NEVADA STATE BOARD of DENTAL EXAMINERS

Board Teleconference Meeting

August 04, 2020

6:00 p.m.

PUBLIC BOOK

Added 8/4/2020

From: Frank DiMaggio
Sent: Thursday, July 30, 2020 1:44 PM
To: 'Joshua Corcran'
Cc: Phil W. Su
Subject: RE: NSBDE - Pre-petition request for reconsideration per NAC 631.050

Dear Dr. Corcoran:

I have reconsidered your application for dental licensure pursuant to your below request. Said application is hereby rejected by me for the reasons previously set forth for the initial rejection of your application for dental licensure as more particularly set forth in the Board's letter to you dated June 23, 2020.. See NAC 631.050.2(a).

Please be advised that the Board is in receipt of your Petition for Review of Application for Dental License and the same is set on the Board Meeting Agenda for August 4, 2020 for consideration of said Petition for Review pursuant to NAC 631.050. The Board Meeting is scheduled to begin at 6:00 p.m. on August 4, 2020.

Should you have any questions, do not hesitate to contact me.

Sincerely,

Frank DiMaggio
Executive Director
Nevada State Board of Dental Examiners
6010 S Rainbow Blvd., Suite A-1
Las Vegas, NV 89118
Office Number (702) 486-7044
Fax (702) 486-7046

From: Joshua Corcran [mailto:[redacted]
Sent: Thursday, July 30, 2020 1:03 PM
To: Phil W. Su
Cc: Frank DiMaggio; Angelica L. Bejar
Subject: Re: NSBDE - Pre-petition request for reconsideration per NAC 631.050

I would like my application for licensure to be reconsidered by the Executive Director and/or Secretary-Treasurer, pursuant to NAC 631.050.

Dr. Joshua Corcran

From: Joshua Corcran [mailto[redacted]
Sent: Wednesday, July 29, 2020 4:29 PM

To: Phil W. Su
Cc: Frank DiMaggio; Angelica L. Bejar
Subject: Re: NSBDE - Pre-petition request for reconsideration per NAC 631.050

I do not have any new information as I submitted all relevant documentation regarding my criminal charges with my initial application as directed. I am basing my petition off of information that I was given during my third year of dental school by the then General Counsel of the board. She advised me that per NAC 631.050(2)(a) my initial application would automatically be denied by the secretary- treasurer based only on the existence of a felony conviction, regardless of the circumstances or charges.

My conviction was 12 years ago and the final disposition occurred nearly 8 1/2 years ago. My charges were the result of an accident due to negligence on my part, but in no way affect my ability to practice dentistry and care for patients. This incident is part of my past, but does not play more than a miniscule part in defining my overall moral character.

I would like the Board to be able to review the circumstances of my conviction and ask me any questions they might need to determine that my moral character is not a concern and that I would be of great value as a licensed dental provider.

Thank you for your time and consideration, and have a great evening!

Dr. Joshua Corcran

July 21, 2020

To Whom it May Concern:

I, Dr. Joshua Michael Corcran, I am writing today to petition the Nevada State Board of Dental Examiners to review my rejected license application at the regularly scheduled board meeting on August 4, 2020. This request is made pursuant to subsection 3 of NAC 631.050. The rejection of my application was due to an existing felony conviction and I have submitted all relevant documentation relating to this conviction to the board with my initial application for licensure.

I would ask that, pursuant to NRS 241.030, that the board enter into a closed session due to the nature of the information that will be discussed regarding my character.

Thank you for your time and consideration in this matter and I look forward to receiving further information regarding my request. Have a great day!

