ATTENTION!

Criminal History Record Checks (CHRC) are required for all applicants. The Board may not reinstate or issue a new license to any applicant, physician or allied health practitioner, if the Board has not received criminal history record information.

The Board recommends that you do not submit your fingerprints for a CHRC earlier than 6 weeks before the date you intend to submit your initial license or reinstatement application to the Board.

The Board is only authorized to retain CHRC information for 90 days. If the CHRC is over 90 days, the applicant will be required to complete a new CHRC.

For detailed instructions on submitting your fingerprints for a CHRC, please read and follow the attached instructions.

MARYLAND
Department of Health Board of Physicians
Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

Notice: Criminal History Records Check Required

Dear Applicant for Initial License or Reinstatement of License:

A full Criminal History Records Check (CHRC) is a qualification of licensure. The Board may not reinstate or issue a new license to any applicant, physician, or allied health practitioner, if the Board has not received criminal history record information.

A CHRC will include both a State and national criminal history records check conducted by the Maryland Department of Public Safety and Correctional Services, Criminal Justice Information System (CJIS) and will be maintained in the Maryland and FBI database for further identification purposes. Applicants have the right to challenge their records, which is discussed in more detail in the FBI NonCriminal Justice Applicant's Privacy Rights notice (https://www.mbp.state.md.us/forms/fbi_privacy_rights.pdf). An applicant for initial licensure or reinstatement shall apply to CJIS for a CHRC and the application shall include:

1. Two complete sets of legible fingerprints taken on forms approved by CJIS and the FBI; and
2. Payment of the required fees.

Timing of CHRCs

The Board recommends that applicants do not submit fingerprints earlier than 6 weeks before the date the applicant/licensee intends to complete the initial license or reinstatement application. The Board is only authorized to retain CHRC information for 90 days. If the CHRC is over 90 days, the applicant will be required to complete a new CHRC.

Fingerprints

A. For Initial Applicants and Reinstatements

All applicants for licensure in Maryland will be required to submit fingerprints for the CHRC. In order to be fingerprinted, the fingerprinting entity will need the following Board specific information:

- CJIS Authorization #: 1600000743
- FBI ORI #: MD 920522Z
- Reason Fingerprinted: Professional License
- Type of Check: Governmental Licensing/ Certification

1. Within Maryland

    a. Go to an authorized location to be fingerprinted prior to mailing in your application to the Board. For a list of electronic fingerprinting locations go to the following website: https://www.dpscs.state.md.us/publicservs/fingerprint.shtml. The Board is not responsible for the list. If there are any concerns about a fingerprinting location, please contact CJIS directly.
    b. Provide the fingerprinting entity the CJIS Authorization number and FBI ORI # provided on page 1 of this letter.
    c. Pay the appropriate fee to the fingerprinting entity.

Once the Board receives the results of the CHRCs, the application process will be completed in accordance to Board regulations and policies.

2. Outside of Maryland
    a. Out of state applicants have the option of using a Maryland location for fingerprinting. If a Maryland location is used, follow the instructions above for applicants within Maryland. If a location outside of Maryland is used, follow the instructions below.
    b. Either:
        i. Write to CJIS-Central Repository at P.O Box 32708, Pikesville, Maryland 21282-2708, or
        ii. Call the Central Repository in Baltimore City at 410-764-4501 or toll free number 1-888-795-0011 to request fingerprint cards.
    c. Have CJIS Authorization and FBI ORI Board #'s available to complete your submission.
    d. Mail the fingerprint card and associated fee to CJIS-Central Repository, P.O Box 32708, Pikesville, Maryland 21282-2708, or overnight the fingerprint card to 6776 Reisterstown Road, Suite 102, Baltimore Maryland 21215.
    e. Please include a check or cashier's check made out to "CJIS Central Repository".

Once the Board received the results of the CHRCs, the application process will be completed in accordance to the Board regulations and policies.

Timing of CHRCs

The Board recommends that applicants do not submit fingerprints earlier than 6 weeks before the date the applicant/licensee intends to complete the initial license or reinstatement application. The Board is only authorized to retain CHRC information for 90 days. If the CHRC is over 90 days, the applicant will be required to complete a new CHRC.

Fees:

Fees are required for CJIS to process each criminal background record check request. All fees must be paid by credit card, check or cashier's check in United States currency. The Central Repository cannot accept cash.

Do not send any payment to the Board, as it does not conduct CHRCs. For additional information contact CJIS at 410-764-4501 or visit https://www.dpscs.state.md.us/publicservs/fingerprint.shtml.

Questions?

