State of Nevada
Division of Public and Behavioral Health

727 Fairview Drive, Suite E
Carson City, NV 89701
Phone: 775-684-1030 Fax: 775-684-1073

Request for Approval of New Provider

This form is to be completed by the new provider in conjunction with the supervisor for the agency.

New Provider Information

Name: _____

Address: _____

Telephone: _____ Fax: _____

Email Address: _____

Agency Information

Name of Requesting Agency: _____

Agency Address: _____

Name of Requesting Supervisor: _____

Qualifications Checklist: Please check the following boxes to indicate the individual meets the minimum qualifications for a provider of treatment as required by NAC 228.110

NAC 228.110	*PROVIDER* Qualification	YES	NO
§ 7(a)	Bachelors or more advanced degree. Please provide a copy or other proof of the degree. ***This requirement can be waived in counties with populations of less than 50,000. See* § 9(a-c). **Attach copy of diploma.**		
§ 7(b)	Supervised by qualified supervisor of treatment.		
§ 7(d)	**Attach a copy of the training log.** ***Up to 30 hours may be completed via distance media.* ***Provider must have completed at least 15 hours of approved training within the immediately preceding two years.*		
§ 7(f)	**Attach a copy of the observation log.** ***This training may be completed by observing videotapes of group counseling sessions in counties with populations of less than 50,000. See* § 11(a-c)		
§ 7(g)	I attest I have never been convicted of a crime which demonstrates unfitness to act as a provider of treatment.		
§ 7(h)	I attest I am free of violence.		
§ 7(i)	I attest I am not currently an abuser of prescription drugs or alcohol or a user of illegal drugs.		

In-Service Observation Log: Use this page to document 60 observation hours required by NAC 228.110

Name of Provider: _____

Date of Observation	Agency	Signatures of Facilitators	# of Hours
_____	_____	_____/_____	_____
_____	_____	_____/_____	_____
_____	_____	_____/_____	_____
_____	_____	_____/_____	_____
_____	_____	_____/_____	_____
_____	_____	_____/_____	_____
_____	_____	_____/_____	_____
_____	_____	_____/_____	_____
_____	_____	_____/_____	_____
_____	_____	_____/_____	_____

Total Hours Observing Male/Female Co-Facilitated Batterer Treatment Groups _____

Note: Total hours must be 60 or more. Copy this form as needed.

Formal Training Log

This form should document formal training hours (all certificates must be attached with request). Please note that only ½ of the formal training may be obtained via distance media. Please indicate whether the course has a clinical component.

Name:_____

Title of Training	Number of Hours	Date Completed	Was this course Completed via Distance Media?	
			Yes	No
			Yes	No
			Yes	No
			Yes	No
			Yes	No
			Yes	No
			Yes	No
			Yes	No
			Yes	No
			Yes	No
			Yes	No
			Yes	No
			Yes	No
			Yes	No
			Yes	No
			Yes	No
			Yes	No
			Yes	No
			Yes	No
			Yes	No
			Yes	No
			Yes	No

Declaration

I hereby declare, under penalty of perjury, that all information provided and attached to this application is to the best of my knowledge true, accurate and complete and I have not withheld, misrepresented, or falsely stated any information relevant to this application.

Original Signature of New Provider _____ Date _____

Original Signature of Agency Supervisor _____ Date _____

You must fill out this form in its entirety.

Please retain form on file with all supporting documents. You may be audited and required to submit this form with supporting documents at any time. Failure to be in compliance may result in action on your certificate, including being put on probation or suspension or revocation of your certificate.