With respect,

DMD

Joshua Corcran, DMD

Nevada State Board of Dental Examiners

6010 S. Rainbow Blvd., Bldg. A, Ste. 1
Las Vegas, NV 89118
(702) 486-7044 • (800) DDS-EXAM • Fax (702) 486-7046

I hereby make application for Nevada Dental licensure by: *(Please check one below)*

Licensure by ADEX Exam (NRS 631.240): $1200 ☐	Licensure by WREB Exam (NRS 631.240): $1200 ■
Licensure by Credential (NRS 631.255): $1200 *(Please select specialty below)*	Indicate Specialty: Board Eligible ☐ Diplomate ☐

Orthodontia ☐	Prosthodontia ☐	O & M Pathology ☐
Endodontia ☐	Pediatric Dentistry ☐	O & M Radiology ☐
Periodontia ☐	Public Health Dentist ☐	O & M Surgery ☐

Limited Licensure (NRS 631.271): $125		Restricted Geographical (NRS 631.274): $600	
Resident: ☐	Instructor: ☐	Underserved County(ies): ☐	FQHC or Non-Profit: ☐
Indicate Residency Program:	*Indicate Instructor Facility:*	*Indicate County(ies)*	*Indicate FQHC Facility or Non Profit*

Military by Reciprocity/Credential: $600.00 ☐	License by Endorsement: $1200 ☐

NOTE: An application is considered complete when the application, all required documents, background information, and fees are on file with the Board office. APPLICATION FEES MUST BE PAID IN ADVANCE AND MAY NOT BE REFUNDED PURSUANT TO NEVADA REVISED STATUTE (NRS) 631.345.
Please type or print legibly. All questions must be answered. If additional space is needed, attach a separate sheet identifying additional information by Section number. Applicants acknowledge they have a continuing responsibility to update all information contained in this application until such time as the Board takes final action on this application. Failure of an applicant to update the information prior to final action of the Board is grounds for subsequent disciplinary action.

Last:	First:	Middle:	Suffix:
Corcran	Joshua	Michael	

Soc. Security #:	Age:	Male / Female	Birthdate:	Birthplace (City, County, State, & Country):
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Have you ever been known by any other name? Yes ☐ No ■

If yes, state in full every other name by which you have been known, the reason therefore, and the inclusive dates so known:
N/A

If a married woman, state maiden name: N/A

If a name change was made by court order, attach a CERTIFIED COPY of the court order.

Are you a U.S. born citizen? Yes [redacted] No [redacted]

If no, are you naturalized? Yes [redacted] No [redacted]

If yes, naturalization # [redacted] Naturalization Date: [redacted] Place: [redacted]

If no, were you born abroad of US citizens? Yes [redacted] No [redacted]

If no, are you a legal resident? Yes [redacted] No [redacted]

Is your application for naturalization pending? Yes [redacted] No [redacted]
Date of Application: Place:

You must submit appropriate proof of Citizenship or legal documentation for lawful entitlement to remain in the U.S. and work in the U.S

$1200
CC [redacted]
6.4.20

Received
MAY 21 2020
NSBDE

(A) HOME ADDRESS & PREVIOUS ADDRESS HISTORY

Current Home Address:	City:	State:	Zip code:
[redacted]	[redacted]	[redacted]	[redacted]

Mailing Address: This is the address that all correspondence from NSBDE will be mailed. If same as current home address please check box. ☐

Mailing Address (If different):	City:	State:	Zip Code:

Telephone Residence:	Telephone Cell:	Email address:
N/A	[redacted]	[redacted]

(B) PREVIOUS STREET ADDRESS

List all home addresses for the past seven (7) years. If you cannot recall certain information please indicate cannot recall. Do not leave blank. Please be sure that if you were in school you have a home address listed in the same state you went to school. (Please add additional pages as needed)

