NATUROPATHIC MEDICAL DOCTOR APPLICATION CHECKLIST

FEES:

Once your application fee of $300 has been received, processing of your application will begin. Application and all license fees are non-refundable. Starting July 1, 2020 applications may be found on the Board of Medicine website, bom.idaho.gov, and will be available for completion and submission to the Board.

LICENSURE FORMS *(Please complete the following forms)*:

APP1: Complete all sections including schooling, exam, and state licensure history. If Applicant has not applied for registration/licensure in other states, write "Not Applicable" in the appropriate section. Applications will be returned for completion of missing information and may delay licensing.

APP2: Complete all sections. Attach additional sheets, if necessary, for employment history. Answer all questions 1-8. Provide details, if necessary, on a separate sheet. Court documents may be required. Application **must** be notarized by a notary public and signed by applicant and original should be mailed to the Board of Medicine.

Fingerprint Card – Once the application is received with payment, the Board will mail you a fingerprint card and the Noncriminal Justice Applicant Privacy Statement. Take the Fingerprint Card to a law enforcement office and return with Noncriminal Justice Applicant Privacy Statement form. **Per the requirements of the FBI, fingerprint cards can only be mailed to and returned from Applicant's personal address.**

AUTHORIZATION FOR RELEASE OF INFORMATION: Without this completed & notarized form, the Board may only discuss the pending status with the applicant.

IDENTITY – As proof of identity, the Board will accept Passports or Birth Certificates. If your current last name does not match the one on your proof of identity, documentation will be required, i.e. marriage license or divorce decree.

EDU: CERTIFICATE OF NATUROPATHIC MEDICAL DOCTOR PROGRAM - Fill in top section. Be sure to sign **at the bottom**. Send this form to Naturopathic Medical Doctor program (Registrar/Program Director) where Applicant completed training. Registrar/Program Director will then return completed form **and** transcripts to the Board of Medicine. Applicant will need to contact school for the necessary fee requirements for transcripts.

VER: VERIFICATION OF REGISTRATION/LICENSURE - This form may be forwarded by Applicant to all states in which Applicant holds or has held licensure/registration. **Most states charge a fee.** If the state in which you are licensed does not complete the verification form, we will accept an email with the state language noting that and a link to the verification section from the applicant.

REMINDERS:

NPLEX EXAM TRANSCRIPTS – No form is provided for your exam transcripts. Please complete the Transcript Request form from the NABNE website and select Idaho. They have our contact information and will send your transcripts directly to the Board of Medicine. These exam transcripts must be received directly from NABNE. **Exam transcripts received directly from applicants will not be accepted.**

Please note: You will need to request results for all four of the examinations as defined in Idaho rule.

1. Part 1 – Biomedical Science
2. Part II – Core Clinical Science
3. Part II - Clinical Elective Minor Surgery
4. Part II – Clinical Elective Pharmacology

FAXED and emailed *supporting* documents can be accepted. FAX# (208) 344-3536. **APP1 & 2 cannot be faxed.**

PLEASE NOTE: Forms received prior to receipt of application and fee will be held in a "Misc. Forms" file for up to one year. After one year, the forms will be thrown away.

No practice is permitted prior to issuance of a license number.
Applicants are advised not to enter irrevocable contracts, purchase or sales agreements, on the assumption that permit/licensure will be granted.

*** Questions? E-mail BOM-Licensing@dopl.idaho.gov ***

State of Idaho
Division Of Occupational and Professional Licenses
Board of Medicine

BRAD LITTLE
Governor
RUSSELL BARRON
Administrator

11341 W Chinden Blvd.
P.O. Box 83720
Boise, ID 83720-0063
(208) 334-3233
dopl.idaho.gov

CREDIT CARD TRANSMITTAL FORM

For security of your financial information, please do not email this form to the Board.

Please type or print legibly

Order Information: _____
(Description of what and who payment is for)

Name as it appears on card: _____

Billing Address: _____

City _____ State _____ Postal Code _____

Telephone Number: _____

Card Number: _____-_____-_____-_____

Type of Card ☐ MasterCard ☐ Visa

Expiration Date: _____ /_____
(MM) (YY)

I authorize the Idaho Board of Medicine to charge the above credit card for a one-time payment in the amount of $ _____ .

Printed Name: _____

Authorized Signature: _____

Please Note: The Board of Medicine does not retain your credit card information.

If you would like to receive a receipt of this transaction, provide your email address below.

