Nevada State Board of Osteopathic Medicine
Application for Physician Assistant License

Dear Applicant:

Thank you for considering obtaining an Osteopathic Medicine License in the State of Nevada. Nevada remains among the fastest growing states in the country. With such population growth, the need for physician assistants is increasing.

The Board of Osteopathic Medicine's primary mission is to protect the public by licensing osteopathic physicians and physician assistants who demonstrate clinical competence to practice medicine as well as the professional and ethical demeanor necessary to lead the modern health care team. With this in mind, we have developed application procedures, which are very thorough so that the board can maintain confidence that the licensees will benefit the community in which they practice.

Balancing the states dramatic need for physician assistants with the public mandate of quality and professional excellence; the increased desire from the profession for license portability; the board has worked tirelessly to modernize the application process. The application you will be completing, although somewhat lengthy in appearance, is as concise as legally permissible.

Nevada upholds some of the highest medical licensing standards in the United States to help maintain the public's trust in the osteopathic medical profession. Additionally, the board has updated the requirements to obtain information considered important in the licensing process, please see below:

1.) **Fingerprinting for NCIC** – National criminal Information Center (FBI)**.** Pursuant to NRS 633.309 all applicants of licensure (except a special license) must submit to the board a completed fingerprint card for a criminal background check. Although a criminal record or history may not be absolute grounds for denial of licensure, these and all issues will be seriously considered and MUST be disclosed on your application before this report is received in our office. If an applicant fails to include on their application a criminal history that is discovered through the criminal background check, the application for licensure WILL be immediately declined.

After we have receive your completed application with the fee, the required education verification or the FCVS report, the criminal background check report, and all other required forms, the packet for licensure will be reviewed by our Executive Director and pre-approved to be sent to our Board Members for their review. All packets must be completed within 30 days of any scheduled board meeting to be considered for that particular board meeting. If the packet is accepted, you will receive a letter by mail letting you know that you have been scheduled for consideration at the next board meeting.

If you do not meet the requirements, there are no other accommodations for special request and you must wait for the next board meeting for final Board approval of your license! No exceptions!

An interview may be required if the Executive Director deems it necessary to explore your packet more thoroughly if certain information was learned during the application process. All applicants required to attend an interview with the Board are notified 21 working days prior to the meeting date via certified mail.

Again, thank you for considering licensure! If you have any questions, regarding the application process, please do not hesitate to contact the Board office and speak with the licensing specialist.

Sincerely,

The Executive Director and Licensing Staff of
Nevada State Board of Osteopathic Medicine
2275 Corporate Circle, Suite 210
Henderson, NV 89074
(702) 732-2147 ext. 222
(702) 732-2079 (Facsimile)
Toll Free: (877) 725-7828

E-Mail: tsine@bom.nv.gov
Website: www.bom.nv.gov

Nevada State Board of Osteopathic Medicine
Application for Physician Assistant Licensure
Requirements and Instructions

Minimum Requirements for Licensure refer to NRS 633.311.

1. 21 YEARS OF AGE and CITIZEN OF THE UNITED STATES OR IS LAWFULLY ENTITLED TO REMAIN AND WORK IN THE UNITED STATES, and,
2. GRADUATION FROM A SCHOOL WITH A DEGREE IN PHYSICIAN ASSISTANT
3. PASSES ALL PARTS OF THE NATIONAL COMMISSION on CERTIFICATION of PHYSICIAN ASSISTANTS (NCCPA) or.
4. COMPLETION OF THE APPLICATION AND ALL REQUESTED DOCUMENTATION; and.
5. SUBMISSION OF 1 (ONE) FINGERPRINT CARD.
6. COMPLETION OF FORM #5 - COLLABORATION AGREEMENT
7. PAYMENT OF FEES: Non-refundable application and initial licensure fee $450.00 (Includes Fingerprinting Fee). Please remit payment of $250.00 with this application.
   - ***a)*** **Licenses issued between January 1 and June 30 will have to pay $450.00.**
   - ***b)*** **Licenses issued between July 1 and November 30 will pay $250.00, but will require to be renewed by December 31.**
   - ***c)*** **Please include a payment of $250.00 with this application; if additional payment is required, you will be contacted.**

   THIS MUST BE RECEIVED BEFORE YOUR LICENSE IS APPROVED.

INSTRUCTIONS

Application (pages 1-9); forms 4 and form 5 are to be completed by the applicant, notarized as indicated, and returned to the Nevada State Board of Osteopathic Medicine with the application fee.

FEES ARE NON-REFUNDABLE AND ONLY APPLY TO THE YEAR THAT YOUR LICENSE IS APPROVED. THIS BOARD HAS A YEARLY RENEWAL.

