NEVADA STATE BOARD OF MEDICAL EXAMINERS

TRANSITIONAL LIMITED PHYSICIAN LICENSE | SUBSTITUTE SUPERVISING PHYSICIAN DECLARATION

Instructions: This Declaration must be completed by the Substitute 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: Substitute Supervising Physician Information

Substitute 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:**

Application Number (if any)**:** **TLP License Number** (if any)**:**

Substitute Supervision Type: ☐ Primary ☐ Secondary

Section III: Qualifications of Substitute 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 Substitute 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 agree to serve as the Secondary Substitute Supervisor for (Transitional Physician);
2. I understand that I may only provide substitute supervision for the Transitional Physician after the Board has received and approved this Substitute Supervising Physician Form;
3. I agree to immediately notify the Board of concerns regarding the Transitional Physician's competence, professionalism, conduct, skills, or any matter that could adversely affect patient safety;
4. I understand that the Transitional Physician may only practice medicine pursuant to the parameters of the approved Written Practice Agreement and the Transitional Physician's approved employment. I have a copy of the Transitional Physician's Written Practice Agreement with (Supervising Physician);
5. I have read the Written Practice Agreement and I will supervise the Transitional Physician according to that Agreement during Supervising Physician's absence and/or unavailability to supervise the Transitional Physician;
6. I will be on the premises and/or available to consult with the Transitional Physician by phone or other electronic means as required by the terms of the Written Practice Agreement while the Transitional Physician performs the medical services identified in the Agreement in the Supervising Physician's absence;
7. Unless designated below in Section V, I will supervise the Transitional Physician at the same practice locations as those identified in the Written Practice Agreement;
8. I understand that the Board must be notified if I am going to supervise the Transitional Physician for more than 14 consecutive days; and
9. I understand that the relationship between the Supervising Physician and the Transitional Physician is intended to be a one-on-one learning relationship, as much as possible, and that my role is intended to supplement the supervision of the Transitional Physician, and not to become the Transitional Physician's main supervisor or main supervision contact.

Section V: Designated Substitute Supervision Practice Locations

List any practice locations where the Substitute Supervising Physician will supervise the Transitional Physician if they are different than the locations provided in the Written Practice Agreement. If there are none, please write N/A.
(Please include business/facility name, full address, and the telephone number for each location.)

Transitional Physician Name

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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SUBSTITUTE SUPERVISING PHYSICIAN SIGNATURE

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

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NOTARY PUBLIC

FOR BOARD USE ONLY:

Affidavit Received:	
Eligibility Verified:	☐ Yes ☐ No