TRAINING HEALTH CARE PROVIDER AUTHORIZATION

(TO REMAIN IN RECIPIENT'S FILE)

I the undersigned, health care provider as defined by NRS 629.091 do hereby attest that I have trained: _____ in how to complete the following service(s)
(Name of the Personal Assistant)
for the recipient: _____.
(Name of the recipient)

1._____

2._____

3._____

4._____

5._____

6._____

7._____

The personal assistant:_____ has
(Name of the Personal Assistant)
demonstrated the knowledge, skill and ability to perform these service(s) competently.

The personal assistant:_____
(Name of the Personal Assistant)
had agreed to refer the recipient:_____
(Name of the recipient for the Self Directed Skilled Services)
back to the attention of the recipient's primary physician, _____
(Physician name and phone number)
when:

1. The condition of the recipient changes or a new medical condition develops.
2. The recipient or their personal care or legal representative becomes unable to self direct the services/care authorized.
3. The progress or the condition of the recipient after the provision of a service is different than expected.
4. An emergency develops.
5. Any other situation described by me occurs; this may include the following:

   a. _____

   b. _____

   c. _____

A provider of health care who determines in good faith that a personal care assistant has complied with and meets the requirements of this section is not liable for civil damages as a result of any act or omission, not amounting to gross negligence, committed by him in making such a determination and is not liable for any act of omission of the personal care assistant, per NRS 629.091.

A new Health Care Provider authorization form will need to be completed:

1. If the patient/recipient's condition changes in regard to stable and predictable;
2. Annually; and
3. If the authorized personal care assistant is unavailable and a new personal care assistant needs to be authorized.

Authorized Health Care Provider's Signature and Title	Date

Authorized Health Care Provider's Name and Title
(typed or printed)

Distribution

Original:	ISO Recipient File
Copy to:	Recipient or Personal Care or Legal Representative
	Personal Care Assistant
	Authorizing Health Care Provider