Should you have any questions, concerns, or to check the status of a criminal history record information request, please contact the **CJIS Call Center at 410-764-4501 or 1-888-795-0011**, Monday-Friday 8:00 a.m. - 5:00 p.m. The Board cannot assist you in this regard.

***Please do not contact the Board to verify receipt or submit receipts. The Board will receive the electronic CHRC notifications within 3 – 14 days.**

ATTENTION NATUROPATHIC DOCTORS!

Naturopathic doctors have the option of paying the **$790** application fee by credit card or by check/money order. Please carefully review the instructions on how to submit your payment by either check/money order or credit card.

Payment by check/money order: To pay by check/money order:

- Download the application;
- Complete it; and
- Mail the completed application and check/money order to the post office box on top of the application:
  - P.O. Box 37217
    Baltimore, MD 21297

Payment by credit card: To pay by credit card:

- Click on the link: https://www.mbp.state.md.us/mbp_ah/naturo_application.aspx;
- Enter the last 4 digits of your social security number and date of birth;
- Complete the online form (first page of the application) with your demographic information;
- Using Visa or MasterCard credit card, pay the ***$790*** fee;
- After you have paid the fee, the next screen will show a *Receipt for Licensure Application for Naturopathic Doctor*.
- Click on the link to download and print the partially completed application;
- Continue completing application;
- When complete, submit entire application to the Board:
  - Maryland Board of Physicians
    P.O. Box 2571
    Baltimore, MD 21215
    Attention: Cecilia Laurent, Allied Health Analyst

Note: *Paying by credit card only provides partial data on the application - enough to get the application fee paid and identify the applicant. After downloading the application, the demographic data will already be pre-filled in* ***blue font****. You MUST complete the rest of the application and mail it to the attention of Cecilia Laurent at the Board to the address listed above.* ***The licensure process will be delayed significantly if the Board does not receive the completed application.***

Except for the Written Attestation, verification of passage of the NPLEX and completed supplemental forms must be sent to the Board directly from the source.

MARYLAND BOARD OF PHYSICIANS

Baltimore, Maryland

www.mbp.state.md.us

NATUROPATHIC DOCTOR APPLICATION FOR LICENSURE

Dear Applicant:

Attached is an application packet for licensure as a Naturopathic Doctor in Maryland. The licensure fee is **$790.00** and is **non-refundable.** Please make your check or money order payable to: **Maryland Board of Physicians.**

Mail your application and payment to:

Maryland Board of Physicians
P.O. Box 37217
Baltimore, MD 21297

Please **DO NOT** mail or hand deliver your application to the Board office or any other address except the address listed above. Applications mailed or hand delivered to the Board office will be forwarded to the above address. This will delay the processing of your application. **Please note: Federal Express (FedEx) and UPS do not deliver to post office boxes.**

Applications are processed in the order they are received. **Please allow at least 3 to 6 weeks for the processing of your application.** Board staff will make every effort to process your application as quickly as possible. Incomplete applications and/or failure to submit the required information will delay the processing of your application.

Board staff will contact you if additional documentation is required. Please make sure your contact information is current. Please do not call the Board to check on the status of your application, as constant interruptions slow down the process.

Documents submitted to support your application must come directly from the source, e.g., verification of education must come directly from your school and verification of other licenses must come from the state board that issued your license. Both credentials must be mailed to the address on top of the forms attached to the application. Verification of passage of the Naturopathic Physicians Licensing Examination (NPLEX) must be verified by the North American Board of Naturopathic Examiners (NABNE).

Board staff will not disclose the status of your application to another party unless you have completed the optional Third Party Release on Page 7 of the application. Please complete the third party release if you want your application disclosed to family members, friends, and future employers, etc.

The Board will keep your application open for 120 days from the original date of receipt. All requirements for licensure must be met within the 120-day period. If the requirements are not met, your application will be closed, and a new application and full licensure fee will be required.

The Board's Website is updated every 24 hours. You may wish to check the Website at *www.mbp.state.md.us* before calling the Board to learn if a license was issued to you. When you visit the Website, click on **Look up a Licensee**.

We look forward to receiving your completed application and will process it as quickly as possible.

Thank you,
The Allied Health Division
Maryland Board of Physicians

Notice: Written Attestation in Maryland

A completed Collaboration and Consultation Agreement with a Maryland licensed physician must be completed and filed with the Board at the time the application is submitted.

