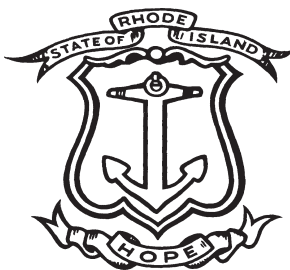


**FOR OFFICE USE ONLY**  
**Naturopathic Physician Checklist**

App. & Fee  
 Naturopathic College Transcript  
 NPLEX Scores - Part I and Part II  
 Collaboration & Consultation Agreement  
 Out of State License Verification



**\*\*\*FOR OFFICE USE ONLY\*\*\***

Receipt # \_\_\_\_\_

ID # \_\_\_\_\_

Issue Date \_\_\_\_\_

License # \_\_\_\_\_

**Rhode Island Department of Health  
 Naturopathic Physician Licensure**

Room 205  
 3 Capitol Hill  
 Providence, RI 02908-5097

***Instructions and License/Application for:***

**Naturopathic Physician**

License # \_\_\_\_\_

Name \_\_\_\_\_

**MILITARY STATUS ELIGIBILITY** *(Documentation Required)*  
*see next page for instructions*

Please check ONE of the following criteria for expedited application:

I am in active military duty or a reservist  
 I am a military veteran with honorable discharge  
 I am the spouse of someone in active military duty or the spouse of a reservist

*Applicant - Print Name*

<i>LAST NAME</i>	<i>FIRST NAME</i>	<i>MI</i>

**Phone: (401) 222-3855**

**TTY/TDD: (800) 745-5555**

**Fax: (401) 222-2158**

# LICENSURE REQUIREMENTS

- Completed Application with Cover Page - Applications are valid for 1 year from the day they are received at RIDOH. If you are not licensed within the year you must submit a new application.
- Check or money order (preferred), made payable (in U.S. funds only) to the RI General Treasurer in the amount of **\$310.00** and attached to the upper left-hand corner of the first (Top) page of the application. THIS APPLICATION FEE IS NONREFUNDABLE. Please be advised that this is an application fee includes the first license **only** up until the next expiration date. All licenses expire biennially from the issue date of this license.
- Official Naturopathic College Transcript submitted directly to this office by the Naturopathic School.
- NPLEX Exam results, Part I and Part II from the North American Board of Naturopathic Examiners (NABNE) sent directly to this office.
- Written collaboration and consultation agreement with a RI licensed physician which shall include all items listed under RIGL 5-36-1 et. al
- If you have ever been licensed in another state, license verification(s) must be sent directly from the state(s) in which you hold or have held a license. (Interstate Verification Form included in this application can be used for that purpose)
- If applying for expedited military status, please complete the Military Expedition Form at the end of this application packet.

## Licensure Information

Please visit the RIDOH website at <http://www.health.ri.gov/licenses> to Verify your license, download Rules and Regulations/Laws for your profession, download change of address forms, other licensing forms or obtain our contact information. HEALTH will not, for any reason, accelerate the processing of one applicant at the expense of others.

## License Certificates

RIDOH will be providing wallet license cards ONLY on issuance of licenses. If you wish to receive a license certificate, suitable for framing, please check the box below and attach a separate check in the amount of \$30.00 made payable to RI General Treasurer.

- I would like to receive a license certificate. I have enclosed a separate check in the amount of \$30.00



# State of Rhode Island

## Naturopathic Physician Licensure

### Application for License to Practice as a Naturopathic Physician

Refer to the Application Instructions when completing these forms. Type or block print only. Do not use felt-tip pens.

#### 1. Name(s)

This is the name that will be printed on your License/Permit/Certificate and reported to those who inquire about your License/Permit/Certificate. Do not use nicknames, etc.

**All questions MUST be answered. Enter "NA" for any question that is NOT APPLICABLE.**

First Name

Middle Name

Surname, (Last Name)



Suffix (i.e., Jr., Sr., II, III)

Degree (DMD,DDS)

Maiden, if applicable

Name(s) under which originally licensed in another state, if different from above (First, Middle, Last).

#### 2. Social Security Number

 -  - 

U.S. Social Security Number

**"Pursuant to Title 5, Chapter 76, of the Rhode Island General Laws, as amended, I attest that I have filed all applicable tax returns and paid all taxes owed to the State of Rhode Island, and I understand that my Social Security Number (SSN) will be transmitted to the Division of Taxation to verify that no taxes are owed to the State."**

#### 3. Gender

 Male

 Female

#### 4. Date of Birth

 /  /  **1**  **9** 

Month

Day

Year

#### 5. Home Address

It is your responsibility to notify the board of all address changes.

