**New Mexico Medical Board**
2055 S. Pacheco Street, Bldg. 400
Santa Fe, NM 87505
505-476-7220, fax 505-476-7237

# 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: _____
Address

_____
City State Zip

Supervising Physician: _____
Name NM License Number

_____
Practice Name

_____
Practice Address City State Zip

## 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 certification of C.V. of trainer.

## Certification:

*I certify that I am the supervising physician 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_____

*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_____

***No service may be provided until this form and all documentation is received by the Board.***

***** 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.