FCVS Is no longer required for physician assistant applicants. We will require original college transcripts, NCCPA certification letter, notarized copy of your passport, or a certified copy of your birth certificate. You may enroll in the FCVS service by going to www.fsmb.org or call 1-817-868-4000.

FBI Fingerprint Card and instructions will be sent to you upon receipt of your COMPLETED APPLICATION and FEE or you can call to get them mailed to you.

Form #1, **VERIFICATION OF LICENS**E: Applicant is to fill out top portion and then forward to each State Board in which a license is/was held. Each state board will complete the bottom portion and return to the *Nevada State Board of Osteopathic Medicine*. Many States charge a fee for verification, which is the responsibility of the applicant. This form will only be accepted if received ***FROM*** that states professional licensing authority or board. We do accept verification through VeriDoc.

Form #4, **AFFIDAVIT OF MORAL AND PROFESSIONAL CHARACTER**: Must be delivered by the applicant to three licensed physicians or physician assistants, (PA, DO or MD) and **returned directly to the Board from the physician completing the affidavit** after being completed and notarized. Additional copies may be obtained by photocopying Form 4.

PHYSICIAN ASSISTANT COLLABORATING AGREEMENT: Must be completed by the physician assistant and the employing physician.

If additional space is required for answers, separate sheets may be attached to the application. All additional sheets must be 8 and ½ x 11 inches in size. Any "Yes" question other than #15 and #16 on the survey section, **MUST** be explained on a separate sheet of paper. **No Application will be processed prior to receipt of all required fees.**

Checklist

After completing the enclosed application, you are responsible for submitting the application along with certain documents. This checklist is intended to help you ensure that all proper documents accompany your application.

Completed Application	☐
State Licensure Verification form sent to the Board from **all** states in which you have ever held **any** healthcare license(s)	☐
Enclose and have notarized the completed "Affidavit and Authorization for Release of Information" form with this application when submitting it to the Board	☐
Education Transcripts, NCCPA certification, passport or birth certificate **or** Federation Credentials Verification Service (FCVS) completed report. **Note:** This Board requires current NCCPA certification.	☐
Initial check in the amount of $250.00 (application and FBI Fingerprint fee). Licenses approved prior to July 1 will require an additional payment of and $200.00.	☐
Child Support Information Form (per NRS 633.307)	☐
Completed Medical Malpractice and or Professional Liability Reporting form or **any and all** malpractice claims, settlements, and or judgments.	☐
A Notarized passport copy or certified birth certificate	☐
1 (one) Completed FBI Applicant Fingerprint Card	☐ ☐
3 (three) Affidavits of Moral and Professional Character from licensed DO, MD, or PA.	☐ ☐ ☐

It is your responsibility to immediately notify the board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license being granted to you by the board.

All forms should be sent directly to the board unless otherwise indicated:

State of Nevada - Board of Osteopathic Medicine
2275 Corporate Circle, Suite 210
Henderson, NV 89074
(702) 732-2147
(702) 732-2079 (fax)
Toll Free: (877) 325-7828 **tsine@bom.nv.gov**

State of Nevada - Board of Osteopathic Medicine
Application for Physician Assistant Licensure

1. Name: Indicate your full legal name. If your name has changed at any time during your life, you must submit a copy of the legal document (marriage certificate, divorce decree, etc.) supporting your name change.

1. Full Name (use no initials)

Last Name	First Name	Middle Name	Suffix	Maiden Name

All other names used

2. Address/Phone: Please complete all sections and indicate which address you wish to be used for public access and which is to be used for mailings from the medical board. Each state's law determines whether each address or phone number is a public record in the state in which you are applying. You may wish to contact the licensing authority for that state for further information. Many boards publish the "Public Access" address on their website; therefore you should consider what your preferred address is for these purposes.

2. Address/Phone

Practice Address
☐ Public Access
☐ Mailing

Street

City | State | Zip Code

Telephone | Fax | E-mail address | Alternate Phone

Home Address
☐ Public Access
☐ Mailing

Street

City | State | Zip Code

Telephone | Fax | E-mail address | Alternate Phone

Are you NCCPA Certified? ☐ **Yes** ☐ **No**
If yes, please complete the following:

NCCPA	Certification Number	Date of Certification	Date of Expiration

Active Military: ☐ **Yes** ☐ **No** **Spouse Active Military:** ☐ **Yes** ☐ **No**

Have you ever served in the Armed Forces of the United States? ☐ **Yes** ☐ **No**
If yes, in which branch and When? _____

Are you the surviving spouse of a veteran? ☐ **Yes** ☐ **No**

Have you ever been assigned to duty for a minimum of 6 continuous years in the National Guard or a reserve component of the Armed Forces of the United States and separated from such service under conditions other than dishonorable? ☐ **Yes** ☐ **No**