1. Address :	City:	State:	Zip Code:
[redacted]	[redacted]		
County: Clark	**Dates:** May 2016	**to**	May 2020
2. Address :	**City:**	**State:**	**Zip Code:**
[redacted]			
County: Clark	**Dates:** May 2013	**to**	May 2016
3. Address :	**City:**	**State:**	**Zip Code:**
County:	**Dates:**	**to**	
4. Address :	**City:**	**State:**	**Zip Code:**
County:	**Dates:**	**to**	
5. Address :	**City:**	**State:**	**Zip Code:**
County:	**Dates:**	**to**	
6. Address :	**City:**	**State:**	**Zip Code:**
County:	**Dates:**	**to**	
7. Address :	**City:**	**State:**	**Zip Code:**
County:	**Dates:**	**to**	
8. Address :	**City:**	**State:**	**Zip Code:**
County:	**Dates:**	**to**	
9. Address :	**City:**	**State:**	**Zip Code:**
County:	**Dates:**	**to**	
10. Address :	**City:**	**State:**	**Zip Code:**
County:	**Dates:**	**to**	

(C) MILITARY SERVICE

Have you ever served in the military? *(if yes, you must answer the questions below)* Yes ■ No ☐

Date of Service: From 2/20/1996 to 2/19/1999		*Military Occupation Specialty/Specialties:* Field Artillery Surveyor	
Branch of Service:	Army/Army Reserve ■	Marine Corps/Marine Corps Reserve ☐	
	Navy/Navy Reserve ☐	Air Force/ Air force Reserve ☐	
	Coast Guard/ Coast Guard Reserve ☐	National Guard ☐	
Date of Service: From 2/20/1999 to 4/4/2004		*Military Occupation Specialty/Specialties:* Military Police	
Branch of Service:	Army/Army Reserve ☐	Marine Corps/Marine Corps Reserve ☐	
	Navy/Navy Reserve ☐	Air Force/ Air force Reserve ☐	
	Coast Guard/ Coast Guard Reserve ☐	National Guard ■	

(D) EDUCATION & CERTIFICATIONS

Doctoral:	Post Doctoral:
University/ College: UNLV School of Dental Medicine	*University/ College:*
City: Las Vegas	*City:*
State: Nevada	*State:*
Years Attended: (month/year) September 2016 to May 2020	Years Attended: (month/year) to
Graduation Date: May 18, 2020	Graduation Date:
Degree Earned: DDS ☐ DMD ■	Specialty (MS):

(E) LASER USE AND CERTIFICATION

I utilize laser radiation in the performance of my practice of dentistry. Yes ■ No ☐

I certify that each laser I use in my practice of dentistry has been cleared by the United States Food and Drug Administration for use in dentistry. Yes ■ No ☐

Attach a copy of proof of course completion of laser proficiency indicating successful completion of a recognized course pursuant to Board regulation NAC 631.033 and NAC 631.035 based on the curriculum guidelines and standards for dental laser education as adopted by the Academy of Laser Dentistry.

(F) CONTINUED CLINICAL COMPETENCY

Have you been out of active practice for two or more years just prior to completing this application? Yes ☐ No ■

If yes, attach a separate sheet with details of how you have maintained your clinical skills.

(G) HISTORY OF IMPAIRMENT

(1) Do you now, or have you ever, abused alcohol, other chemical substances, or do you have any medical/mental impairments or emotional condition(s) that would impair your ability to perform as a licensee pursuant to NRS and NAC Chapters 631? *(If yes, submit details on separate sheet)* Yes [redacted] No [redacted]

(2) Do you now, or have you ever had, any contagious or infectious disease(s) that would impair your ability to perform as a licensee pursuant to NRS and NAC Chapters 631? *(If yes, submit details on separate sheet)* Yes [redacted] No [redacted]

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(H) DENTAL PRACTICE & EMPLOYMENT HISTORY

Have you ever been engaged in private dental practice, been employed as a dentist, been self-employed or done business under a fictitious name (D.B.A.)? Yes ☐ No ■

If yes, list the following information for the past ten years including the dates you practiced dentistry: the names of all employers; partners, associates or persons sharing office space; list dates of self-employment and nature of business; list all fictitious names (D.B.A.), dates and nature of business; and the reason for leaving each practice. If you were unemployed for any period of time please write the month and year of unemployment. (Use additional sheets if necessary)

