STATE OF NEVADA

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DEPARTMENT OF BUSINESS AND INDUSTRY
OFFICE OF NEVADA BOARDS, COMMISSIONS AND COUNCILS STANDARDS
NEVADA STATE BOARD OF OPTOMETRY

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

1. successfully complete the "Treatment and Management of Ocular Disease Examination" administered by the National Board of Examiners in Optometry or an equivalent examination approved by the Board;

2. through co-management with an ophthalmologist licensed in this State, the District of Columbia, or any other State or territory of the United States, have treated at least 15 persons who were: (a) Diagnosed with glaucoma by the ophthalmologist or the ophthalmologist confirmed the diagnosis of glaucoma by the optometrist; and (b) Treated by the optometrist in consultation with that ophthalmologist, for at least 12 consecutive months wherein the optometrist conducted at least three optometric examinations of each such patient beginning not earlier than October 1, 1999;

3. hold a Nevada-issued Optometric Pharmaceutical Agents Certificate (OPAC) (formerly known as Therapeutic Pharmaceutical Agents (TPA)); and

4. 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 your completed required documents and pay the application fee of $175. Payment also may be submitted with a check via US Mail to Nevada State Board of Optometry, PO Box 1824, Carson City, NV 89702.

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

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.:

_____

Synopsis of treatment plan:

2. HPI Patient No.: _____

Date Treatment commenced by O.D.:

_____

Synopsis of treatment plan:

3. HPI Patient No.: _____

Date Treatment commenced by O.D.:

_____

Synopsis of treatment plan:

4. HPI Patient No.: _____

Date Treatment commenced by O.D.:

_____

Synopsis of treatment plan:

GLAUCOMA CERTIFICATE BY CO-MANAGEMENT
REQUIRED PATIENT INFORMATION

5. HPI Patient No.: _____

Date Treatment commenced by O.D.:

_____

Synopsis of treatment plan:

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6. HPI Patient No.: _____

Date Treatment commenced by O.D.:

_____

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.:

_____

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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15. 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.:

_____

Synopsis of treatment plan:

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OPHTHALMOLOGIST CERTIFICATION OF COMPLIANCE FOR OPTOMETRIST APPLICATION TO TREAT PERSONS WITH GLAUCOMA

STATE OF _____)
) ss.
COUNTY OF _____)

I, _____, (circle one) M.D. or D.O., 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, District, Commonwealth, or U.S. territory of _____;

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 _____, _____.

_____
Ophthalmologist

OPTOMETRIST CERTIFICATION OF COMPLIANCE
APPLICATION TO TREAT GLAUCOMA PURSUANT TO NRS 636.2895

STATE OF _____)
) ss.
COUNTY OF _____)

I, _____, O.D., am of lawful age and under penalty of perjury pursuant to NRS 53.045 certify as follows:

1. I am a currently licensed and practicing optometrist in the state of Nevada, holding license number_____;

2. I possess a valid Nevada certificate to administer and prescribe optometric pharmaceutical agents pursuant to NAC 636.730;

3. I have submitted a form in compliance with subsection 3 of NRS 636.2893 attesting that I have treated, in consultation with an ophthalmologist licensed in this State, or any other State or territory of the United States, at least 15 persons for at least 12 consecutive months each, and in a manner consistent with NAC 636.280 and NAC 636.290 wherein I conducted at least three optometric examinations of each patient over a period of not less than 1 year beginning no earlier than October 1, 1999;

4. I have provided copies of the medical records for each patient to the co-managing ophthalmologist, together with a proposed course of treatment for each patient;

5. I was notified by the co-managing ophthalmologist that he/she agreed with or recommended adjustments to the course of treatment I outlined; and

6. I 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 penalty of perjury under the laws of the State of Nevada that the foregoing is true and correct.

DATED this _____ day of _____, _____.

_____
Optometrist