Have you ever served the Commissioned Corps of the United States Public Health Service or the Commissioned Corps of the National Oceanic and Atmospheric Administration of the United States in the capacity of a commissioned officer while on active duty in defense of the United States and separated from such service under conditions other than dishonorable? ☐ **Yes** ☐ **No**

3. Identification

/ /

Date of Birth (mm/dd/yyyy) | Birth City | Birth State | Birth Country

Gender | Social Security Number | Are you a U.S. Citizen? ☐ Yes ☐ No

Height | Weight | Color of Hair | Color of Eyes

Your social security number is required to facilitate reporting to the federal Healthcare Integrity & Protection Data Bank (42 U.S.C. Sections 1320a-7e(b), 5 U.S.C. Section 552a, and 45 C.F.R. pt. 61) and for accurate identification under the federal and state child support enforcement law (42 U.S.C. Section 666 and applicable state law). It may also be used for reporting to the National Practitioner Data Bank (42 U.S.C. Section 11101 and 45 C.F.R. pt. 60) and for other investigative/enforcement purposes in compliance with state laws governing physician discipline or as otherwise required by state or federal law (NRS 633.326).

4. List name and address for any and all colleges or universities attended other than schools where professional medical education was received.

4. Colleges or Universities (attach additional pages if necessary)

1. School Name | Address

City | State | Zip Code | Country | Attendance Dates From – To | Graduation Date | Degree

2. School Name | Address

City | State | Zip Code | Country | Attendance Dates From – To | Graduation Date | Degree

5. Medical School: List **all** medical schools you have attended, even those from which you did not graduate in chronological order. Attach an additional sheet if necessary.

5. Medical School (attach additional pages if necessary)

1. _____
School Name Address

_____
City State Zip Code Country Attendance Dates From – To Graduation Date Degree

2. _____
School Name Address

_____
City State Zip Code Country Attendance Dates From – To Graduation Date Degree

6. Child Support Information (per NRS 633.326)

Please mark the appropriate response:

_____ I am NOT subject to a court order for the support of a child.

_____ I AM subject to a court order for the support of one or more children and am in compliance with the order or am in compliance with a plan approved by the District Attorney or other controlling public agency enforcing the order for the repayment of the amount owed pursuant to the order; or

_____ I AM subject to a court order for the support of one or more children and am not in compliance with the order or a plan approved by the District Attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

_____
Signature of Applicant

7. Examination History:

7. Examination History

List each licensure examination, U.S. or international, you have taken (USMLE, NBME, NBOME, Etc.). If additional space is necessary, please enclose a separate sheet with your application and include all the information below.

Examination	Most Recent Date taken(Month/Year)	Passed (P) or Failed (F)	Number of attempts
☐ NCCPA	_____	☐ P ☐F	_____

8. State or Professional Licensure: You must complete the attached "Licensure Verification" form and forward it to **all** states in which you have held **any** healthcare license or certification. The verifying entity must forward all documentation directly to this board. Some state boards charge a fee for this information. Contact the state board where you hold or held a license to determine their requirements.

8. State Licensure

1. State_____Type _____License Number_____Status_____Issue Date_____
   (Special, Training, or Full License)
2. State_____Type_____License Number_____Status_____Issue Date_____
   (Special, Training, or Full License)
3. State_____Type_____License Number_____Status_____Issue Date_____
   (Special, Training, or Full License)
4. State_____Type_____License Number_____Status_____Issue Date_____
   (Special, Training, or Full License)
5. State_____Type_____License Number_____Status_____Issue Date_____
   (Special, Training, or Full License)
6. State_____Type_____License Number_____Status_____Issue Date_____
   (Special, Training, or Full License)

9.Chronology of Activities (copy and attach additional pages if necessary)

Dates: From/To	Practice/Employment
1. From: To:	_____ Practice/Employment Name _____ Practice/Employment Address City State Zip Code Country Position & Department: _____% Clinical ____ % Administrative ____ ☐Employment ☐Staff Privileges ☐Affiliation ☐Other _____
2. From: To:	_____ Practice/Employment Name _____ Practice/Employment Address City State Zip Code Country Position & Department: _____% Clinical ____ % Administrative ____ ☐Employment ☐Staff Privileges ☐Affiliation ☐Other _____
3. From: To:	_____ Practice/Employment Name _____ Practice/Employment Address City State Zip Code Country Position & Department: _____% Clinical ____ % Administrative ____ ☐Employment ☐Staff Privileges ☐Affiliation ☐Other _____

10. Questions: Please answer yes or no to the following questions. All, **'yes'**, answers in questions **1 through 14 must be explained** on a **separate sheet of 81/2 x 11 piece of paper**. Each numbered question corresponds to a numbered, 'yes', or, 'no', check box on the right side of this page.

