New Mexico Medical Board
2055 S. Pacheco Street
Building 400
Santa Fe, NM 87505
505-476-7220 505-476-7233 fax

Certification of Training
For Use of Medical Therapeutic and Cosmetic Devices

Please review Rule 16.10.13 prior to completing this form.

General Information:

Name of Medical Assistant: _____
Last First MI

Address of Medical Assistant: _____

_____
City State Zip Phone

_____
Email address

Supervising Physician (MD): _____
Name NM Medical License #

_____
Practice Name Phone

_____
Practice Address City State Zip

_____
Email address

Medical Therapeutic or Cosmetic Device Information:

Name and description of device: _____

Manufacturer:_____

Intended Use of Device:_____

Hours of Training on Device:_____

Name and Affiliation of Trainer:_____

Please attach training outline* and CV of trainer

***** Training outline must include device physics and safety, basic principles of use, clinical application of the device, indications for use, contraindications for use, pre-operative care, post-operative care, recognition and acute management of complications, and infectious disease procedures. ***No service may be provided until this form and all documentation is received by the Board.***

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Certification:

I certify that I am the supervising physician (MD) named in this document and assume full responsibility for the medical assistant named above. I also acknowledge that I have read and understand the rules pertaining to the supervision of medical assistants using medical therapeutic or cosmetic devices as defined in 16.10.13 of the Medical Board Rules.

Physician Signature_____

Date

I certify that the information contained in this form is an accurate description of the training I have received. I further acknowledge that I have read and understand the rules pertaining to the use of medical therapeutic or cosmetic devices by medical assistants.

Medical Assistant Signature_____

Date