1st Line Address (Apartment/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City

State

 - 

Zip Code

Country, if NOT U.S.

Postal Code, if NOT U.S.

 - 

Home Phone

 - 

Home Fax

Email Address (Format for email address is Username@domain e.g. applicant@isp.com)

#### 6. Primary Business Address

It is your responsibility to notify the board of all address changes.

**This address will appear on the Department of Health web site.**

Name of Business/Work Location

1st Line Address (Department/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City

State

 - 

Zip Code

Country, if NOT U.S.

Postal Code, if NOT U.S.

 - 

Business Phone

Extension

 - 

Business Fax

<b>7. Preferred Mailing Address</b> Please check <u>ONE</u>	<input type="checkbox"/> Please use my <b>Home Address</b> as my preferred mailing address  <input type="checkbox"/> Please use my <b>Business Address</b> as my preferred mailing address
--	--

<b>8. Qualifying Education</b>  Please list the name and information about the school that you attended that qualifies you for this license.	<table style="width:100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; height: 15px; width: 100%;"></td> </tr> <tr> <td style="font-size: 8px;">Type of School (University, College, etc.)</td> </tr> <tr> <td style="border: 1px solid black; height: 15px; width: 100%;"></td> </tr> <tr> <td style="font-size: 8px;">Name of School</td> </tr> <tr> <td style="border: 1px solid black; width: 100px; height: 15px;"></td> <td style="border: 1px solid black; width: 100px; height: 15px;"></td> </tr> <tr> <td style="font-size: 8px;">Date Graduated</td> <td style="font-size: 8px;">Date Graduated</td> </tr> <tr> <td style="font-size: 8px; text-align: center;">Month</td> <td style="font-size: 8px; text-align: center;">Year</td> </tr> </table>		Type of School (University, College, etc.)		Name of School			Date Graduated	Date Graduated	Month	Year
Type of School (University, College, etc.)											
Name of School											
Date Graduated	Date Graduated										
Month	Year										

<b>9. National Board Examination</b>  Please indicate the date of your examination and whether you passed.	Date Completed <table style="display: inline-table; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 15px;"></td> <td style="border: 1px solid black; width: 20px; height: 15px;"></td> <td style="padding: 0 5px;">Month</td> </tr> </table> <table style="display: inline-table; border-collapse: collapse; margin-left: 20px;"> <tr> <td style="border: 1px solid black; width: 20px; height: 15px;"></td> <td style="border: 1px solid black; width: 20px; height: 15px;"></td> <td style="border: 1px solid black; width: 20px; height: 15px;"></td> <td style="border: 1px solid black; width: 20px; height: 15px;"></td> <td style="padding: 0 5px;">Year</td> </tr> </table> Passed? <input type="checkbox"/> <input type="checkbox"/>			Month					Year
		Month							
				Year					

<b>10. Naturopathic Physician Licensure</b>  List all states or countries in which you are now, or ever have been licensed to practice naturopathic medicine	<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width: 50%; vertical-align: top;">                     State/Country: _____  <input type="checkbox"/> Active    <input type="checkbox"/> Inactive                 </td> <td style="width: 50%; vertical-align: top;">                     State/Country: _____  <input type="checkbox"/> Active    <input type="checkbox"/> Inactive                 </td> </tr> <tr> <td style="vertical-align: top;">                     _____  <input type="checkbox"/> Active    <input type="checkbox"/> Inactive                 </td> <td style="vertical-align: top;">                     _____  <input type="checkbox"/> Active    <input type="checkbox"/> Inactive                 </td> </tr> <tr> <td style="vertical-align: top;">                     _____  <input type="checkbox"/> Active    <input type="checkbox"/> Inactive                 </td> <td style="vertical-align: top;">                     _____  <input type="checkbox"/> Active    <input type="checkbox"/> Inactive                 </td> </tr> <tr> <td style="vertical-align: top;">                     _____  <input type="checkbox"/> Active    <input type="checkbox"/> Inactive                 </td> <td style="vertical-align: top;">                     _____  <input type="checkbox"/> Active    <input type="checkbox"/> Inactive                 </td> </tr> </table> <p><b>DOCUMENTATION:</b> Send a Reciprocity Release Form to each entity.</p>	State/Country: _____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive	State/Country: _____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive	_____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive	_____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive	_____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive	_____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive	_____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive	_____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive
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_____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive	_____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive								
_____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive	_____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive								
_____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive	_____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive								

