ND 2
Verification of
Professional Education
Supplemental Form

MARYLAND BOARD OF PHYSICIANS
P.O. Box 2571
Baltimore, Maryland 21215-0095
Telephone: 410-764-4777 or 800-492-6836

**For Board Use Only**
Program accredited?
_____ Y _____ N
Date verified: _____

# VERIFICATION OF PROFESSIONAL EDUCATION FOR NATUROPATHIC DOCTOR LICENSURE

## Part 1

APPLICANT: Complete Part 1 and send this form to the institution where you completed your naturopathic medicine program.

Name: _____
Last name and generational indicator (Jr., Sr., II, III, etc.) First name Middle name Maiden name

Date of Birth: _____/_____/_____ Social Secuity Number: _____- _____ - _____
mm dd yyyy

Professional School of Graduation: _____

Attended from: _____ to _____

Date of Graduation: _____ Degree Received: _____
mm/yyyy

Applicant's Signature: _____ Date: _____

## Part 2

REGISTRAR, DEAN, PRINCIPAL or OTHER AUTHORIZED OFFICIAL: **Please email this form to: mdh.mbpcredentials@maryland.gov**

I hereby certify that the above-named individual graduated from this institution on: _____
Date of Graduation (mm/yyyy)

The individual graduated with a(n):

☐ Associate's Degree ☐ Certificate ☐ Bachelor's Degree ☐ Master's Degree ☐ Other:_____ (specify)

in _____. The program was accredited by: _____
Educational Program CNME

_____ _____
Printed Name of Authorized Official Name of Institution

_____ _____ _____
Title of Authorized Official Telephone Number Fax Number

_____ _____
Signature of Authorized Official Date

SEAL OF THE INSTITUTION