1. Have any disciplinary or administrative actions ever been taken against any healing art license which you now hold or have held by the U.S. Military, U.S. Public Health Service, or other U.S. federal government entity? 1. ☐Yes ☐No

2. 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? 2. ☐Yes ☐No

3. Have you ever had a medical license revoked, suspended, or limited in any state, or U.S. territory? 3. ☐Yes ☐No

4. Have you ever voluntarily surrendered a license to practice in the healing arts in any state, country or U.S. territory? 4. ☐Yes ☐No

5. Have you ever failed a state licensure examination, any part of FLEX, COMLEX, USMLE, or NBOME even if subsequently passed? 5. ☐Yes ☐No

6. Have you ever had staff privileges in a hospital denied, suspended, limited, revoked or non-renewed, or have you ever resigned from a medical staff in lieu of disciplinary or administrative action? (This does not include suspensions or restrictions for failure to complete medical records). 6. ☐Yes ☐No

7. Have you ever been investigated for, charged with, or convicted of unprofessional conduct, professional incompetence, gross malpractice or malpractice, or any other violation or statute, rule or regulation governing the practice of medicine by any medical licensing board or other agency (including Federal), hospital or medical society or **sued in a court of law for alleged malpractice**? 7 ☐Yes ☐No

8. Have you ever been denied membership or expelled from a medical society or other professional medical organization including the AOA, AMA, any member specialty board of the AOA or ABMS? 8. ☐Yes ☐No

9. Are you currently in treatment for a mental illness, drug addiction, or acute substance, drug or alcohol abuse? 9. ☐Yes ☐No

10. Do you regularly take any prescription drug for therapeutic purposes? 10. ☐Yes ☐No

11. Have you ever surrendered your state or federal controlled substance registration or had it restricted in any way? 11. ☐Yes ☐No

12. Are you now or within the past year, addicted to controlled substances, including, but not limited to narcotics or alcohol? 12. ☐Yes ☐No

13. Are you now or have been within the past year investigated for, charged with or convicted of, or pled nolo contendere to a violation of any federal, state or local law relating to the manufacture, distribution, or dispensing of controlled substances, or to drug addiction? 13. ☐Yes ☐No

14. Have you ever been arrested, investigated for, charged with or convicted of, or pled nolo contendere to any offense, misdemeanor or felony in any state, the United States, or a foreign country? ((Except minor traffic violations). 14. ☐Yes ☐No

15. Do you attest to knowledge of safe injection practices and CDC Guidelines? 15. ☐Yes ☐No

16. If granted a license, do you intend to practice in Nevada? 16. ☐Yes ☐No

If yes, LOCATION _____

When: _____

Affidavit and Authorization for Release of Information: You must attach a recent (less than 6 months old) passport quality, color photograph of yourself to this form. Take the form to a notary public and sign the form in the presence of the notary public. The notarized form then must be sent directly to this Board.

Affidavit
And
Authorization For Release of Information

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have or shall make with respect thereto are true, that I am the original and lawful possessor and person named in the various forms and credentials furnished or to be furnished with respect to my application and that all documents, forms or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the Application for Physician Assistant Licensure and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me to furnish to the Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the Board or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

I hereby release, discharge and exonerate the Board, its agents or representatives and any person furnishing information, of any and all liability of every nature and kind arising out of investigation made by the Board.

I will immediately notify the board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license to practice medicine being granted to me by the board

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my licensure or permit to practice medicine.

Applicant's Signature (must be signed in the presence of a notary)

_____

Applicant's **Printed** Last Name

_____

Applicant's **Printed** First Name, Middle Initial, and Suffix (e.g., Jr.)

_____

Date of Signature

Applicant Photograph

Securely tape or glue in this square a current, front-view, 2-inch by 2-inch passport-type color photograph of yourself

NOTARY

Dated _____ Signed _____

State of _____ County of _____

SUBSCRIBED AND SWORN TO before me this _____ day of _____, 20___.

My commission expires: _____ (NOTARY PUBLIC SIGNATURE & SEAL)

Form #1

Licensure Verification Form

(Copy this form for multiple licenses)

I am applying for a license to practice medicine with the **State of Nevada - Board of Osteopathic Medicine**. The Board requires that this form be completed by each state or Canadian province in which I hold or have held licenses, whether now current or not. Please complete the form and return it directly to the following Board:

To be completed by applicant

Applicant Name: _____
Last First Middle Suffix

Date of Birth: _____ Social Security Number: _____ License Number: _____
(From State/Province you are sending this form to)

The applicant's social security number is to be used for purposes of identification and may not be used for any other reason.

I hereby authorize the licensing agency of the State/Province of _____ to furnish the information to the Board indicated below.

Signature of Applicant _____ Date _____

Board Name: NEVADA STATE BOARD OF OSTEOPATHIC MEDICINE

Address: 2275 Corporate Circle, Suite 210 Henderson NV 89074
Street City State Zip Code

TO BE COMPLETED BY STATE LICENSING BOARD OR CANADIAN PROVINCE

Name of Licensee: _____
Last First Middle Suffix

License Type: _____ License Number: _____ Issue Date: _____

Is this license current? ☐Yes ☐No Expiration Date: _____

1) Have formal disciplinary proceedings been initiated against applicant's license by a disciplinary authority in your state?
☐Yes ☐No ☐Cannot answer under state law
If Yes, please explain: _____

2) Has the applicant ever been warned, censured, placed on probation, formal consent, reprimand or in any other manner disciplined or has applicant's license been revoked, suspended, or in any other manner limited by a licensing or disciplinary authority in your state?
☐Yes ☐No ☐Cannot answer under state law
If Yes, please explain: _____

Affix Board Seal Here

Board Authorized Signature: _____

Title: _____

Date: _____

Return to:
State of Nevada - Board of Osteopathic Medicine
2275 Corporate Circle, Suite 210
Henderson, NV 89074

Form #2

Medical Malpractice/Professional Liability Claims Information

(Copy this form to report multiple claims)

Date of Claim/Suit:_____ Date You Received Notice:_____

State/County of Event: _____ Date of Event:_____

Court Case Number _____ Court Filing Date: _____
Court Where Filed In: _____

Insurance Company (or specify if self-insured):_____

Insurance Claim No. (or if self-insured write n/a):_____

Claimant:_____

Respondent:_____

Brief Description of Allegations:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

***** Please attach/mail a copy of the Summons/Complain/Claim notice with form*****

Claim Status & Effective Date of That Status:

☐Open (pending) ☐Arbitration/Medication ☐Closed (settled) ☐Dismissed ☐Other

Date of Closure: _____

Amount of judgment or settlement $_____ Amount paid on your behalf $ _____

*****Refer to NRS 633.527 for all requirements of reporting Malpractice Claims/Board Actions*****

Nevada State Board of Osteopathic Medicine
2275 Corporate Circle, Suite 210
Henderson, NV 89074

Form #3

State of Nevada - Board of Osteopathic Medicine
Hospital Privileges Verification

(Copy this form for multiple Hospitals)

Applicant Instructions: Complete Section 1 and Section 2 of this form then send this form to **each and every Hospital you currently hold Medical Staff Privileges**.

Section 1: Applicant Information

Last Name:_____ First Name:_____ Middle Name:_____

Name if different when diploma awarded:_____

Social Security Number:_____ Date of Birth:_____

The applicant's social security number is to be used for purposes of identification and may not be used for any other reason.

Waiver for release of information: I authorize this hospital or medical center listed below to provide any and all information pertaining to my medical staff privileges at your institution to the State of Nevada - Board of Osteopathic Medicine.

_____ _____
Applicant's Signature Date

Section 2: INSTRUCTIONS TO THE CHIEF OF MEDICAL STAFF OR DESIGNATED OFFICIAL OF THE MEDICAL STAFF
Please complete Section 3 of this form and attach a LETTER OF GOOD STANDING FROM THE CHIEF OF STAFF OR OFFICIAL and forward this information directly to this Board to the following address:

Board Name:_____

Address_____

City_____ State_____ Zip Code_____

Section 3: HOSPITAL VERIFICATION

Institution Name:_____

Institution Address: _____
Street City State Zip Code

Affiliated Medical School Name:_____

Type of Privileges/Specialty:_____

From Date: _____/_____/_____ To Date: _____/_____/_____

Current Status of Medical Privileges: _____

(Continued on Next Page)

Form #3 continued

Unusual Circumstances:

Did this individual ever take a leave of absence or break from his/her staff privileges?	☐Yes	☐No
Were this individual's privileges ever suspended for reasons other than failure to complete medical records?	☐Yes	☐No
Was this individual ever disciplined or placed under investigation?	☐Yes	☐No
Were any negative reports ever filed by colleagues, allied health professionals or patients?	☐Yes	☐No
Were any limitations or special requirements placed upon this individual because of questions of medical incompetence, disciplinary problems or any other reason?	☐Yes	☐No

Please explain any "Yes" response from above (attach additional pages if necessary):_____

_____

_____

_____

_____

_____

I certify that to the best of my knowledge and belief the foregoing is a true, accurate and complete statement of the record of the individual named on this form.