MARYLAND BOARD OF PHYSICIANS

P.O. Box 37217
Baltimore, Maryland 21297
Telephone: 410-764-4775 or 800-492-6836
www.mbp.state.md.us

NATUROPATHIC DOCTOR APPLICATION FOR LICENSURE

INSTRUCTIONS AND IMPORTANT INFORMATION

1. **Name:** If the name on the application form differs from the name on any of your supporting documentation, you must submit a copy of a marriage license, divorce decree, or a court order authorizing the change of name. The Maryland Board of Physicians (the Board) must be notified of any change in your name on a timely basis.

2. **Non-Public Address:** The non-public (home) address will be the location to which the Board directs all correspondence. If your address changes during the application process, please notify the Board in writing.

3. **Public Address:** The public address (business address) is your address of record and is available to the public. However, if no public address is listed, the non-public address will be made available to the public.

4. **Contact Information (Telephone Numbers and E-mail Address):** The Board will contact you using the information provided.

5. **Date of Birth:** Health Occupations Article §14-5F-11(c), Annotated Code of Maryland, requires applicants to be at least 21 years old. Date of birth will also be used for identification and criminal background checks.

6. **Gender:** Disclosure of gender is not a requirement of licensure. The information provided will be used for identification purposes and for criminal background checks only.

7. **Race and Ethnicity:** Disclosure of race and ethnicity is not a requirement of licensure. The information provided will be used for identification purposes and for criminal background checks only.

8. **Social Security Number:** Maryland law requires the Board to collect U.S. Social Security numbers from all persons applying for professional licenses or certificates. Disclosure of your Social Security number is mandatory. The Board is permitted by State or Federal law or regulation to use the Social Security number for the following purposes:

   A. Verification of identity with respect to actions related to your license (COMAR 10.32.01);
   B. Administration of the Child Support Enforcement Program (Family Law Article, §10-119.3);
   C. Identification by the Department of Assessments and Taxation of new businesses in Maryland (Health Occupations Article, §1-210);
   D. Verification by the Maryland Medicaid program of licensure and sanctions for providers participating in Medicaid [42 U.S.C. §1396a(a)(49); 42 U.S.C. §1396r-2; 42 U.S.C. §1320a-7].

9. **Employment Activities:** Please complete and include all employment history beginning with the date you graduated from an accredited naturopathic medicine program.

NATUROPATHIC DOCTOR APPLICATION FOR LICENSURE

INSTRUCTIONS AND IMPORTANT INFORMATION CONTINUED

10. **Verification of Professional Education:** Complete the top portion of the **Verification of Professional Education form (ND 2)** and forward it to the Council on Naturopathic Medical Education (CNME) accredited Naturopathic medical program from which you graduated with a degree in naturopathic medicine. *The school must return the form directly to the Board at the address listed on the top of the form.*

11. **Naturopathic Physicians Licensing Examination:** Applicants for licensure as a Naturopathic Doctor must have taken and passed the Naturopathic Physicians Licensing Examination (NPLEX). To request a verification, go to the NABNE's Website (www.nabne.org) and request a written or electronic verification of certification be sent directly to the Board. Electronic verifications may be sent to the Board's e-mail address at mdh.mbpcredentials@maryland.gov. Written verifications may be sent to: *P.O. Box 2571, Baltimore, MD 21215*. (Please do not send your application to this address.) Please do not have the NABNE send the verifications to you.

12. **Oral and Written Competency in English:** Demonstrate verbal and written competency in the English language by:

    a. Graduation from an English-speaking high school, undergraduate school, or professional school; **OR**

    b. Achieving a passing score of at least 26 on the spoken part **and** 79 on the written part of the Test of English as Foreign Language (TOEFL).

    Provide evidence that you achieved a passing score on the TOEFL.

13. **Licensure in Other States:** If you have ever held a license, certification, or registration to practice as a Naturopathic Doctor in any state or jurisdiction or to practice ANY other health care profession in any state, including Maryland, complete the top portion of the **Verification of Other State Licenses form (ND 3)** and send it to the licensing board in each state in which you are or have been licensed/certified/registered. PLEASE check with the applicable state board to see if there is a fee required for this information prior to mailing the form. If you were licensed by the Board of Physicians in another profession, you do not need to complete the **ND 3** form. **Please do not send copies of your licenses.** *The state licensing authority must return the form directly to the Board at the address listed on the top of the form.*

14. **Character and Fitness Questions:** Answer the Character and Fitness questions "YES" or "NO." If you answer "YES" to any item, please provide a detailed explanation, on a separate sheet of paper, and any supporting documents. If you were dishonorably discharged from the military, please provide documentation that shows, including, but not limited to, the type of service, date and type of discharge, e.g. DD 214. Failure to provide a detailed explanation of a "YES" response and the required supporting documentation will delay the application process.

