NEVADA STATE BOARD OF OPTOMETRY



Carson City, Nevada 89702
Telephone: (775) 883-8367
Facsimile: (775) 305-0105
E-Mail: admin@nvoptometry.org

You may qualify to treat glaucoma in two distinct ways: by co-management with an ophthalmologist, or by endorsement from another jurisdiction.

TO QUALIFY FOR A CERTIFICATE BY CO-MANAGEMENT TO TREAT PERSONS DIAGNOSED WITH GLAUCOMA under NRS 636.2893, a Nevada licensed optometrist must:

- 1. hold a Nevada-issued OPAC (fka TPA),
- 2. co-manage not fewer than 15 glaucoma patients with regular input and oversight by a Nevadalicensed ophthalmologist for not less than one year <u>each</u>, and
- 3. provide patient notes and sworn documents from both the ophthalmologist and the applicant that the requirements for the certificate have been met (see example).

Upon completion of the requirements and the forms, go to the Board website, click on the glaucoma application link, upload completed required documents and pay the application fee of \$175. Of course, the materials also may be submitted with a check via US Mail to the address above. Forms for your use and sample patient notes follow this page.

TO QUALIFY FOR A CERTIFICATE BY ENDORSEMENT TO TREAT PERSONS DIAGNOSED WITH GLAUCOMA pursuant to NRS 636.2897, a Nevada licensed optometrist who:

- 1. holds a Nevada-issued OPAC (fka TPA),
- 2. holds a current unrestricted ability in another jurisdiction to treat persons diagnosed with glaucoma, and has not been reported to the National Practitioners Data Bank within the immediate last 5 years, and
- 3. swears or affirms that he or she has engaged in not fewer than 50 glaucoma patient encounters or has completed requirements to obtain the ability to treat glaucoma patients in another jurisdiction which were substantially similar to the requirements for a Nevada certificate and provides an explanatory narrative and relevant evidence of the same,

may complete the on-line application, pay the application fee, and upload an explanatory narrative and any relevant evidence.

This information sheet is for guidance only and is not a substitute for your careful consideration of NRS and NAC Chapters 636.

Optometrist Name, License No:	
Primary Practice Address:	
Ophthalmologist Signature & date	Date:
Optometrist Signature & date	Date:
1. HPI Patient No.:	3. HPI Patient No.:
Date Treatment commenced by O.D.:	Date Treatment commenced by O.D.:
Synopsis of treatment plan:	Synopsis of treatment plan:
	-
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2. HPI Patient No.:	4. HPI Patient No.:
Date Treatment commenced by O.D.:	Date Treatment commenced by O.D.:
Synopsis of treatment plan:	Synopsis of treatment plan:
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5. HPI Patient No.:	7. HPI Patient No.:
Date Treatment commenced by O.D.:	Date Treatment commenced by O.D.:
Synopsis of treatment plan:	Synopsis of treatment plan:
6. HPI Patient No.:	
Date Treatment commenced by O.D.:	Date Treatment commenced by O.D.:
Synopsis of treatment plan:	Synopsis of treatment plan:
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9. HPI Patient No.:	11. HPI Patient No.:
Date Treatment commenced by O.D.:	Date Treatment commenced by O.D.:
Synopsis of treatment plan:	Synopsis of treatment plan:
10. HPI Patient No.:	12. HPI Patient No.:
Date Treatment commenced by O.D.:	Date Treatment commenced by O.D.:
Synopsis of treatment plan:	Synopsis of treatment plan:
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13. HPI Patient No.:	15. HPI Patient No.:
Date Treatment commenced by O.D.:	Date Treatment commenced by O.D.:
Synopsis of treatment plan:	Synopsis of treatment plan:
14. HPI Patient No.:	-
Date Treatment commenced by O.D.:	
Synopsis of treatment plan:	
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OPHTHALMOLOGIST CERTIFICATION OF COMPLIANCE FOR OPTOMETRIST APPLICATION TO TREAT PERSONS WITH GLAUCOMA

STATI	E OF)				
COUN) ss. TY OF)				
I,	, (circle one) M.D. or D.O.,				
	a License Number, am of lawful age and under penalty of perjury pursuant 5 53.045 certify as follows:				
1.	I am currently a licensed and practicing ophthalmologist in good standing in the state of Nevada;				
2.	My mailing address is;				
3.					
4.	. As a consulting ophthalmologist, I have either diagnosed the patient with glaucoma, or confirmed the diagnosis of the optometrist, as noted on the attached form, and regularly have provided my feedback on the medical records and proposed treatment plans submitted to me by the optometrist above.				
5.	. In my opinion, the optometrist identified herein is competent to continue treating such patients without further supervision.				
6.	I understand this sworn Declaration is for the optometrist identified herein to comply with subsection 3 of NRS 636.2893.				
	I declare under penalty of perjury under the laws of the State of Nevada that the foregoing is true and correct.				
	DATED this,				
	Ophthalmologist				

OPTOMETRIST CERTIFICATION OF COMPLIANCEAPPLICATION TO TREAT GLAUCOMA PURSUANT TO NRS 636.2895

STAT	E OF)		
COUN	NTY OF) ss.		
			, am of lawful age and under penalty of perjury	
oursua	ant to NRS 53.045 certify	y as follows:		
1.	I am a currently license number	1 0 1	tometrist in the state of Nevada, holding licens	
2.	I possess a valid Nevad agents pursuant to NAC		inister and prescribe optometric pharmaceutica	
3.	have treated, in consult	tation with an ophthleast 12 consecutive	th subsection 3 of NRS 636.2893 attesting that halmologist licensed in the State of Nevada, are months each, and in a manner consistent with	
4.			records for each patient to the co-managin course of treatment for each patient;	
5.	I was notified by the recommended adjustment		ophthalmologist that he/she agreed with of treatment I outlined;	
6.	. I conducted such necessary optometric examinations of the patient as the consulting ophthalmologist and I deemed prudent during the course of the patients' treatment; and			
7.	period of not less than	acknowledge the records for each of the 15 patients treated must be retained by me for a period of not less than five years, and that the records are subject to examination by the Nevada State Board of Optometry.		
	I declare under foregoing is true and co		under the laws of the State of Nevada that th	
	DATED this	day of		
			Ontomatrist	
			Optometrist	