

Application to Participate in Nevada DIRECT (NV DIRECT) Secure Messaging Service

Please mail complete application to:

Nevada Office of Health Information Technology
Department of Health and Human Services
4126 Technology Way, Suite 100, Carson City, NV 89706 (775) 684-7591

Applicant requests to enroll and participate in NV DIRECT and agrees to all of the following:

- Review two key provisions of the HIE-enabling legislation passed by the Nevada Legislature in 2011 (NRS 439.581-595).
 - NRS 439.591, patient consent for the transmittal of PHI via an HIE system, such as NV DIRECT, is required. Some providers are incorporating this requirement into their HIPAA consent process.
 - NRS 439.595 provides immunity from liability, under specific conditions, for health care providers who use an HIE system, such as NV DIRECT, to receive PHI and make clinical care decisions based on that information.
- Complete the NV DIRECT Participant Attestation Form after successfully sending a clinical message via the NV DIRECT Secure Messaging Service.
- Complete and submit all enrollment documents:
 - Application
 - Participant Agreement
 - Certificates of Insurance (see Participant Agreement)

Principal Applicant (All fields must be completed)

Last Name First/Middle Name

Medical License No.
(If applicable)

License Type: MD DO PA RN APN
 Other, specify.

National Provider Identifier
(If applicable)

Organization Name

Nevada Business License Number:

Business Address:

City State Zip

Business Phone Number Email

Organizational Applicants

If signing on behalf of multiple health care providers and clinical staff of an organization, please complete the following for each member who is requesting to participate in NV DIRECT (use additional sheet if necessary)

Last Name	First Name	National Provider ID	Medical License #	License Type or Clinical Title	Email address

Please check one:

- Applicant is a Health Care Provider that is a Covered Entity as described at 45 C.F.R. § 160.103.
- Applicant is signing on behalf of Health Care Providers that are Covered Entities as described at 45 C.F.R. § 160.103.

Does the applicant have an Electronic Health Record or Electronic Medical Record (EHR or EMR)?

- Yes No

If yes, please provide: EHR/EMR Vendor

System Name

Version:

Will the applicant be participating in NV DIRECT to demonstrate the ability to share clinical data electronically in order to meet Meaningful Use requirements for the EHR Incentive Reimbursement Program?

- Yes No

Subscription:

- Connectivity grant funds available for the first 200 NV DIRECT qualifying participants, waiving the initial subscription fee of \$125.
- Future annual costs will be determined within the next year.

I hereby attest and certify that I am fully authorized to submit this application for participation in NV DIRECT, and that the information provided is true, complete, accurate, and reflects the Applicant's activities.

(Sign in the Presence of a Notary)

Signature

Date

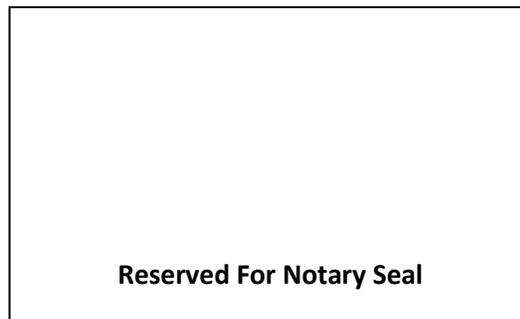
Print Name

State of Nevada
County of _____

I hereby certify that on this _____ day of _____, in the year 201____, before me, _____ personally appeared the signer and subject of this Application to Participate in NV DIRECT Secure Messaging Service, has signed and affirmed to the same in my presence.

WITNESS my hand and official seal.

Notary Signature



Printed Name

My Commission Expires: _____

Date Application Received: _____	
By: _____ (signature)	Print Name: _____
Approved: ____ Yes ____ No	Date: _____
Approved By: _____ (signature)	
Print Name: _____	\$125 Fee Waived <input type="checkbox"/> Yes <input type="checkbox"/> No