NEVADA STATE BOARD OF MEDICAL EXAMINERS

TRANSITIONAL LIMITED PHYSICIAN LICENSE | PROPOSED SUPERVISING PHYSICIAN AFFIDAVIT

Instructions: This Affidavit must be completed by the Proposed Supervising Physician and submitted directly to the Nevada State Board of Medical Examiners (Board) at 9600 Gateway Drive, Reno, NV 89521, or by email to sb124info@medboard.nv.gov.

Section I: Proposed Supervising Physician Information

Supervising Physician Name:

Primary Practice Address:

Nevada Medical License Number:

Telephone:

Email Address:

Practice Specialty: ☐ Internal Medicine ☐ Family Medicine ☐ Pediatrics

Subspecialties (please list, if any):

Note: Transitional physicians may only practice internal medicine, geriatric medicine, family medicine, and hospice and palliative medicine*. See NRS 630.2667(8)(a)(3). *Denotes that this is a subspecialty of internal medicine or family medicine and these subspecialties are permissible for transitional physicians.*

Section II: Transitional Physician Information

Name:

Date of Birth:

/ /

Section III: Qualifications of Proposed Supervising Physician

I hereby swear or affirm that:

1. I hold an active license to practice medicine in the State of Nevada and my license is in good standing as defined in NAC 630.105;
2. I practice medicine full-time in the State of Nevada and my practice is in the specialty and/or subspecialty noted above;
3. I have completed an ACGME-approved residency or fellowship in the specialty and/or subspecialty noted above;
4. I have actively practiced medicine for at least five (5) years; and
5. I have not been prohibited by the Board from serving as a supervising physician.

Disciplinary History: I ☐ HAVE / ☐ HAVE NOT had any disciplinary action imposed against me in Nevada or any other jurisdiction. *(If you checked HAVE, please provide dates, nature of violations, and penalties below):*

Section IV: Statement of Responsibility

I hereby swear or affirm that:

1. I have had substantial direct professional contact with the transitional limited physician (TLP) license applicant (Applicant), and based upon that contact and my professional judgment, I have determined that the applicant possesses sufficient knowledge and skills to safely practice medicine under my supervision, and I am willing to serve as the Applicant's supervising physician if he or she is issued a TLP license;
2. I understand that I must ensure that the Applicant practices in the same specialty as I do;
3. I understand that I will be responsible for the medical activities performed by the Applicant while under my supervision;
4. I agree to continuously monitor, supervise, and periodically evaluate the Applicant's professional performance and competency and to teach the Applicant skills and knowledge that he or she may need in order to safely and competently practice medicine independently in the future;
5. I agree to develop a written program of supervision for the Applicant and to submit all reports required by the Board, including periodic evaluations of the Applicant's performance;
6. I agree to immediately notify the Board of concerns regarding the Applicant's competence, professionalism, conduct, skills, or any matter that could adversely affect patient safety;
7. I understand that the Applicant may only practice medicine after he or she has received a TLP license and (1) the Board has approved me as the Applicant's supervisor, (2) the Board has approved a written practice agreement between me and the Applicant, NRS 630.2667(3), and (3) the Board has approved the Applicant's offer of employment, NRS 630.2667(2)(b);
8. I understand that the Applicant may only practice medicine pursuant to the parameters of the approved written practice agreement and the Applicant's approved employment. I agree to ensure that the written practice agreement for the Applicant is updated, as needed, and that the updated written practice agreement is submitted to the Board for approval prior to those changes going into effect;
9. I agree to follow the requirements of Section 21 of LCB File No. R112-25 with regard to my presence on the premises while the Applicant is providing medical services, designating a substitute supervising physician, if necessary, and notifying the Board if I will be unavailable to supervise the Applicant for more than fourteen (14) consecutive days; and
10. If a termination of my written practice agreement with the Applicant becomes necessary, I agree to follow the procedures outlined in Section 23 of LCB File No. R112-25 with regard to providing notice to the Board and safeguarding the health, safety, and welfare of the public or any patient served by the Applicant.

Section V: Supervision Practice Location(s)

List all premises where the Applicant will provide medical services under supervision:
(Please include business/facility name, full address, and the telephone number for each location.)

Section VI: Notarized Declaration

I declare under penalty of perjury under the law of the State of Nevada that the foregoing statements are true and correct, and I understand that submission of false or misleading information to the Board constitutes grounds for disciplinary action.

DATED this day of , 20 .

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PROPOSED SUPERVISING PHYSICIAN SIGNATURE

SUBSCRIBED and SWORN before me by
in the presence of (notary)
on this day of , 20 .

_____

NOTARY PUBLIC

FOR BOARD USE ONLY:

Affidavit Received:	_____
Eligibility Verified:	☐ Yes ☐ No