Signature:_____

Print name:_____

AFFIX INSTITUTIONAL SEAL HERE
(If no seal is available, this form must be notarized)

Title:_____

Date:_____

Phone number:_____ Fax:_____

E-mail: _____

Return to:

State of Nevada - Board of Osteopathic Medicine
2275 Corporate Circle, Suite 210
Henderson, NV 89074
702-732-2147
702-732-2079 (fax)
Toll Free: (877) 325-7828

Form #4

STATE OF NEVADA – BOARD OF OSTEOPATHIC MEDICINE
Affidavit of Moral and Professional Character

(This form may be duplicated a total of THREE from different physicians is required)

This letter of recommendation must be signed by a licensed D.O., M.D., or P.A.

_____, 20

City State Date

To the Nevada State Board of Osteopathic Medicine:

I certify that I am licensed under the laws of _____ to practice either allopathic or osteopathic medicine and that I have known the applicant,

_____, P.A., for _____ years, that I personally knew the applicant while actively engage in the practice of osteopathic medicine; that he/she is of good moral character and worthy of professional recognition, that he/she is free from habits liable to interfere with the provision of professional services, has good standing in the community in which he/she resides and is worthy of receiving a license to practice osteopathic medicine in the State of Nevada.

_____ _____

Signature Address

_____ _____

Print Name

_____

Subscribed and sworn to before me on the _____
day of _____, 20 _____

_____ Notary Public State of _____

Signature of Notary

My Commission expires on _____

Residing at _____

Please return completed form to the:

Nevada State Board of Osteopathic Medicine
2275 Corporate Circle, Suite 210
Henderson, NV 89074
702-732-2147

NOTIFICATION TO NEVADA STATE BOARD OF OSTEOPATHIC MEDICINE
OF SUPERVISION OF PHYSICIAN ASSISTANT

COMES NOW _____ being first duly sworn who deposes and says that: I, the undersigned physician, am duly licensed to practice medicine in the state of Nevada by the Nevada State Board of Osteopathic Medicine, possess an active license to practice medicine in the state of Nevada, license number _____, am in good standing with the Nevada State Board of Osteopathic Medicine. I am engaged in the practice of medicine in the state of Nevada, am current on all my required CME and am not aware of any disciplinary action, formal or informal, pending against me by the Nevada State Board of Osteopathic Medicine or any other jurisdiction's medical licensing entity. **I have checked with the Nevada State Board of Osteopathic Medicine and determined that the physician assistant I am going to supervise has never been formally disciplined by the Nevada State Board of Osteopathic Medicine and is licensed by the Nevada State Board of Osteopathic Medicine.**

I have read and am aware of the provisions of Chapter 633 of the Nevada Revised Statutes concerning the duties of a supervising physician, as well as Chapter 633 of the Nevada Administrative Code which are the regulations adopted by the Nevada State Board of Osteopathic Medicine concerning a physician's relationship with a physician assistant and/or advanced practitioner of nursing. I have read and am aware of the regulation of the Nevada State Board of Osteopathic Medicine under Chapter 633 of the Nevada Administrative Code that precludes a physician from simultaneously supervising more than three physician assistants or collaborating with more than three advanced practitioners of nursing, or with a combination of more than three physician assistants and advanced practitioners of nursing.

I hereby certify that this relationship does not violate the limitation cited above concerning the total number of physician assistants or advanced practitioners of nursing with whom I may simultaneously supervise or collaborate. Upon receipt of same, I will be supervising the following named physician assistant at the following practice location(s):

_____ _____
Practice Location Telephone # Practice Location Telephone #

_____ _____
Practice Location Telephone # Practice Location Telephone #

I am aware that a copy of this Notification will be placed in my licensing file at the offices of the Nevada State Board of Osteopathic Medicine.

WHEREFORE, I set my hand this _____ day of _____, 20_____.

_____ _____
Supervising Physician Name (Print or Type) Supervising Physician (Signature)

The above named physician, being first duly sworn, deposes and states that he/she appeared before me, a notary public, on the ____ day of _____, 20__, and in my presence, executed this one-page document.

_____
Notary Public

COMES NOW _____ being first duly sworn who deposes and says that: I, the undersigned physician assistant, am duly licensed as a physician assistant in the state of Nevada by the Nevada State Board of Osteopathic Medicine, and am in good standing with the Nevada State Board of Osteopathic Medicine, and have never been formally disciplined by the Board for a violation of the Medical Practice Act of the state of Nevada. That I have read and am aware of the provisions of Chapter 633 of the Nevada Revised Statues and the Nevada Administrative Code as those laws apply to physician assistants. I am aware that a copy of this Notification will be placed in my licensing file at the offices of the Board, and, that the provisions of the Nevada Administrative Code 633.288(3)(b) require that if this relationship is terminated my failure to notify the Board of the termination within 10 days or my continuing to practice this portion of my practice until such time as I advise the Board of my new supervising physician, is grounds for disciplinary action against me.

WHEREFORE, I set my hand this _____ day of _____, 20_____.

