Emergency Providers Organization of Nevada

Nevada Division of Public and Behavioral Health

Nevada Crisis Standards of Care

Registration Application

Please note, all information provided on this registration application will be kept confidential at all times, and is the sole property of the Nevada Division of Public and Behavioral Health, where all employees are regularly trained on HIPAA and confidentiality requirements.

In the event of a catastrophic public health emergency, approved applicants of the Emergency Providers Organization of Nevada (EPON) may be called upon to serve all Nevadans by way of the State Disaster Medical Advisory Committee (SDMAC) to assist in the development of Crisis Standards of Care (CSC) recommendations. CSC recommendations will then be processed through the Nevada Division of Emergency Management to be approved by the Governor.

Approved EPON applicants may also be asked that in a time of a catastrophic emergency, to report to designated healthcare facilities (priority assignments) listed on the EPON ID card in order to best serve those in need based upon the type of disaster. After your application has been vetted and approved by the Nevada Division of Public and Behavioral Health, you may be asked to also register with the state volunteer registry, https://servnv.org/, in order to offer an additional layer of liability protection for your service to the State of Nevada during a catastrophic public health emergency.

Please fill out the application below and return to Malinda Southard, Health Program Manager via email at: msouthard@health.nv.gov; fax: 775-684-5951; or mail to: Nevada Division of Public and Behavioral Health, Public Health Preparedness Program, Attn: Malinda Southard, Health Program Manager, 4150 Technology Way, Suite 200, Carson City, NV 89706.

In order for your application to be considered complete, please attach a 2"x2" passport-style photo (head and shoulders) to be included on your EPON ID card. Digital photos will be accepted with signed application.

SECTION 1: APPLICANT INFORMATION

Full Name:	
Address:	
24-hour Contact #:	
Secondary Telephone #:	
Primary Email:	
Secondary Email:	

SECTION 2: PRIMARY PROFESSIONAL LICENSE INFORMATION

Professional License Type:	
(MD, DO, RN, MA, PA, NP, SA, RT, XRT, DC, Behavioral Health Provider Credentials, etc.), or check ☐ for Student of _____	
***Primary Specialty**:* *If board certified, list certifying board*	
Name of Licensing Board:	
License Number:	
Date of Expiration:	
Name of Liability Insurance Carrier: (if applicable)	
Policy Number: (if applicable)	
***Sub-specialty**:* *If board certified, list certifying board*	
Name of Licensing Board:	
License Number:	
Date of Expiration:	
Name of Liability Insurance Carrier: (if applicable)	
Policy Number: (if applicable)	

SECTION 2A: ADDITIONAL PROFESSIONAL LICENSE INFORMATION

If no additional professional licenses, go to Section 3

Professional License Type:	
***Specialty**:* *If board certified, list certifying board*	
Name of Licensing Board:	
License Number:	
Date of Expiration:	
Name of Liability Insurance Carrier: (if applicable)	
Policy Number: (if applicable)	

SECTION 3: CURRENT EMPLOYMENT INFORMATION

You may list an additional current employer in Section 3A.

Name of Current Employer:	
Address of Current Employer:	
Phone of Current Employer:	
Date Started with Current Employer:	

SECTION 3A: ADDITIONAL EMPLOYMENT INFORMATION

Please complete this section for additional current employer.

Name of Employer:	
Address of Employer:	
Phone of Employer:	

SECTION 4: FACILITY PRIVILEGES

Please list all facilities for which you currently hold privileges.

SECTION 5: PROFESSIONAL REFERENCES

Please list three professional references in your specialty.

Name:	Title:	Phone:	Email:

SECTION 6: ADDITIONAL INQUIRIES

Language(s) Spoken:_____

Can you provide interpreter services? _____ **If so, for what language(s)**:_____

Have you ever been involved in a critical disaster management response? (Y/N) _____

Are you a member of the military? (If so, please check appropriate category below)

Active: ☐ **Retired**: ☐ **Reserves**: ☐

Who is your military employer? (I.e. Dept. of Defense or affiliates) _____

I certify under penalty of perjury under the laws of the State of Nevada, that the information provided on this form and any attachments (including the photo being an accurate representation of me) is true and current:

Name Printed	Title
Signature	Date

The Nevada Division of Public and Behavioral Health will review your application and notify you upon decision. Once your application is approved, the Nevada Division of Public and Behavioral Health will issue you an EPON ID card and information sheet, valid for two years from the date of issuance. Upon expiration of the EPON ID card, you will be asked to fill out an updated EPON application.

PERSONAL INFORMATION COLLECTION, ACCESS AND DISCLOSURE

Disclosure of your personal information is mandatory. Failure to provide any of the required information will result in the form being rejected as incomplete. The information provided will be used to determine member status of the Emergency Providers Organization of Nevada, by the Division of Public and Behavioral Health. The information collected will be retained by the Division of Public and Behavioral Health. Applicants may obtain information regarding the location of submitted forms and records by contacting the Division of Public and Behavioral Health at the contact information located on Page 1 of this Application.