<b>11. Collaborative Agreement RI Licensed Physician</b>	Please list the name and license number of the RI licensed physician in which you have entered into a Collaborative Agreement.				
	<table style="width:100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; height: 15px; width: 100%;"></td> </tr> <tr> <td style="font-size: 8px;">Physician Name</td> </tr> <tr> <td style="border: 1px solid black; height: 15px; width: 100%;"></td> </tr> <tr> <td style="font-size: 8px;">RI License Number</td> </tr> </table>		Physician Name		RI License Number
Physician Name					
RI License Number					

<b>12. Board Discipline</b>  List any disciplinary actions by licensing boards in other states.  <input type="checkbox"/> Check here if not applicable.	<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width: 60%;">                     Licensing Board (abbreviate) and Nature of Action (e.g. TX - Professional Misconduct):                 </td> <td style="width: 10%; text-align: center;">                     Month                 </td> <td style="width: 10%; text-align: center;">                     Year                 </td> <td style="width: 20%;">                     Type of Discipline:                 </td> </tr> <tr> <td style="border-bottom: 1px solid black;"></td> <td style="text-align: center;"> <table style="display: inline-table; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 15px;"></td> <td style="border: 1px solid black; width: 20px; height: 15px;"></td> </tr> </table> </td> <td style="text-align: center;"> <table style="display: inline-table; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 15px;"></td> <td style="border: 1px solid black; width: 20px; height: 15px;"></td> </tr> </table> </td> <td style="border-bottom: 1px solid black;"></td> </tr> <tr> <td style="border-bottom: 1px solid black;"></td> <td style="text-align: center;"> <table style="display: inline-table; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 15px;"></td> <td style="border: 1px solid black; width: 20px; height: 15px;"></td> </tr> </table> </td> <td style="text-align: center;"> <table style="display: inline-table; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 15px;"></td> <td style="border: 1px solid black; width: 20px; height: 15px;"></td> </tr> </table> </td> <td style="border-bottom: 1px solid black;"></td> </tr> </table> <p><b>Please describe any <u>prior or pending Board action or investigation</u>. Please attach any relevant supplemental materials. If necessary you may continue of a separate 8 1/2 x 11 sheet of paper.</b></p>	Licensing Board (abbreviate) and Nature of Action (e.g. TX - Professional Misconduct):	Month	Year	Type of Discipline:		<table style="display: inline-table; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 15px;"></td> <td style="border: 1px solid black; width: 20px; height: 15px;"></td> </tr> </table>			<table style="display: inline-table; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 15px;"></td> <td style="border: 1px solid black; width: 20px; height: 15px;"></td> </tr> </table>					<table style="display: inline-table; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 15px;"></td> <td style="border: 1px solid black; width: 20px; height: 15px;"></td> </tr> </table>			<table style="display: inline-table; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 15px;"></td> <td style="border: 1px solid black; width: 20px; height: 15px;"></td> </tr> </table>			
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**13. Criminal Convictions**

Respond to the question at the top of the section, then list any criminal conviction(s) in the space provided.

If necessary, you may continue on a separate 8 1/2 X 11 sheet of paper.

Have you ever been convicted of a violation, plead Nolo Contendere, or entered a plea bargain to any federal, state or local statute, regulation, or ordinance or are any formal charges pending; including use of illicit substances or operating a motor vehicle while intoxicated. (Please include any offenses which have been expunged from your record)?  Yes  No

Abbreviation of State and Conviction<sup>1</sup> (e.g. CA - Illegal Possession of a Controlled Substance):

_____	Month	Year
	<input type="text"/>	<input type="text"/>
_____	<input type="text"/>	<input type="text"/>
_____	<input type="text"/>	<input type="text"/>

<sup>1</sup>For purposes of this section, a person shall be deemed to be convicted of a crime if he/she plead guilty or if he/she was found or adjudged guilty by a court of competent jurisdiction or has been convicted of a felony by the entry of Nolo Contendere in any state.

**14. Questions**

Check either Yes or No for each question.

NOTE: If you answer "Yes" to any question, you are **required** to furnish complete details, including date, place, reason and disposition of the matter.

1. Has any Health Professional license, certificate, registration, or permit you hold or have held, been disciplined or are any formal charges pending?  Yes  No
2. Have you ever been denied a license, certificate, registration or permit in any state?  Yes  No
3. Are you physically and mentally fit to practice naturopathy with or without reasonable accomodation?  Yes  No

**Note:** If you answered "yes" to any of these questions you must submit a written explanation on a separate 8 1/2 X 11" sheet of paper.

**15. Affidavit of Applicant**

Complete this section and sign.

Make sure that you have completed all components accurately and completely.

