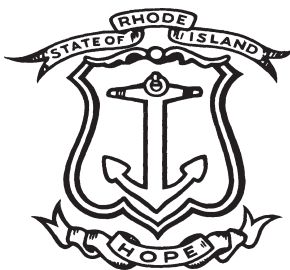


FOR OFFICE USE ONLY
Naturopathic Physician Checklist

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

LAST NAME

FIRST NAME

MI

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 you must include one of the following: Leave Earning Statement (LES), Letter from Command, Copy of Orders or DD-214 showing honorable discharge.

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

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

8. Qualifying Education 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										

9. National Board Examination 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> </tr> <tr> <td style="font-size: 8px; text-align: center;">Month</td> <td style="font-size: 8px; text-align: center;">Year</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> <td style="border: 1px solid black; width: 20px; height: 15px;"></td> <td style="border: 1px solid black; width: 20px; height: 15px;"></td> </tr> <tr> <td style="font-size: 8px; text-align: center;">Year</td> <td colspan="3"></td> </tr> </table> Passed? <input type="checkbox"/> <input type="checkbox"/>			Month	Year					Year			
Month	Year												
Year													

10. Naturopathic Physician Licensure 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%; border-bottom: 1px solid black;">State/Country:</td> <td style="width: 10%;"></td> <td style="width: 10%; text-align: center;"><input type="checkbox"/> Active <input type="checkbox"/> Inactive</td> <td style="width: 50%; border-bottom: 1px solid black;">State/Country:</td> <td style="width: 10%;"></td> <td style="width: 10%; text-align: center;"><input type="checkbox"/> Active <input type="checkbox"/> Inactive</td> </tr> <tr> <td style="border-bottom: 1px solid black;"></td> <td></td> <td style="text-align: center;"><input type="checkbox"/> Active <input type="checkbox"/> Inactive</td> <td style="border-bottom: 1px solid black;"></td> <td></td> <td style="text-align: center;"><input type="checkbox"/> Active <input type="checkbox"/> Inactive</td> </tr> <tr> <td style="border-bottom: 1px solid black;"></td> <td></td> <td style="text-align: center;"><input type="checkbox"/> Active <input type="checkbox"/> Inactive</td> <td style="border-bottom: 1px solid black;"></td> <td></td> <td style="text-align: center;"><input type="checkbox"/> Active <input type="checkbox"/> Inactive</td> </tr> <tr> <td style="border-bottom: 1px solid black;"></td> <td></td> <td style="text-align: center;"><input type="checkbox"/> Active <input type="checkbox"/> Inactive</td> <td style="border-bottom: 1px solid black;"></td> <td></td> <td style="text-align: center;"><input type="checkbox"/> Active <input type="checkbox"/> Inactive</td> </tr> </table> <p>DOCUMENTATION: 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
State/Country:		<input type="checkbox"/> Active <input type="checkbox"/> Inactive	State/Country:		<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																				

11. Collaborative Agreement RI Licensed Physician	Please list the name and license number of the RI licensed physician in which you have entered into a Collaborative Agreement.
	Physician Name
	RI License Number

12. Board Discipline 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%; border-bottom: 1px solid black;">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%; border-bottom: 1px solid black;">Type of Discipline:</td> </tr> <tr> <td style="border-bottom: 1px solid black;"></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-bottom: 1px solid black;"></td> </tr> <tr> <td style="border-bottom: 1px solid black;"></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-bottom: 1px solid black;"></td> </tr> </table> <p>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.</p>	Licensing Board (abbreviate) and Nature of Action (e.g. TX - Professional Misconduct):	Month	Year	Type of Discipline:								
Licensing Board (abbreviate) and Nature of Action (e.g. TX - Professional Misconduct):	Month	Year	Type of Discipline:										

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 Conviction¹ (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"/>

¹For 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.).

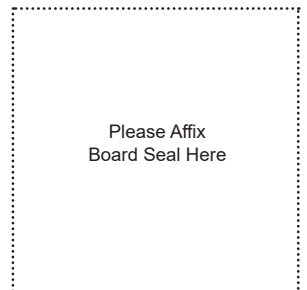
Certification:

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.