_____ _____
Physician Assistant Name (Print or Type) Physician Assistant (Signature)

The above named _____ (Print Physician Assistant Name), being first duly sworn, appeared before me on the _____day of _____, 20_____, and, in my presence, executed this document consisting of one (1) page.

_____
Notary Public

Complete original form is to be mailed directly to:
Nevada State Board of Osteopathic Medicine
2275 Corporate Circle, Suite 210, Henderson, NV 89074

Written Collaborating Agreement
Supervising Physician and Physician Assistant

This is a Written Collaboration agreement, in compliance with NAC 633.288, between _____, Physician Assistant (hereinafter "the Physician Assistant") and _____D.O. (hereinafter "the Doctor"). Through this agreement, the Doctor and the Physician Assistant affirm they each have read and are aware of the Nevada Revised Statutes (NRS 633) and Nevada Administrative Code (NAC 633) that govern the supervision of a physician assistant by a Nevada licensed physician, and each affirm they will comply with all the statutes and regulations governing such supervision.

We agree that the Physician Assistant's practice shall be within the scope of practice of the Doctor, and that that scope of practice shall be: _____. We agree that the Physician Assistant will provide services at the following location and at the following times:

Location: _____
Times: _____

We agree that in furtherance of the Physician Assistant's practice under the supervision of the Doctor, the Physician Assistant may perform the following tasks [check all that apply and add any that are not on the following list]:

___ (a) Obtaining the medical histories of patients;
___ (b) Performing physical examinations;
___ (c) Ordering and performing diagnostic and therapeutic procedures;
___ (d) Implementing a treatment plan outlined by a supervising physician;
___ (e) Monitoring the effectiveness of therapeutic interventions;
___ (f) Assisting at surgery;
___ (g) Offering counseling and education to meet the needs of patients;
___ (h) Making appropriate referrals; and
___ (i) Pronouncing death, excluding the diagnosis of the cause of death.
___ (j) _____
___ (k) _____
___ (l) _____
___ (m) _____
___ (n) _____
___ (o) _____
___ (p) _____

We agree that the Doctor shall ensure that:

(a) The physician assistant is clearly identified to the patients as a physician assistant;

(b) The physician assistant performs only those medical services which are specified in the written collaborating agreement between the supervising physician and the physician assistant; and

(c) The physician assistant strictly complies with:

(1) The provisions of the registration certificate issued to the physician assistant by the State Board of Pharmacy pursuant to NRS 639.1373; and

(2) The regulations of the State Board of Pharmacy regarding controlled substances, poisons, dangerous drugs or devices.

We agree that the Doctor will:

(a) Except as otherwise provided in NRS 633.469, provide supervision in person at least once each month to the physician assistant.

(b) Be available for consultation at all times during which the physician assistant is performing medical services.

(c) Review and initial at least 10 percent of the charts of the patients of the physician assistant at least four times each year.

(d) Develop and carry out a program to ensure the quality of care provided by the physician assistant, which must include, without limitation:

(1) An assessment of the medical competency of the physician assistant;

(2) A review and initialing of selected charts;

(3) An assessment of a representative sample of the referrals or consultations made by the physician assistant with other health professionals as required by the condition of the patient;

(4) Direct observation of the ability of the physician assistant to take medical histories from and perform examinations of patients representative of those cared for by the physician assistant; and

(5) Maintenance by the supervising physician of accurate records and documentation regarding the program for each physician assistant supervised.

(e) Examine a patient cared for by a physician assistant for a recurring illness that is not a chronic illness if the patient does not show improvement within a reasonable period of time.

We agree that if there are additional terms and conditions that will apply to or govern our relationship – such as, for example, the terms of the quality assurance program – that we will attach those to this document and that those will be deemed incorporated into this document as if they were set out herein.

_____ PA-C **_____D.O.**

(printed name) (printed name)

_____ _____

(signature) (signature)

NRS 633.469 Supervising osteopathic physicians: Requirements of supervision.

1. A supervising osteopathic physician shall provide supervision to his or her physician assistant continuously whenever the physician assistant is performing his or her professional duties.

2. Except as otherwise provided in subsection 3, a supervising osteopathic physician may provide supervision to his or her physician assistant in person, electronically, telephonically or by fiber optics. When providing supervision electronically, telephonically or by fiber optics, a supervising osteopathic physician may be at a different site than the physician assistant, including a site located within or outside this State or the United States.

3. A supervising osteopathic physician shall provide supervision to his or her physician assistant in person at all times during the first 30 days that the supervising osteopathic physician supervises the physician assistant. The provisions of this subsection do not apply to a federally qualified health center.

