License Type

License Status

Active

Issue Date

Jun-28-2018



Expiration Date

Apr-30-2025



Notes

Other License Details

Licensee/Applicant

LANDGREN MILLS, Benedict Stefan



Licensing Board or Regulatory Authority

Maryland

License Number

D95831

State / Province

Maryland

Country

United States



Application

Application - LANDGREN MILLS, Benedict Stefan

License Type

License Status

Active

Issue Date

Oct-27-2022



Expiration Date

Sep-30-2024



Notes

Other License Details

Licensee/Applicant

LANDGREN MILLS, Benedict Stefan



Licensing Board or Regulatory Authority

Nevada

License Number

LL2908

State / Province

Nevada

Country

United States



Application

Application - - LANDGREN MILLS, Benedict Stefan

License Type

License Status

Expired

Issue Date

Oct-16-2017



Expiration Date

Nov-19-2017



Notes

Postgraduate Training

| Licensee / Applicant | Name of School or Institution | Specialty Type | Date From | Date To ↑ | Program Type |
|---------------------------------|--|-----------------------|-------------|-------------|--------------|
| LANDGREN MILLS, Benedict Stefan | Montefiore Medical Center | Other | Jul-01-2014 | Jun-30-2015 | Internship |
| LANDGREN MILLS, Benedict Stefan | Los Angeles Harbor - UCLA Medical Center | Obstetrics/Gynecology | Jul-01-2015 | Jun-30-2018 | Residency |

Postgraduate Training Details

Licensee / Applicant *

LANDGREN MILLS, Benedict Stefan



Program Type *



Date From

Jul-01-2014



Name of School or Institution

Montefiore Medical Center

Specialty Type

Other



Other (Specialty)

Obstetrics Gynecology and Women's Health

Date To

Jun-30-2015



Application

Application - - LANDGREN MILLS, Benedict Stefan



Historical Major Program

Historical Degree Attained

Location Details

City

Bronx

Zip / Postal Code

10467

State / Province

New York

Country

United States



County



Street Address 1

Postgraduate Training Details

Licensee / Applicant *

LANDGREN MILLS, Benedict Stefan



Program Type *

Residency



Date From

Jul-01-2015



Name of School or Institution

Los Angeles Harbor - UCLA Medical Center

Specialty Type

Obstetrics/Gynecology



Other (Specialty)

Training Status *



Accreditation Type

ACGME (Accreditation Council for Graduate Medical Education)



Date To

Jun-30-2018



Application

Application - - LANDGREN MILLS, Benedict Stefan



Historical Major Program

Historical Degree Attained

Location Details

City

Torrance

State / Province

California

County



Zip / Postal Code

90502

Country

United States



Street Address 1

Specialties

| Licensee / Applicant | ▼ Specialty Type | ▼ Primary Specialty? | ▼ Effective Date | ▼ End Date |
|---------------------------------|-------------------------|----------------------|------------------|------------|
| LANDGREN MILLS, Benedict Stefan | Obstetrics / Gynecology | Yes | Jul-01-2014 | N/A |

Specialty Details

Licensee / Applicant *

LANDGREN MILLS, Benedict Stefan 

Effective Date

Jul-01-2014 


Application

Application - LANDGREN MILLS, Benedict Stefan 

Primary Specialty?

Yes No

Specialty Type *

Obstetrics / Gynecology 

Other (Specialty)

End Date



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MAY 02 2024

ATTENTION APPLICANT!
RESPONSIBILITY STATEMENT NEVADA STATE BOARD OF
MEDICAL EXAMINERS

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

Because you are applying for the privilege of practicing medicine, perfusion or respiratory care 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

