NEVADA STATE BOARD OF OPTOMETRY

Post Office Box 1824
Carson City, Nevada 89702
Telephone: (775) 883-8367
Facsimile: (775) 305-0105
E-Mail: admin@nvoptometry.org

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 Optometric Pharmaceutical Agents Certificate (OPAC) (formerly known as Therapeutic Pharmaceutical Agents (TPA)),
2. co-manage not fewer than 15 glaucoma patients with regular input and oversight by a Nevada-licensed ophthalmologist for not less than one year, and
3. provide patient notes and sworn documents from the ophthalmologist and the applicant affirms that the requirements for the certificate have been met.

Upon completion of the requirements and the forms, go to the Board website, click on "For Optometrists" then "Glaucoma by Certification or Glaucoma by Endorsement," complete the application, upload completed required documents and pay the application fee of $175. Payment also may be submitted with a check via US Mail to the address in the above letterhead.

GLAUCOMA CERTIFICATE BY CO-MANAGEMENT
REQUIRED PATIENT INFORMATION

Optometrist Name, License No: ____

Primary Practice Address: ____

Ophthalmologist Signature & date ______________________________ Date: ____________

Optometrist Signature & date ______________________________ Date: ____________

1. HPI Patient No.: ________________

Date Treatment commenced by O.D.:

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Synopsis of treatment plan:

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2. HPI Patient No.: ________________

Date Treatment commenced by O.D.:

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Synopsis of treatment plan:

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3. HPI Patient No.: ________________

Date Treatment commenced by O.D.:

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Synopsis of treatment plan:

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4. HPI Patient No.: ________________

Date Treatment commenced by O.D.:

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Synopsis of treatment plan:

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GLAUCOMA CERTIFICATE BY CO-MANAGEMENT
REQUIRED PATIENT INFORMATION

5. HPI Patient No.: ____________________

Date Treatment commenced by O.D.:

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Synopsis of treatment plan:

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6. HPI Patient No.: ____________________

Date Treatment commenced by O.D.:

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Synopsis of treatment plan:

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7. HPI Patient No.: ____________________

Date Treatment commenced by O.D.:

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Synopsis of treatment plan:

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8. HPI Patient No.: ____________________

Date Treatment commenced by O.D.:

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Synopsis of treatment plan:

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GLAUCOMA CERTIFICATE BY CO-MANAGEMENT
REQUIRED PATIENT INFORMATION

9. HPI Patient No.: ____________________

Date Treatment commenced by O.D.:

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Synopsis of treatment plan:

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10. HPI Patient No.: ____________________

Date Treatment commenced by O.D.:

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Synopsis of treatment plan:

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11. HPI Patient No.: ____________________

Date Treatment commenced by O.D.:

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Synopsis of treatment plan:

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12. HPI Patient No.: ____________________

Date Treatment commenced by O.D.:

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Synopsis of treatment plan:

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GLAUCOMA CERTIFICATE BY CO-MANAGEMENT
REQUIRED PATIENT INFORMATION

13. HPI Patient No.: ____________________

Date Treatment commenced by O.D.:

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Synopsis of treatment plan:

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14. HPI Patient No.: ____________________

Date Treatment commenced by O.D.:

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Synopsis of treatment plan:

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15. HPI Patient No.: ____________________

Date Treatment commenced by O.D.:

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Synopsis of treatment plan:

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OPHTHALMOLOGIST CERTIFICATION OF COMPLIANCE FOR OPTOMETRIST APPLICATION TO TREAT PERSONS WITH GLAUCOMA PURSUANT TO NRS 636.2893, 636.2895

STATE OF ___________________)
) ss.
COUNTY OF _________________)

I, ____, (circle one) M.D. or D.O., Nevada License Number____________, am of lawful age and under penalty of perjury pursuant to NRS 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. ____,O.D., has, in consultation with me, treated not fewer than 15 persons for at least 12 consecutive months each, and in a manner consistent with NAC 636.280 and NAC 636.290.

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 _____day of _________________, _____.

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Ophthalmologist