Southern Nevada Health District

PHYSICIAN ADVISOR VERIFICATION OF PHYSICIAN ASSISTANT SKILLS
(Please Type or Print)

NAME:_____ PA LICENSE # _____ EXP. DATE: _____

MAILING ADDRESS:_____
Street City State Zip

PHONE: Home ( ) Work ( )

PERMITTEE:_____ SOC. SEC. #_____ D.O.B._____

ADDRESS:_____

A. Mark those skills for which proof of training can be provided and for which physician authorization is given as allowed under NAC 632.225.

1. ( ) Orotracheal Intubation
2. ( ) Nasotracheal Intubation
3. ( ) Esophageal Intubation
4. ( ) Peripheral Venous Lines
5. ( ) Central Venous Lines
   Identify Line: _____
6. ( ) Needle Cricothyroidotomy
7. ( ) Needle Thoracentesis
8. ( ) Tube Thoracostomy
9. ( ) MAST/PASG
10. ( ) External Pacing
11. ( ) Intraosseous Infusion
12. ( ) Pericardiocentesis
13. ( ) Other EMS Nursing/PA Procedures Beyond Basic Nursing Education (List on Separate Page)

B. Mark any specialty training courses which you have completed and provided copies of any certificates awarded.

1. ( ) CCRN
2. ( ) ENP
3. ( ) Flight Nurse
4. ( ) ACLS
5. ( ) PALS / PEPP
6. ( ) PHTLS
7. ( ) Extrication
8. ( ) Other (List on separate page)

CERTIFICATION: I hereby certify that all entries made on this form are true. I understand that the documentation may be audited and that any false statement may cause the Health District to request the Nevada State Board of Medical Examiners to undertake an official investigation of my records.

SIGNATURE_____ DATE:_____
Physician Assistant

PHYSICIAN ADVISOR VERIFICATION: I hereby verify that I have authorized the Physician Assistant named above to perform those procedures identified above in accordance with written policies/protocols which I have issued. A copy of those protocols is attached.

SIGNATURE _____ DATE _____

EMPLOYER VERIFICATION: We hereby verify that the above information is accurate and the above named Physician Assistant is employed or a volunteer member of our agency and is functioning in accordance with the written policies/protocols of the Physician Advisor named above.

Ambulance Operator: _____
(Type or Print)

_____
Signature Date