Email Address: _____

IDAHO STATE BOARD OF MEDICINE

P.O. Box 83720 · Boise, ID 83720-0063 · (208) 327-7000
Express Mail: 11341 W Chinden Blvd, Bldg 4 · Boise, ID 83714

APPLICATION – NATUROPATHIC MEDICAL DOCTOR LICENSE

FOR USE OF THE BOARD						
IDENTITY	EDU	Transcripts	NPLEX PT1	NPLEX PT2-CORE	NPLEX PT2-M SUR	Date Received
NPLEX PT2-RX	VER		NPDB	FP STATEMENT	FP CARD	FP REPORT
			FNMRA	Date Submitted	Date Approved	App Fee Paid

Before completing, please see attached instructions.

Please note: Payment of additional fees for licensure will be required after approval of application.

NMD Application - Fee $300

All fees are nonrefundable

Make check(s) payable to: IDAHO STATE BOARD OF MEDICINE

First Name	**Middle Name**	**Last Name**

Alternate Name(s)	**Social Security No.**
Primary - Telephone *(Public Access)*	**Secondary – Telephone (personal)**
Primary - Current Mailing Address-(Public Access) *(Street)*	**Date of Birth** (*Month/Day/Year*)
(*City, State, Zip*)	**Place of Birth**
Secondary - Current Mailing Address-(Home) *(Street)*	**US Citizen**
(*City, State, Zip*)	**Gender**
Email Address	**NPI Number**

NAME AND LOCATION OF SCHOOLS *(INCLUDE CITY/STATE)*	**START DATE** *(Month/Year)*	**END DATE** *(Month/Year)*
NMD Program		

EXAMINATION HISTORY	**DATE**	**PASS/FAIL**	**NUMBER OF ATTEMPTS**
PART I – BIOMEDICAL SCIENCE			
PART II – CORE CLINICAL SCIENCE			
PART II – CLINICAL ELECTIVE MINOR SURGERY			
PART II – CLINICAL ELECTIVE PHARMACOLOGY			

STATE LICENSURE HISTORY	**Year Issued**	**CURRENT**		**NUMBER**
		Yes	**No**	

In chronological order, account for all periods of time from completion of professional school to present **leaving no gap in time of more than one month.** Include post-graduate study, private practice, military service, etc. Copy and attach additional pages if necessary.

DATES: FROM / TO	PRACTICE / EMPLOYMENT
From: Month: _____ Year: _____ **To:** Month: _____ Year: _____	Practice/Employment Name _____ *(or list non-working time as indicated above)* Practice/Employment Address _____ City _____ State/Province _____ ZIP Code _____ Country _____ Position & Department _____ % Clinical _____ % Administrative _____ Employment ☐ Staff Privileges ☐ Affiliation ☐ Other _____
From: Month: _____ Year: _____ **To:** Month: _____ Year: _____	Practice/Employment Name _____ *(or list non-working time as indicated above)* Practice/Employment Address _____ City _____ State/Province _____ ZIP Code _____ Country _____ Position & Department _____ % Clinical _____ % Administrative _____ Employment ☐ Staff Privileges ☐ Affiliation ☐ Other _____

IF THE ANSWER TO ANY OF THE FOLLOWING QUESTIONS IS YES, PLEASE PROVIDE DETAILS ON A SEPARATE, ATTACHED SHEET.

Y	N	
☐	☐	1. Are you in active service in the U.S. Military, an honorably discharged U.S. Military veteran, or a spouse of either one? *[If so, please be prepared to provide additional documentation]*
☐	☐	2. Have you ever failed a licensing examination for a professional license/registration?
☐	☐	3. Have you ever had an application for a professional license/registration denied or refused?
☐	☐	4. Have you ever been investigated by any licensing board, hospital, healthcare organization, agency or professional association in connection with medical incompetency, practice act violations, unprofessional conduct or unethical conduct ***(even if no action resulted from the investigation)?*** *[If so, please be prepared to provide additional documentation]*
☐	☐	5. Have you ever been found in violation of performing procedures or practicing beyond the scope approved by a licensing or regulatory agency?
☐	☐	6. Are you now or have you ever been a defendant in any malpractice proceedings, **regardless of the outcome?** *[If so, please be prepared to provide additional documentation]*
☐	☐	7. Have you ever been arrested, charged with or convicted of a felony or misdemeanor other than minor traffic violations, **regardless of the outcome**? *This includes withheld judgments and matters that have been expunged.* *[If so, please be prepared to provide additional documentation]*
☐	☐	8. Are you currently suffering from any physical or mental condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice your medical profession with reasonable skill or safety?

