PHYSICIAN
APPLICATION FOR REGISTRATION RENEWAL
FOR THE BIENNIAL REGISTRATION PERIOD 2001- 2003
NEVADA STATE BOARD OF MEDICAL EXAMINERS
Post Office Box 7238 Reno, Nevada 89510 Phone (775) 688-2559

Date Received by Board
JUL 10 2001
JUN 30 2001
(For Board Use Only)

License No. 9141
File No.

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

X	ACTIVE STATUS	$600.00
	INACTIVE STATUS	$200.00
	RETIRED STATUS	$ 50.00
	SUPERVISING/COLLABORATING PHYSICIAN	$200.00

(RETIRED STATUS REQUIRES THAT THE APPLICANT NOT PRACTICE MEDICINE ANYWHERE)

file no: 12785 candidate no: 7323

Conrad R MURRAY M.D.
3121 S Maryland Pkwy
Suite # 602
Las Vegas NV 89109

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 (702)-866-6802 Fax Number (702)-866-6904

4. **IF YOU HAVE RETIRED OR MOVED YOUR PRACTICE,** indicate the location of patient records below:

Name N/A

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:

CONFIDENTIAL LA Dist Atty-8261

Meharry Medical College May 28th 1989

06963

Exhibit 462 - 8261

6. Indicate below your primary, secondary and tertiary practice specialties using the following codes:

SCOPE OF PRACTICE
SPECIALTY CODES

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

	Code		Code		Code
Primary Specialty	9	**Secondary Specialty**	30	**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 pres
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 __X__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 __X__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 __X__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 __X__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 __X__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 __X__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 __X__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 __X__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 __X__No

10. Have you ever been denied membership or expelled from a medical society or other professional medical organization? ____Yes __X__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 <u>other than</u> the Nevada State Board of Medical Examiners? ____Yes __X__No

12. Have you ever surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? ____Yes __X__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. (<u>Please Note</u>: 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.)
①	Valley Medical Hospital, Shadow lane LV, NV 89106		Suspension of Coronary and peripheral intervention Privileges.	8/25/00 – present.
②	Sunrise Hospital	3186 S. Maryland Pkway, LV, NV 89109	Suspension of Coronary and peripheral intervention privileges	1/01 – 5/01
③	Sunrise Hospital	" "	Reinstatment of Coronary + peripheral intervention privileges	5/01

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

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. My reason for non-compliance is that this order is schedule for hearing on July 19th 01 at the Superior Court San Jose California. This matter was reset to accomodate the schedule of my attorney. I also believe that the order was incorrect + needs to be corrected or modified.

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:

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).**