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

Date of Report:

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, 9600 Gateway Drive, Reno, NV 89521; Fax: 775-688-2553; Email: nsbme@medboard.nv.gov

FOR OFFICIAL USE ONLY

PLEASE PRINT OR TYPE

Date of Sentinel Event:

MM DD YYYY 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:YesNo
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:

DUTCOME OF SENTINEL EVENT (If death, actual physical injury with permanent loss or actua
osychological injury with permanent loss occurred, please indicate.)

Describe the Outcom	e:
CORRECTIVE ACTI place, please indicate.	ONS (If equipment repair or procedure, policy, or process modification or change took)
Corrective Action Tal	ken:
	e sign and date below. A separate Sentinel Event Report Form is required for each entinel event. A signature is required on each and every form.)
Print Name:	
License Number:	
Office Address:	
Doctor's Signature: _	Date: