

State of Arizona
Board of Homeopathic and Integrated Medicine
Examiners

1400 W. Washington, Room 230 Phoenix, AZ 85007

Telephone (602) 542-8154 Fax (602) 542-3093

www.azhomeopathbd.az.gov

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APPLICATION FOR LICENSE AS A HOMEOPATHIC PHYSICIAN

1. **Name** _____
(As you wish it to appear on your license)
2. **Clinic Address** _____
- City** _____ **State** ____ **Zip code** _____
- Home Address** _____
- City** _____ **State** _____ **Zip code** _____
- Daytime telephone** _____ **FAX** _____
- Email address:** _____
-

3. I hereby request: **(initial your request)**
- _____ licensure by written examination. I anticipate taking the written examination on _____
(refer to examination & meeting schedule)
(indicate date here. The application fee is applicable for one year from the date filed)
- _____ that, pursuant to the Americans with Disabilities Act (ADA) a reasonable accommodation be made for the examinations initialed below. I have attached, on a separate piece of paper, an explanation of the accommodation requested.
- _____ written examination
- _____ oral interview examination
4. _____ I enclose the application fee of \$550 (U.S. funds) payable to the **Board of Homeopathic and Integrated Medicine Examiners** and understand that this fee is not refundable.

EDUCATION

- 5. List below the approved medical school from which you received your MD or DO degree and have the school submit written verification of your graduation to the Board.

Name of medical school **year of graduation**

- 6. List below the approved hospital program at which you interned, and attach a copy of your completion certificate to this application.

Name of hospital program **years of internship**

- 7. As listed on the "Summary of Post Graduate Course Studies" form and enclosed in this application, I am submitting **(initial appropriate blank)**:

_____ 300 hours of approved coursework, with a minimum of 40 hours in classical homeopathy, and the remaining hours in **any combination** of approved coursework in acupuncture, chelation therapy, complex homeopathy, electro-therapeutics and EAV, neuromuscular integration, or orthomolecular therapy/nutrition,. **(Attach a separate Summary sheet for each category, each sheet covering documentation of hours attended in each category)**

and or

_____ completion of preceptorships that provided instruction in one or more of the following practice modalities: acupuncture, chelation therapy, complex homeopathy, electro-therapeutics and EAV, neuromuscular integration, or orthomolecular therapy/nutrition. **(Note: evidence of completion of a preceptorship must be supported by documentation described AAC R4-38-104 and are subject to review and approved by the Board).**

- 8. List three doctors who will be sending the Board a letter of recommendation. **Each letter must be sent on the doctor's professional letterhead and the doctor's signature must be notarized.**

- 9. List all states/ jurisdictions (including Canadian provinces and foreign countries) in which you are or ever have been licensed to practice medicine. Have each state /jurisdiction submit written verification to the Board the status of your license there.

- 10. List specialty colleges of which you are a member, and specialty boards by which you are (or were) certified. **Attach copies of your membership/certification to the completed application.**

11. List the dates and places you have practiced medicine, including military service (and rank) if applicable. **Enclose a copy of your curriculum vitae with your application.**

BACKGROUND

Please answer "yes" or "no" to each question.

- _____ 12. Within the past ten years, have any medical malpractice suits been filed against you, including claims for which no corresponding lawsuit was filed?
- _____ 13a. Have you ever been convicted of, or pled guilty or *nolo contendere* to any criminal charges requiring adjudication in an adult court of record?
- _____ 13b. Have you been charged with any crimes that are pending adjudication in an adult court of record?
- _____ 14. Has any state or jurisdiction ever refused or denied you a license to practice medicine, or allowed you to withdraw your application during the consideration of such action?
- _____ 15. Has any state or jurisdiction ever placed your license to practice medicine on probation, ever suspended, limited or restricted your license or revoked your license, or accepted the surrender of your license during the consideration of such action?
- _____ 16. Has any state or jurisdiction (including federal agencies) ever suspended, limited, restricted, revoked, denied or accepted surrender of your privilege to possess, dispense or prescribe controlled substances?
- _____ 17. Within the past ten years, have you had any mental illness or psychological condition that impaired your ability to practice medicine or function as a student of medicine?
- _____ 18. Are you now, or have you been within the past ten years, dependent upon alcohol or drugs?
- _____ 19. Has any specialty practice board or college ever suspended, revoked or denied re-certification of your standing with that board or college?
- _____ 20. In compliance with the Personal Responsibility/Work Opportunity Reconciliation Act (PRWORA) regarding State and local benefits (professional licenses are defined as a benefit) please mark whether you are a citizen of the United States. Yes () No ().
- If you are not a citizen of the United States, do you hold qualified alien status? Yes ()
No ()
- (Please attach a copy of a document that evidences your status as a either a citizen of the U.S. or a qualified alien. A list of acceptable documents is attached)***

IF YOU ANSWERED "YES" TO ANY QUESTION (12-19) ABOVE, ON A SEPARATE SHEET OF PAPER PROVIDE DETAILS DESCRIBING THE INCIDENT, THE DATE AND LOCATION OF THE INCIDENT. IDENTIFY THE AGENCY, COURT OR ORGANIZATION INVOLVED AND ANY ACTION TAKEN.

DESCRIPTION OF YOUR INTENDED PRACTICE:

20. Check all modalities that you intend to offer under your supervision. (*Note: AAC R4-38-103 states that an applicant who wishes to practice a specific treatment modality...shall demonstrate proficiency in the modality by completing the indicated number of postgraduate course hours or certification by the indicated credentialing authority.*) Please include copies of evidence of training or certification if not already provided with your summary of postgraduate education.

Modality	Certified? Yes/No
___ Acupuncture, Classical	_____
___ Acupuncture, electro-diagnosis	_____
___ Chelation Therapy	_____
___ Classical (Kentian) homeopathy	_____
___ Complex homeopathy and electro therapeutics (EAV and related)	_____
___ Neuromuscular Integration	_____
___ Orthomolecular therapy/Nutrition	_____
___ Other (please specify) _____	_____

Pursuant to A.R.S. § 32-2933(27), attach any informed consent material patients will sign for other diagnostic or therapeutic procedures used in your practice, including but not limited to: electro-diagnosis or therapy apparatus, other non-traditional therapy apparatus, homeopathic treatments or substances in use less than ten years.

Pursuant to ARS §32-2933 (41) it is an act of unprofessional conduct for failure to obtain a **signed informed consent** from a patient prior to beginning examination or treatment. **This informed consent shall include language which makes it clear that the physician is providing homeopathic medical treatment instead of or in addition to standard conventional allopathic treatment.**

IDENTIFICATION

- 21. Date of birth_____
- 22. Place of birth_____
- 23. Gender_____
- 24. Height_____
- 25. Weight_____
- 26. Eye color_____
- 27. Hair color_____
- 28. Identifying marks _____

OVER THESE WORDS,
 ATTACH TWO PICTURES
 OF YOUR FACE TAKEN
 WITHIN THE PAST 60
 DAYS. DOUBLE PRINT
 PASSPORT PHOTOS
 ARE ACCEPTABLE.

SIGNATURE AND ATTESTATION OF APPLICANT

29. I, _____, am the applicant and hereby attest that all answers given above and all documentation I have provided or caused to be provided in support of this application are complete, true and correct. I further attest that I have provided to the Board of Homeopathic and Integrated Medicine Examiners any additional information, even that not explicitly requested, which bears on my competency to practice medicine, or on my ability and willingness to practice in a professional manner. I understand that providing false, deceptive or incomplete information to the Board may result in the denial of my application for licensure or charges of unprofessional conduct. I further agree that, in consideration of the issuance of a license to practice medicine as a homeopathic physician in the State of Arizona, I will abstain from unethical and deceptive advertising, from unethical and immoral conduct and practice, from charging excessive fees and from association with firms or individuals who exploit the public for monetary gain by employment of physicians.

Signature of applicant _____
Date

Sworn and subscribed before me this _____ **day of** _____, **20**_____.

Signature of Notary Public **My commission expires** _____

SEAL

AUTHORIZATION FOR RELEASE OF INFORMATION

I, the undersigned, hereby authorize individuals, organizations, previous employers, and schools to provide any information they may have regarding me, whether or not it is in their official records. This may include otherwise privileged or confidential information relative to my professional qualifications, credentials, clinical or professional competence, character, mental or moral behavior, or any matter that bears on consideration of a license to practice, permit or registration offered by or through the **Arizona Board of Homeopathic and Integrated Medicine Examiners**, 1400 West Washington, Room 230, Phoenix, Arizona 85007. Telephone (602)-542-8154, FAX: (602)-542-3093.

I, the undersigned, release all individuals, organizations, previous employers, and schools from all liability for any damages that may result from issuing this information.

Further, I extend to the **Arizona Board of Homeopathic and Integrated Medicine Examiners**, its authorized representatives, and any third parties absolute immunity and release from liability for information gathered from public records and/or interviews as outlined above.

I, the undersigned, agree that a photocopy of this authorization is to be accepted with the same authority as the original, and I specifically waive written notice from any present or former employer and/or organization that may provide information based upon this authorized request.

Name (please print)

Street Address

City, State and Zip Code

Date of Birth

Social Security Number

Maiden, former name or aliases (please print)

Signature

Date