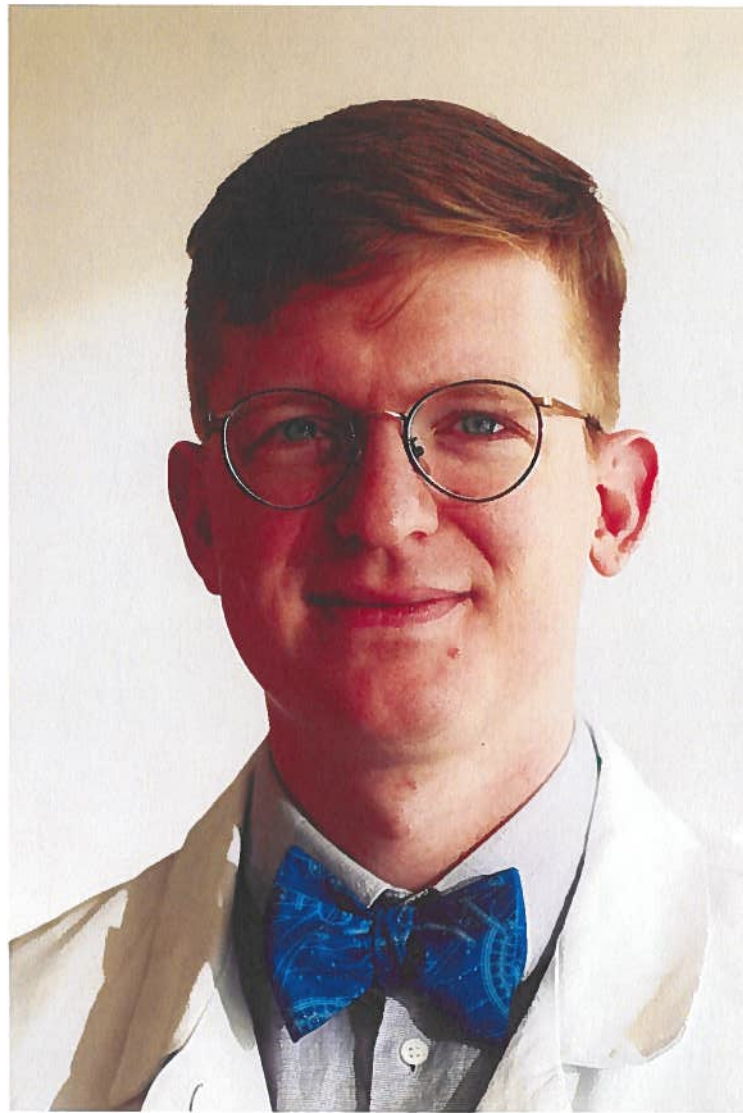
I have read this responsibility statement and understand that I alone am accountable for completing my application for medical licensure in Nevada.

Print your name Benedict Landgren Mills

Sign your name _____

Date 4/23/24

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



APPLICATION – ROTATING RESIDENT LICENSE #LL2908

Benedict Stefan Landgren Mills

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

RECEIVED
Date Received by Board

DEC 13 2016

License No. _____

File No. _____

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

NEVADA STATE BOARD OF
MEDICAL EXAMINERS
(For Board Only)

Identity:

1. Present Legal Name Landgren Mills Benedict Stefan _____
Last First 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 1000 West Carson Street Torrance CA Los Angeles CA 90502
Street City County State 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 () () () ()
Office Fax Home Cellular (Optional)

Email address _____

5. Date of Birth 89 _____ Place of Birth _____ Gender F X M
(Month / Day / Year) (City, State, Country)

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

7. Social Security Number _____ Color of Eyes _____ Color of Hair _____ Height _____ Weight _____
NRS 630.197(1)(a) An applicant for the issuance of a license to practice medicine shall include the social security number of the applicant in the application submitted to the Board.
NRS 630.165(5) The applicant bears the burden of proving and documenting his qualifications for licensure.

Questions:

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

Ability to practice medicine is to be construed to include all of the following:

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

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

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

FOR ALL "YES" RESPONSES TO THE FOLLOWING QUESTIONS, YOU MUST SUBMIT YOUR 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 X No

9. If you currently have a medical condition which in any way impairs or limits your ability to practice medicine; is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, the manner in which you have chosen to practice or by any other reasonable accommodation? _____ Yes _____ No X N/A

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 X N/A

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

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/or 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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NEVADA STATE BOARD OF
MEDICAL EXAMINERS

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DEC 13 2016

NEVADA STATE BOARD OF MEDICAL EXAMINERS

13. Have you EVER been arrested, investigated for, charged with, convicted 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 jurisdiction which is a misdemeanor, gross misdemeanor, felony, violation of the Uniform Code of Military Justice, or synonymous thereto in a foreign jurisdiction, including 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
Yes No