I, \_\_\_\_\_, affirm that the information provided on my application form and documentation provided to support my application is true, accurate and unaltered. I acknowledge that pursuant to R.I.G.L. 11-18-1, knowingly making a false statement on my application form is punishable as a misdemeanor and that such an act shall constitute case for denial, suspension or revocation of my license/permit to practice as a Naturopathic Physician in the State of Rhode Island.

I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Department of Health of any change in the answers to these questions after this application and this affidavit is signed.

Signature of Applicant \_\_\_\_\_

Date of Signature (MM/DD/YY) \_\_\_\_\_



Substitute forms are not acceptable. This form may be duplicated as needed.

# Rhode Island Naturopathic Physician Licensure

Room 205, 3 Capitol Hill  
Providence, RI 02908-5097  
(401) 222-2828

## RECIPROCITY RELEASE FORM

I am applying for a license to practice as a naturopathic physician in the State of Rhode Island. The Rhode Island Department of Health requires that the following form be completed by the jurisdiction in which I am now or was previously licensed. This constitutes your authority to release all information in your files, favorable or otherwise, directly to the Rhode Island Department of Health at the above address.

Print/Type Full Name

Signature

Date

Previous Names Used

Social Security Number

Date of Birth

License Number

Date Issued

### THIS SECTION TO BE COMPLETED BY THE BOARD

Basis for issuing License:

NPLEX

License Status:  Active  Inactive  Lapsed

Original Date Issued:

Expiration Date:

Questions:

- Has this naturopathic physician ever been investigated by your Board?  Yes  No
- Has this naturopathic physician incurred any disciplinary proceedings in your state, or is any action pending?  Yes  No
- Has the applicant's license ever been denied, surrendered, reprimanded, suspended, revoked or placed on probation?  Yes  No
- Are you aware of any information about this naturopathic physician submitted to the National Practitioner Data Bank?  Yes  No
- Do you know of any information that may discredit this person?  Yes  No

If you answer "Yes" to questions 1-5, please provide a written explanation below, and attach a copy of all supporting documentation (e.g., Board order, complaint, etc.).

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Certification:

Signature \_\_\_\_\_ Date \_\_\_\_\_

Type or Print Name \_\_\_\_\_

Title \_\_\_\_\_

Full Name and of Licensing Board including State \_\_\_\_\_



Please Affix Board Seal Here

Please return directly to the Department at the above address. Thank you for your prompt cooperation.



## Rhode Island Department of Health Military Expedition Form

Please attach this form to the *front* of your completed application and mail to the address shown on the application cover.

Pursuant to Rhode Island General Laws § [5-88-1](#) et seq., upon application, this state may recognize occupational licenses, certificates or permits obtained from other states for military members and their spouses who relocate to this state pursuant to military orders. The Rhode Island Department of Health (RIDOH) will expedite your or your spouse's health professional license application provided the following conditions are met.

### I. PROFESSION/LICENSE TYPE

Please indicate the profession and/or license type you are applying for so that your application can be routed to the correct office:

Profession/License Type: \_\_\_\_\_

### II. MILITARY STATUS

Please check ONE of the following criteria for expedition:

I am in active military duty or a reservist.

I am the spouse of someone in active military duty or the spouse of a reservist.

I am a military veteran with honorable discharge. *You do not need to complete the rest of this application – please skip to the signature line.*

### III. PROOF OF MILITARY STATUS

Please attach a copy of proof of your military status such as one of the following: Leave Earning Statement (LES), Letter from Command, or Copy of Orders

### IV. MILITARY CHANGE OF STATION ORDER

Permanent Change of Station Order

### V. PROOF OF GOOD STANDING

Proof of good standing from the board in the other state in which the person has a license.

### VI. Criminal Background Check (a "BCI") (*unless required in the initial license application*)

BCI completed from the RI Attorney General's Office.

### VII. ATTESTATIONS:

Check all that apply:

No board in any other state has revoked the license for which I am applying as a result of negligence or intentional misconduct.

I have never surrendered an occupational license, certificate, or permit because of negligence or intentional misconduct.

I do not have a complaint, allegation, or investigation currently pending before a board in another state which relates to unprofessional conduct or an alleged crime.

I attest that the above responses and information are true and accurate to the best of my knowledge and that none of the information set forth above is false, erroneous, or defective in any important, as set forth in R.I. Gen. Laws § 11-18-1. I understand that this application is being made to the Rhode Island Department of Health, which shall rely upon my attestation and the information provided in this document.

Signature of Applicant

Date

*On a case-by-case basis RIDOH may grant a temporary license should the military member or spouse need additional time to complete education, training, and/or experience for the licensure in Rhode Island. RIDOH will contact the applicant directly should that be needed.*