4. Before beginning to supervise a physician assistant, a supervising osteopathic physician must communicate to the physician assistant:

(a) The scope of practice of the physician assistant;

(b) The access to the supervising osteopathic physician that the physician assistant will have; and

(c) Any processes for evaluation that the supervising osteopathic physician will use to evaluate the physician assistant.

5. A supervising osteopathic physician shall not delegate to his or her physician assistant, and the physician assistant shall not accept, a task that is beyond the physician assistant's capability to complete safely.

6. As used in this section, "federally qualified health center" has the meaning ascribed to it in 42 U.S.C. § 1396d(l)(2)(B).

(Added to NRS by 2007, 1832; A 2013, 2019)

NAC 633.288 Physician assistants and supervising physicians: Collaborating agreements; limitations. (NRS 633.291, 633.434, 633.466, 633.469)

1. Except as otherwise provided in this section, a physician assistant must enter into a written collaborating agreement with a supervising physician before the physician assistant may perform medical services under the supervision of that supervising physician. Such an agreement must:

(a) Describe the location, times and manner in which the physician assistant will assist the supervising physician;

(b) Specify the medical services that the physician assistant is authorized to perform;

(c) Be signed by the physician assistant and the supervising physician; and

(d) Be notarized.

2. A physician assistant may perform only those medical services specified in the written collaborating agreement.

3. A physician assistant who has entered into a written collaborating agreement with a supervising physician shall:

(a) Submit a copy of the agreement to the Board within 10 days after entering into the written collaborating agreement.

(b) Notify the Board in writing within 10 days after the termination of the written collaborating agreement.

4. Except as otherwise provided in this subsection, a physician assistant may not perform medical services under the supervision of more than three supervising physicians. A physician assistant employed by a medical facility may not perform medical services at the medical facility under the supervision of more than one supervising physician. As used in this subsection, "medical facility" has the meaning ascribed to it NRS 449.0151.

5. A physician assistant may perform medical services under a temporary written collaborating agreement that is valid for not more than 30 days if the agreement is approved by the Board.

6. A supervising physician may not supervise more than a total of three physician assistants and advanced practitioners of nursing at one time. As used in this subsection, "advanced practitioner of nursing" has the meaning ascribed to it in NRS 453.023.

7. A physician assistant who has been subject to disciplinary action pursuant to this chapter or chapter 633 of NRS may only be supervised by a supervising physician who has been approved by the Board to supervise that physician assistant.

(Added to NAC by Bd. of Osteopathic Med. by R192-07, eff. 12-17-2008)

NAC 633.289 Supervising physicians: Responsibilities. (NRS 633.291, 633.434, 633.466, 633.469)

1. A supervising physician is responsible for all of the activities related to the performance of medical services conducted by the physician assistant whom he or she supervises, including, without limitation:

(a) Obtaining the medical histories of patients;

(b) Performing physical examinations;

(c) Ordering and performing diagnostic and therapeutic procedures;

(d) Implementing a treatment plan outlined by a supervising physician;

(e) Monitoring the effectiveness of therapeutic interventions;

(f) Assisting at surgery;

(g) Offering counseling and education to meet the needs of patients;

(h) Making appropriate referrals; and

(i) Pronouncing death, excluding the diagnosis of the cause of death.

2. The supervising physician shall ensure that:

(a) The physician assistant is clearly identified to the patients as a physician assistant;

(b) The physician assistant performs only those medical services which are specified in the written collaborating agreement between the supervising physician and the physician assistant; and

(c) The physician assistant strictly complies with:

(1) The provisions of the registration certificate issued to the physician assistant by the State Board of Pharmacy pursuant to NRS 639.1373; and

(2) The regulations of the State Board of Pharmacy regarding controlled substances, poisons, dangerous drugs or devices.

3. A supervising physician:

(a) Except as otherwise provided in NRS 633.469, shall provide supervision in person at least once each month to the physician assistant.

(b) Must be available for consultation at all times during which the physician assistant is performing medical services.

(c) Shall review and initial at least 10 percent of the charts of the patients of the physician assistant at least four times each year.

(d) Shall develop and carry out a program to ensure the quality of care provided by the physician assistant, which must include, without limitation:

(1) An assessment of the medical competency of the physician assistant;

(2) A review and initialing of selected charts;

(3) An assessment of a representative sample of the referrals or consultations made by the physician assistant with other health professionals as required by the condition of the patient; (4) Direct observation of the ability of the physician assistant to take medical histories from and perform examinations of patients representative of those cared for by the physician assistant; and (5) Maintenance by the supervising physician of accurate records and documentation regarding the program for each physician assistant supervised.

4. A patient cared for by a physician assistant for a recurring illness that is not a chronic illness must be examined by the supervising physician of the physician assistant if the patient does not show improvement within a reasonable period of time.

(Added to NAC by Bd. of Osteopathic Med. by R192-07, eff. 12-17-2008)