14. Have you previously applied for medical licensure in Nevada (including a residency program)?

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.) |
|--|--------------------|----------------------------------|---|
| Warren Alpert Medical School of Brown University | RI Providence | Providence, RI | 8/2010 to 5/2014 |

(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 |
|----------------------------|---------------------|------------------------|
| W.A. Med School of Brown U | Providence, RI, USA | |

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.) |
|---|---------------------------|--------------|--|-------------------|---|
| PGY 1 | Montefiore Medical Center | Brooklyn NY | I | OB/gyn | 7/2014 to 6/2015 |
| PGY 2-3 | Harbor-UCLA | Torrance, CA | F | OB/gyn | 7/2015 - ongoing |

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

21. 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 |
|------------|----------------|------------------------------|--------------------|
| Step 1 | 6/2012 | 202 | 1 |
| Step 2 CK | 10/2013 | 234 | 1 |
| Step 2 CS | 11/2013 | pass | 1 |
| Step 3 | 5/2015 | 1219 | 1 |

22. State your scope of practice / specialty(ies) OB/gyn

23. 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).

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

NEVADA STATE BOARD OF MEDICAL EXAMINERS

24. 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 (%) |
|--------------|-------------------------------|----------------|--------------|----------------------|
| intern years | Bronx/Bronx/US | 7/2016 | | |
| | Bronx/New York/USA | 7/2014 | 6/2015 | 100% |
| residency | Torrance/CA/USA | 7/2015 | ongoing | 100% |

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

25. 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 |
|----------------------------|-----------|-------------------------------|--------|
| California | 140251 | 1/13/2016 | active |

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

26. 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

27. 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

28. 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

29. 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

30. 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

31. 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

32. 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.) |
| | | | | |

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

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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 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.

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

Applicant: _____

Date: 12/6/16

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: Benedict Landgren Mills

Signature of Applicant/Licensee: _____

Electronic Mail Address: _____

Date: 12/6/16

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 Corp
- Coast Guard

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Military occupation specialty or specialties?

- | | | | |
|--------------------------|-----------------------------|--------------------------|------------------------------------|
| <input type="checkbox"/> | Administration or Personnel | <input type="checkbox"/> | Logistics or Supply |
| <input type="checkbox"/> | Aviation | <input type="checkbox"/> | Maintenance |
| <input type="checkbox"/> | Civil Engineering | <input type="checkbox"/> | Medical Services |
| <input type="checkbox"/> | Communications | <input type="checkbox"/> | Security Forces or Military Police |
| <input type="checkbox"/> | Infantry or Armor | <input type="checkbox"/> | Other |
| <input type="checkbox"/> | Legal or Chaplain Corps | | |

Dates of service in the Military:

From: / / To: / /
 DD MM YYYY DD MM YYYY

APPLICANT PHOTOGRAPH

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

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



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

Signature of applicant

12/8/16

Date

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NEVADA STATE BOARD OF
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NEVADA STATE BOARD OF MEDICAL EXAMINERS LICENSURE APPLICATION ATTESTATION

I, Benedict Landgren Mills
(Print your full name)

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

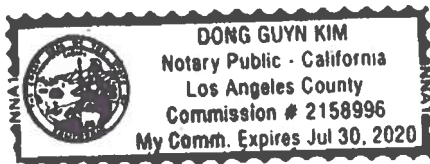
I am responsible to keep the Board informed of any circumstance or event that would require a change to my initial responses provided to the Board in my application for licensure, and which occurs prior to my being granted licensure to practice medicine in the state of Nevada.

Signature of applicant 12/8/2016
Date

(NOTARY SEAL)

State of _____ County of _____
Subscribed and sworn to before me this _____ day of _____, 2_____
Notary Public for the State of _____
My Commission Expires: _____
Residing at: _____
City State

Signature of Notary



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

State of California
County of Los Angeles
Subscribed and sworn to (or affirmed) before me on this 8th day
of Dec, 2016, by Benedict Landgren
Mills

_____, proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.
Signature [Signature] (Seal)

END OF APPLICATION

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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 Benedict Landgren Mills

Sign your name _____

Date 12/6/2016

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.