Current Practice Address (If any):	*City:*	*State:*	*Zip Code:*

Telephone:	*Fax:*	*Email address:*

(I) PREVIOUS EMPLOYMENT

1. Practice Address:	*City:*	*State:*	*Zip Code:*

From: *To:* *(Include month/year)*	Telephone:

Name of Employers, Associates, Etc...	*Reason for leaving:*

2. Practice Address:	*City:*	*State:*	*Zip Code:*

From: *To:* (Include month/year)	Telephone:

Name of Employers, Associates, Etc...	*Reason for leaving:*

3. Practice Address:	*City:*	*State:*	*Zip Code:*

From: *To:* (Include month/year)	Telephone:

Name of Employers, Associates, Etc...	*Reason for leaving:*

4. Practice Address:	*City:*	*State:*	*Zip Code:*

From: *To:* (Include month/year)	Telephone:

Name of Employers, Associates, Etc...	*Reason for leaving:*

5. Practice Address:	*City:*	*State:*	*Zip Code:*

From: *To:* (Include month/year)	Telephone:

Name of Employers, Associates, Etc...	*Reason for leaving:*

(J) EXAMINATION AND LICENSURE HISTORY

NATIONAL BOARD EXAMINATION

Part I	Date Taken: 5/11/2018	PASS ■	FAIL ☐
Part II	Date Taken: 9/28/2019	PASS ■	FAIL ☐

Please list below all dental/hygiene clinical examinations in which you have participated: *(Use additional sheets if necessary)*

CLINICAL EXAMS:

ADEX ☐	Date(s) of Clinical Examination:		to		PASS ☐	FAIL ☐
WREB ■	Date(s) of Clinical Examination:	3/13/2020	to	3/16/2020	PASS ■	FAIL ☐

OTHER EXAMS:

Regional/State, Territory, DC:

Date(s) of Clinical Examination: to PASS ☐ FAIL ☐

Regional/State, Territory, DC:

Date(s) of Clinical Examination: to PASS ☐ FAIL ☐

Have you ever applied for a license to practice dentistry? Yes ☐ No ■

If yes, list the following for each state, territory or the District of Columbia. Use additional sheets if necessary:

State, Territory, DC:	Date of Application:
Result of Application (Granted, Denied,Pending):	
State, Territory, DC:	Date of Application:
Result of Application (Granted, Denied,Pending):	
State, Territory, DC:	Date of Application:
Result of Application (Granted, Denied,Pending):	

1	Have any proceedings been initiated against you to revoke or suspend your dental license?	Yes ☐	No ■
2	At the time you filed this application, were any disciplinary proceedings pending against you, including complaints or investigations, in any other state, territory or the District of Columbia?	Yes ☐	No ■
3	Have you ever been terminated or attempted to terminate or surrender a dental license in any state, territory or the District of Columbia?	Yes ☐	No ■
4	Have you ever been denied a dental license in this state, another state, or a territory of the U.S. or the District of Columbia?	Yes ☐	No ■

If you answered 'yes' to questions J1, J2 , J3 and/or J4, provide a full explanation of each answer on a separate sheet and attach to this application.

(K) MALPRACTICE

Have you ever had any claims of malpractice filed against you?	Yes ☐ No ☒
If yes, list all malpractice, neglience lawsuits and claims you have ever had against you. Include dates, names, settlements or resolutions. Please include malpractice and lawsuits that were dismissed. Provide additonal pages as needed.	
Do you or have you ever carried malpractice (professional liability) insurance?	Yes ☐ No ☒
List all malpractice carriers since licensed or for the past 10 years (which ever is longer). Leave no time gaps and account for periods with no insurance. Provide additional pages as needed.	

