Nevada State Board of Medical Examiners
Sentinel Event Report Form for 2008

FOR OFFICIAL USE ONLY

Pursuant to NRS 630.30665, Physician required to report certain information concerning surgeries, this report is to be completed and submitted to the Nevada State Board of Medical Examiners by the date required in the instructions for the preceding calendar year. Failure to report is grounds for disciplinary action.

PLEASE PRINT OR TYPE

Date of Sentinel Event ___/ ___/___
MM DD Year

Patient's Nevada County of Residence: ________________________

Patient's State, or Country, of Residence (if not Nevada): ________________________

Patient's Date of Birth: _____________________

Patient' Gender: ______**Male** _____**Female**

Did the Sentinel Event occur in a practice office: _____**Yes** ____**No**

If NO, in what type of facility did the sentinel event occur? (Do NOT report an event if it took place outside of Nevada or in a facility listed on page three (3) of the instructions or on Form B.)

____

What are the primary and secondary specialties of the physician performing the surgery or procedure?

____

____

DESCRIPTION OF SENTINEL EVENT

What was the surgery/procedure being performed? ___________________________________

Describe the sentinel event:

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OUTCOME OF SENTINEL EVENT(*If death, actual physical injury with permanent loss or actual psychological injury with permanent loss occurred, please indicate)*

Describe the Outcome:

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CORRECTIVE ACTIONS *(If equipment repair or procedure, policy, or process modification or change took place, please indicate)*

Corrective Action Taken:

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SIGNATURE *(Please sign and date below. A separate Sentinel Event Form is required for each and every reportable sentinel event. A signature is required on each and every form.)*

Print Name: ____

License Number: ____________________

Office Address: ________________________________

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Doctor’s Signature: ________________________________ **Date:** ____________________