



**POINT-OF-CARE TEST
ANALYST
APPLICATION & CHECKLIST**

Division of Public and Behavioral Health
727 Fairview Drive, Suite E
Carson City, Nevada 89701
Phone: (775) 684-1030 Fax: (775) 684-1075
Website: <http://dpbh.nv.gov/Reg/RegulatoryPgms/>

THIS BOX FOR OFFICAL USE ONLY

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COMPLETE THIS FORM. PLEASE FILL IN THIS FORM ELECTRONICALLY, PRINT, SIGN, DATE AND SUBMIT. *(If unable to complete electronically type or print in black or blue ink and submit)*

INCOMPLETE APPLICATIONS WILL DELAY PROCESSING OF YOUR CERTIFICATE

INDICATE APPLICATION TYPE. *(Check only one):*

- Initial Certificate**
- Reactivation of Certificate**

PERSONAL INFORMATION
Name
Maiden/Previous Name (if applicable)
Social Security Number (REQUIRED)
Date of Birth
Email Address
Mailing Address (Must be home address or PO BOX)
City, State
Zip Code
Phone Number

LABORATORY INFORMATION
Employer/Laboratory Name
Nevada Lab License Number
Laboratory Street Address
City
State
Zip Code
Laboratory Phone Number
Laboratory Fax Number

COMPLETE ALL SECTIONS

(Regulations governing medical laboratories and laboratory personnel may be found at:

<http://leg.state.nv.us/NAC/NAC-652.html>)

Application Attestations *(Check if applicable)*

If you do not provide a method of electronic communication, such as an e-mail address or any other method by which to communicate with you other than by telephone or U.S. mail, you must check this box attesting that this is not feasible and acknowledging that the U.S. mail is the only means which to communicate with you.

Child Support Information: (Must check one box)

- I am not subject to a court order for the support of a child.
- I am subject to a court order for the support of one or more children and am in compliance with the order or with a plan approved by the district attorney or other public agency enforcing the order for repayment of the amount owed pursuant to the order.
- I am subject to a court order for the support of one or more children and I am not in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order. You are required to contact the district attorney or other public agency enforcing the order to determine the actions that you may take to satisfy the arrearage.

❖ Your application **will be denied** if you do not complete this section.

Certified in Nevada (laboratory personnel) (Indicate Yes or No)

Do you currently hold a Nevada laboratory personnel certificate? Yes No

If yes, provide your certification number here: _____

INITIAL APPLICANTS MUST COMPLETE THIS SECTION

I have submitted with my application (Must check both boxes):

- A signed, dated letter on laboratory letterhead or a certificate from a director verifying that I have successfully completed training approved by the director in the performance of the preanalytic, analytic and postanalytic phases of point-of-care tests **AND** which lists the specific tests I have been trained to perform.
- A copy of my professional license or on-line verification results showing I have an active **Nevada license/certificate as** a registered nurse, an advanced practice registered nurse, a licensed practical nurse, a practitioner of respiratory care, a physician assistant, a registered pharmacist who has participated in the development of written guidelines and protocols as described in subsection 8 of [NRS 639.0124](#) **or** a certified laboratory assistant who has successfully completed training approved by a director in performing point-of-care tests.

IF YOU ARE APPLYING FOR A REACTIVATION OF A CERTIFICATE YOU MUST COMPLETE THIS SECTION

(Must check both boxes)

- I have submitted with my application copies of my CEU certificates which add up to 10 CEU contact hours.
- I certify it has been 5 years or less since my certification has expired.

Note: If it has been more than 5 years since your certification has expired you must apply as an Initial Applicant by completing the initial applicant's section.

Previous Certification Number: _____ Expiration Date: _____

I understand that knowingly making a false statement on this application will be cause for denial, suspension, or revocation of licensure. I have examined this application and it is complete. I declare under penalty of perjury that the foregoing is true and correct.

Executed on:

Applicant's Signature: _____ Date: _____

ALL APPLICANTS MUST SUBMIT, WITH YOUR APPLICATION, TO THE ADDRESS PROVIDED BELOW:

- A completed, signed **and** dated application.
- A **\$75** fee via personal check, cashier's check or money order. **Pay to the order of Nevada State Treasurer.**
- All documents required to be submitted with this application.

Notes:

- ❖ Where letters are required, if it takes more than one letter to show you have the required years of experience please include all letters needed.
- ❖ Certificate issued is valid for two (2) years after the date on which it was issued.
- ❖ You may work as a temporary employee for a period not exceeding 6 months while the application is being processed.
- ❖ It is your responsibility to renew your certification before it expires, regardless of whether you receive a renewal notification or not.
- ❖ Allow up to six months processing time.
- ❖ If insufficient funds are submitted a \$25 fee will be assessed.

Submit completed application, including all requested documentation and fee to:

Division of Public and Behavioral Health
Medical Laboratory Services
727 Fairview Drive, Suite E
Carson City, NV 89701

If you have any questions please contact 775-684-1030 and request Medical Laboratory Services.

Change of Information

You must notify the Division of any change to the information contained in your application within 30 days after the change by completing and submitting the Change of Name or Address Form for Clinical Laboratory Personnel found at:

<http://dpbh.nv.gov/uploadedFiles/dpbhngov/content/Reg/MedicalLabs/Docs/Applications/changeofaddress.pdf> Failure to comply with this requirement is grounds for denial of your application or the suspension or revocation of your license, as applicable.