Carrier:	*Policy Number:*		
Address :	*City:*	*State:*	*Zip Code:*
From: *To:* (Include month/year)	Telephone:		
Carrier:	*Policy Number:*		
Address :	*City:*	*State:*	*Zip Code:*
From: *To:* (Include month/year)	Telephone:		
Carrier:	*Policy Number:*		
Address :	*City:*	*State:*	*Zip Code:*
From: *To:* (Include month/year)	Telephone:		
Carrier:	*Policy Number:*		
Address :	*City:*	*State:*	*Zip Code:*
From: *To:* (Include month/year)	Telephone:		
Carrier:	*Policy Number:*		
Address :	*City:*	*State:*	*Zip Code:*
From: *To:* (Include month/year)	Telephone:		
Carrier:	*Policy Number:*		
Address :	*City:*	*State:*	*Zip Code:*
From: *To:* (Include month/year)	Telephone:		

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(L) MORAL CHARACTER

1	Have you ever been reprimanded, censored, restricted or otherwise disciplined?	Yes ☐	No ■
2	Have any claims or complaints of malpractice, formal or informal, ever been made or filed against you, or have any proceedings been instituted against you?	Yes ☐	No ■
3	Have you ever been arrested, convicted, charged with, entered a plea of nolo contendere or pleaded guilty to the violation of any law [misdemeanor(s) or felony(ies)]?	Yes ■	No ☐

If your answer is 'yes' to any of the foregoing questions (1-3), furnish a written statement of each occurrence giving the complete facts. For each incident, state the date, case number, the nature of the charge the disposition of the matter, and the name and address of the authority in possession of the records thereof. You must provide certified copies of any arrest or conviction and/or any plea agreements entered into for any felony(ies) or misdemeanor(s).

4	Have you ever been denied participation in, or suspended from the Medicaid or Medicare benefit program?	Yes ☐	No ■

If your answer is 'yes' to questions 4, furnish a written statement of each occurrence giving the complete facts. For each incident, state the date, the nature of the charge the disposition of the matter, and the name and address of the authority in possession of the records thereof.

5	Do you hold a DEA license?	Yes ☐	No ■	If yes list DEA Number #
6	Have you ever surrendered your DEA number or had it revoked or restricted?	Yes ☐	No ■	

(M) STATEMENT OF CHILD SUPPORT

Pursuant to state and federal mandated requirements, I further certify that (CHECK the appropriate box):

1	I am NOT subject to a court order for the support of one or more children.	■
2	I AM subject to a court order for the support of one or more children and: (*continue to 2a or 2b below*)	☐
2a	I am NOT in compliance with a plan approved by the district attorney or other public agency enforcing the order for the payment of the amount owed pursuant to the court order for the support of one or more children.	☐
2b	I AM in compliance with a plan approved by the district attorney or other public agency enforcing the order for the payment of the amount owed pursuant to the court order for the support of one or more children.	☐

(N) AFFIDAVIT AND PLEDGE

I hereby expressly waive all provisions of law forbidding any physician or other person who has attended or examined me or who may hereafter attend or examine me from disclosing any knowledge or information that is thereby acquired, and I hereby consent that such knowledge or information may be disclosed to the Nevada State Board of Dental Examiners.

The person named as the applicant in the foregoing application and questionnaire, being first duly sworn, deposes and says: I am the applicant for dental licensure referred to; and I have carefully read and understand the questions in the foregoing questionnaire and have answered them truthfully, fully, and completely, without mental reservation of any kind. I further understand I have a continuing obligation to inform the Board should any of my answers since filing this application change prior to the Board issuing my license. In the event I fail to update the answers which have changed since submitting this application, I understand that such failure is ground for revocation of any license issued or denial of the application.

I hereby authorize educational and other institutions, my references (past and present), business and professional associates (past and present), insurance carriers, professional societies, governmental agencies and instrumentalities (local, state, federal or foreign), and independent information gathering services to release to the Nevada State Board of Dental Examiners any information, files or records requested by the Board in connection with the processing of this application.

