Nevada State Board of Medical Examiners
14-Day Sentinel Event Report Form

Pursuant to NRS 630.30665, physician required to report within 14 days of occurrence, sentinel events occurring in-office or at other facilities NOT a medical facility as defined under NRS 449.0151 and/or NOT out of state.
SEND report to: NSBME, 1105 Terminal Way, Suite 301, Reno, NV 89502-2144
Fax: 775-688-2321; Email: nsbme@medboard.nv.gov

FOR OFFICIAL USE ONLY

PLEASE PRINT OR TYPE

Date of Sentinel Event: ____/____/_____ (MM DD YYYY) **Date of Report:** ____/____/_____ (MM DD YYYY)

Patient's Nevada County of Residence: _____

Patient's State, or Country, of Residence (if Not Nevada): _____

Patient's Date of Birth: _____

Patient's 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 as defined under NRS 449.0151.)**

_____

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:

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:

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

Corrective Action Taken:

SIGNATURE *(Please sign and date below. A separate Sentinel Event Report 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: _____

_____

_____

Doctor's Signature: _____ **Date:** _____