Nevada State Board of Medical Examiners
Sentinel Event Report Form for 2010

FOR OFFICIAL USE ONLY

Pursuant to NRS 630.30665 Physician required to report certain information concerning surgeries, this report is to be completed and submitted to the Nevada State Board of Medical Examiners by the date required in the instructions for the preceding calendar year. Failure to report is grounds for disciplinary action.

PLEASE PRINT OR TYPE

Date of Sentinel Event: ___/___/___
MM DD Year

Patient's Nevada County of Residence: _____

Patient's State, or Country, of Residence (if Not Nevada): _____

Patient's Date of Birth: _____

Patient's Gender: _____Male _____Female

Did the sentinel event occur in a practice office: _____Yes _____No

If NO, in what type of facility did the sentinel event occur? **(Do NOT report an event if it took place outside of Nevada or in a facility listed on pages two (2) and three (3) of the Instructions or on Form B.)**

_____

What are the primary and secondary specialties of the physician performing the surgery or procedure?

_____
_____

DESCRIPTION OF SENTINEL EVENT

What was the surgery/procedure being performed? _____

Describe the sentinel event:

_____
_____
_____

OUTCOME OF SENTINEL EVENT *(If death, actual physical injury with permanent loss or actual psychological injury with permanent loss occurred, please indicate.)*

Describe the Outcome:

_____

_____

_____

_____

_____

CORRECTIVE ACTIONS *(If equipment repair or procedure, policy, or process modification or change took place, please indicate.)*

Corrective Action Taken:

_____

_____

_____

_____

_____

SIGNATURE *(Please sign and date below. A separate Sentinel Event Report Form is required for each and every reportable sentinel event. A signature is required on each and every form.)*

Print Name: _____

License Number: _____

Office Address: _____

_____

_____

Doctor's Signature: _____ **Date:** _____