I hereby pledge myself to the highest standards and ethics in the Practice of Dentistry and further pledge to abide by the laws and regulations pertaining to the practice of dentistry. I understand that a violation of this pledge may be deemed sufficient cause for the revocation of a license issued by the Board.

I hereby understand and agree that the title of all licenses shall remain with the Nevada State Board of Dental Examiners and subject to surrender by Order of said Board.

I UNDERSTAND THAT ANY OMISSIONS, INACCURACIES, OR MISREPRESENTATIONS OF INFORMATION ON THIS APPLICATION ARE GROUNDS FOR REJECTION OF THIS APPLICATION AND THE REVOCATION OF A LICENSE WHICH MAY HAVE BEEN OBTAINED THROUGH THIS APPLICATION.

APPLICANT

DMD
Applicant Signature

CORCRAN, JOSHUA M
Applicant (printed) Last Name, First, MI, Suffix (e.g., Jr.)

5/18/2020
Date of Signature (must correspond with notory date)

[redacted]
Applicants Date of Birth (month/day/year)

[redacted]
Social Security Number

NOTORY

State of NV County of CLARK

The statement on this document are subscribed and sworn before me this

18th day of MAY ,20 20

Notory Public

2/15/2023
My Commission Expires

RYAN SHIBATA
Notary Public, State of Nevada
County of Clark
No. 07-2921-1
My Appt. Exp. Feb. 15, 2023

Received
MAY 21 2020
NSBDE

Nevada State Board of Dental Examiners

6010 S. Rainbow Blvd., Bldg. A, Ste. 1
Las Vegas, NV 89118
(702) 486-7044 • (800) DDS-EXAM • Fax (702) 486-7046

NOTARIZED AUTHORIZATION FOR RELEASE OF INFORMATION, DOCUMENTS AND RECORDS

I, Joshua Corcran, designate the Nevada State Baord of Dental Examiners to collect, verify and maintain information, and copies of documents and records that can subsequently be provided to professional licensing boards, hospitals and other entities when I apply for licensure, staff membership, employment, or other privileges.

I request and authorize every person, institution, professional licensing board or any state in which I hold or may have held a license to practice my professional, Joint Commission on National Dental Examinations, hospital, clinic, government agency (local, state, federal or foreign), law enforcement agency, or other third parties and organizations, and their representatives to release information, records, transcripts, and other other documents, concerning my professional qualifications and competence, ethics, character, and other information pertaining to me to the Nevada State Board of Dental Examiners.

I further request and authorize that the requested information, documents and records be sent directly to:

Nevada State Board of Dental Examiners
6010 S Rainbow Blvd., Suite A-1
Las Vegas, NV 89118

I hereby release, discharge, and hold harmless the Nevada State Board of Dental Examiners, or representatives and any person furnshing information, records, or documents of any and all liablilty. I authorize the Nevada State Board of Dental Examiners to release information, material, documents, orders or the like relating to me or this application to any entity at my request.

By my signature below, I acknowledge that information, documents and records required to be furnished by another organization, educational institutions, individual, or any person or groups must be sent directly by such persons to Nevad State Board of Dental Examiners. I understand that Nevada State Board of Dental Examiners will not accept such information, records, or documents forwarded by me.

A photocopy or facsimile of this authorization shall be as valid as the orginal and shall be valid for a period of one (1) year from the date of signature.

APPLICANT

DMD
Applicant Signature

CORCRAN, JOSHUA M
Applicant (printed) Last Name, First, MI, Suffix (e.g., Jr.)

5/18/2020
Date of Signature (must correspond with notory date)

[redacted]
Applicants Date of Birth (month/day/year)

[redacted]
Social Security Number

NOTORY

State of NV County of CLARK

The statement on this document are subscribed and sworn before me this

18th day of MAY ,20 20

Notory Public

2/15/2023
My Commission Expires

Received
MAY 21 2020
NSBDE

RYAN SHIBATA
Notary Public, State of Nevada
County of Clark
No. 07-2921-1
My Appt. Exp. Feb. 15, 2023