NOTE

Attach a 2″x2″ passport photo.

DO NOT STAPLE PHOTO TO APPLICATION

I, the undersigned, being first fully sworn, depose and say that I am the person herein described and identified; that the answers to the accompanying questions and statements made in this application are true and correct; that I am the lawful holder of the degrees/credentials listed, and that such degrees/certificates were procured in the regular course of instruction and examination without fraud or misrepresentation.

I hereby authorize all hospitals, institutions or organizations, my references, personal associates, business associations (past and present) and all government agencies and instrumentalities to release to this licensing Board and information, files or records requested by this Board in connection with the processing of this application. I further authorize this Board to release to the organizations, individuals and groups listed above any information which is material to my application or pertinent to my practicing as a naturopathic medical doctor.

I have carefully read the questions in the accompanying application and have answered them completely, without reservation of any kind, and declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information with this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice as a naturopathic medical doctor in the State of Idaho.

_____

Applicant's signature (must be signed in the presence of a notary)

_____

Applicant's printed last name, first name, middle initial, and suffix (e.g. Jr.)

_____

Date of signature (must correspond to date of notarization)

State of _____ County of _____

Subscribed and sworn to before me this _____ day of _____, 20_____.

Notary Signature _____

My commission expires _____

CERTIFICATE OF NATUROPATHIC MEDICAL DOCTOR PROGRAM

Please have the following completed by the appropriate educational institution and return directly to the Idaho State Board of Medicine, PO Box 83720, Boise, ID 83720-0063; Express Mail: 11341 W. Chinden Blvd. Bldg 4, Boise, ID 83714; Fax: (208) 344-3536.

Full Name of Applicant:	
Address:	
Social Security Number:	**Date of Birth:**
Degree	**Date of Degree:**

Dates of Attendance:	**From (Date)**	**To (Date)**
First Year		
Second Year		
Third Year		
Fourth Year		

As an official of the school named, I certify that the person named above received a degree as noted after fulfilling all requirements.

PLEASE INCLUDE A COPY OF MY OFFICIAL TRANSCRIPTS

_____
Please type or print name of Registrar

_____
Signature of Registrar

(SEAL)

_____
Name of School or Facility

_____
If changed, present name

_____
City **State** **Zip**

_____
Date of this Certification

_____
Applicant's Signature

VERIFICATION OF LICENSURE/REGISTRATION

Applicant's Name: _____

Applicant's Address: _____

My Registration/License No. is: _____

I am applying for licensure to practice as a Naturopathic Medical Doctor in the State of Idaho. The Idaho State Board of Medicine requires verification of registration/licensure from each state wherein I hold or have held registration/licensure. This is your authority to release any information in your files favorable or otherwise, directly to: Idaho State Board of Medicine, P.O. Box 83720, Boise, ID 83720-0063; Express Mail: 11341 W. Chinden Blvd. Bldg 4, Boise, Idaho 83714; Fax: (208) 344-3536.

State of: _____ **Registration/License No.:**_____ **Issue Date:**_____

Name of Registrant/Licensee: _____

Issued by: _____ **Endorsement/Reciprocity with:**_____

_____**Examination (NABNE)**

Status: Current Yes _____ No _____ **Expiration Date**_____

Do you have any record of disciplinary or legal action that should be considered with this Naturopathic Medical Doctor's application? If the identified applicant has a disciplinary record, please consider this a request for public record.

Yes _____ No _____

Comments:

_____
Signature

_____
Title

_____
Date

(Board Seal)

_____
State Board

Verification - Not an Endorsement

Idaho State Board of Medicine

NONCRIMINAL JUSTICE APPLICANT PRIVACY STATEMENT

As an applicant who is the subject of a national fingerprint-based criminal history record check for a non-criminal justice purpose you have certain rights which are discussed below.

This serves as notification from **Idaho State Board of Medicine** that your fingerprints will be used to check the criminal history records of the State of Idaho and the FBI and that those records will be used solely for the purpose requested and may not be disseminated outside the receiving department, related agency or other authorized entity. The collection of applicant fingerprints in Idaho is authorized by Idaho Code §67-3008.

- If you have a criminal history record, the officials making a determination of your suitability for the job, license, or other benefit must provide you the opportunity to complete or challenge the accuracy of the information in the record.
- Procedures for obtaining a change, correction, or updating of your criminal history record are set forth at Title 28, Code of Federal Regulations (CFR), Section 16.34.
- If you have a criminal history record, you should be afforded a reasonable amount of time to correct or complete the record, or decline to do so, before being denied the job, license, or other benefit based on information in the criminal history record.
- Disclosure of your Social Security number is voluntary and is solicited pursuant to the Federal Privacy Act and Idaho Code §67-3012 to aid the processing of an interstate background check request for noncriminal justice purposes allowed by federal statute, federal executive order or a state statute that has been approved by the attorney general.

The fingerprints and information reported from this request may be disclosed pursuant to your consent, and may also be disclosed by the FBI without your consent as permitted by the Federal Privacy Act of 1974 (5 USC 552a(h)). Routine uses include, but are not limited to, disclosures to appropriate governmental authorities responsible for civil or criminal law enforcement, counterintelligence, national security or public safety matters to which the information may be relevant; to State and local governmental agencies and nongovernmental entities or application processing as authorized by Federal and State legislation, executive order, or regulation, including employment, security, licensing, and adoption checks. Depending on the nature of your application, other authorities may include numerous Federal or State statutes pursuant to Public Law 92-544 or other authorized authorities.
According to Idaho state law and if agency policy permits, you may be provided a copy of your FBI criminal history record for review and possible challenge upon submission of a written request. If agency policy does not permit it to provide you a copy of the record, you may obtain a copy of the record by submitting fingerprints and a fee to the FBI. Information regarding this process may be obtained at http://www.fbi.gov/about-us/cjis/background-checks.

If you decide to challenge the accuracy or completeness of your FBI criminal history record, you should send your challenge to the agency that contributed the questioned information to the FBI. Alternatively, you may send your challenge directly to the FBI at the same website address as provided above. The FBI will then forward your challenge to the agency that contributed the questioned information and request the agency to verify or correct the challenged entry. Upon receipt of an official communication from that agency, the FBI will make any necessary changes/corrections to your record in accordance with the information supplied by that agency. (See 28 CFR 16.30-16.34)
If a change, correction or update needs to be made to an Idaho criminal history record, that process information is available on the Idaho State Police website. http://www.isp.idaho.gov/BCI/index.html.

Your signature below acknowledges this agency has informed you of your privacy rights for fingerprint-based background check requests used by the agency for non-criminal justice purposes.

I do ☐ do not ☐ want a copy of the Privacy Act Statement.

Signature of Applicant: _____ Date_____

Print Applicant Name: _____

Authorization for Release of Information

This form is to be completed by the applicant with the name(s) of any other individual(s) or entity(s), besides the applicant, that the applicant would allow this Board to discuss the status of the pending application, i.e. spouse, staff member, etc, and returned with the application. **Without this completed form, the Board may only discuss the pending status with the applicant.**

☐ I will be the only individual inquiring about the status of my application. If you are not authorizing the release of information to a third party, you will **not** need to have this form notarized, just sign and date below.

☐ I authorize the following individuals to inquire about the status of my application (see below):

_____
First Name Last Name Relationship to Applicant

_____
Name of Entity (University, Hospital, etc)

_____ _____
Telephone Number Email Address

_____
First Name Last Name Relationship to Applicant

_____
Name of Entity (University, Hospital, etc)

_____ _____
Telephone Number Email Address

I hereby authorize and direct the Idaho State Board of Medicine, employees, agents, officers, representatives, and attorneys at any time to release information regarding my filed application for an Idaho license and/or permit with the Idaho State Board of Medicine to the individuals named above.

I further authorize the Idaho State Board of Medicine, employees, agents, officers, representatives, and attorneys who have such information to consult with or discuss such information with any of the individuals named above.

Upon my knowledge and with legal consultation, I understand the nature of this Authorization for Release of Information with regard to my filed application for an Idaho license and/or permit with the Idaho State Board of Medicine.

I, and my heirs, do hereby release the Idaho State Board of Medicine, Committee on Professional Discipline of the Idaho State Board of Medicine, and its members, employees, agents, officers, representatives, and attorneys, from all liability and all claims of any nature whatsoever pertinent to the information released.

Name of Applicant: _____
(First, Middle, Last)

Signature: _____ Date: _____

State of: _____
:ss
County of: _____

On this ____ day of _____, 20____, before me, the undersigned, a Notary Public in and for said State, personally appeared _____, known or identified to me to be the person whose name is subscribed to the within instrument, and acknowledged to me that he/she executed the same.

I WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal the day and year in this certificate first above written.

_____
Notary Public for _____

Residing at: _____

My commission expires: _____

NMD