15. **Release:** Sign and date the certification. You are giving the Board and Naturopathic Medicine Advisory Committee permission to request additional information to support your application for licensure.

16. **Optional Third Party Release:** If you wish the Board to release your information to a third party, complete the third party release statement.

17. **Cooperation in an Investigation**: You are asked to cooperate fully with any request for information related to your practice as a Naturopathic Doctor.

18. **Certification and Passport Quality Photo:** Sign and date the certification in the presence of a notary public after you have affixed a recent **original** passport quality (2" x 2") color photo to the application in the space provided.

NATUROPATHIC DOCTOR APPLICATION FOR LICENSURE

INSTRUCTIONS AND IMPORTANT INFORMATION CONTINUED

Supplemental Forms ND 1, ND 2, and ND 3:

Written Attestation (ND 1): The Consultation and Collaboration Agreement must be completed by the Naturopathic Doctor (N.D.) and submitted with your application for licensure. *(See details below)*

Verification of Professional Education (ND 2): Complete the top half of this form and send it to the educational institution where you completed your accredited N.D. medical education. *The authorized official at the institution must send the form directly to the Board. The form should not be sent with the application.*

Verification of Other State Licenses (ND 3): Complete the top half of this form if you were issued a license/ certification/registration as an N.D. or ANY other health care provider. *The form should not be sent with the application.*

Please keep a copy of your application.

LICENSURE: If your application is approved, you will receive a license and an approval letter. The approval letter contains the license number assigned to you, the effective date of the license, and the date the license expires. Regardless of the date of initial licensure, your license will expire on **March 31st of the first even year** following the date on which you are initially licensed.

RENEWAL: You will have to renew your license if you plan to continue practicing in Maryland. A renewal notice will be sent at least 30 - 60 days prior to the expiration of your license to the most current street address on file with the Board. **You will be required to renew your license online by March 31st of every even year whether or not you receive the renewal notice.**

WRITTEN ATTESTATION: An applicant shall complete and submit to the Board a Board-approved written attestation that states that the applicant has a collaboration and consultation agreement with a Maryland physician licensed under Title 14 of the Health Occupations (H.O.) Article.* The written attestation also must include the name and license number of the physician with whom the applicant has a collaboration and consultation agreement and state that the applicant will require patients to sign a consent form that the N.D.'s practice of naturopathic medicine is limited to the scope of practice identified in H.O. Article, §14-5F-14 and describes the differences in scope of practice between N.D.s and physicians.

In addition, the written attestation must state that N.D.s shall refer patients to and consult with physicians and other health care providers licensed or certified under the H.O. Article as needed. In cases where the N.D. diagnoses a patient with a life threatening condition, the written attestation must state that the N.D. shall counsel and discuss with the patient the potential benefits offered by other physicians or other healthcare professionals and shall attempt to make the appropriate referral.

**Note: An applicant shall inform the physician named as a collaborating physician in the attestation that the physician has been named.*

PRACTICING AS A NATUROPATHIC DOCTOR (N.D.): A person may not practice, attempt to practice, or offer to practice as an N.D. in Maryland unless licensed to practice by the Board. A person may not represent or imply to the public by title or by description of services, methods or procedures that the person is an N.D. unless licensed by the Board to practice as an N.D. An N.D. may not perform or attempt to perform or offer to perform any acts beyond the scope of the license. An individual licensed to practice naturopathic medicine in Maryland may not use the title "physician."

The Maryland Board of Physicians supports the Americans with Disabilities Act (ADA) and will provide this material in an alternative format to facilitate effective communication with sensory impaired individuals (for example, Braille, large print, audio tape). If you need such accommodation, please notify the Board's ADA designee, Yemisi Koya, at 410-764-4777 or 1-800-492-6836.

For the hearing impaired, please contact the Maryland Relay Services TTY/Voice number at 1-800-735-2258. If you have a complaint concerning the Board's compliance with the ADA, please contact Dr. Koya.

Maryland Board of Physicians

Check One:
- ☐ Initial Licensure
- ☐ Reinstatement

Name of Profession: _____

ATTENTION

If You Are a Veteran, Service Member or Military Spouse

PLEASE REVIEW AND COMPLETE BEFORE PROCEEDING

"Veteran" *means a former service member who was discharged from active duty under circumstances other than dishonorable within one year before the date on which the application for license, certificate, or registration is submitted.*

"Veteran" *does not include an individual who has completed active duty and has been discharged for more than one year before the application for a license, certification, or registration is submitted.*

"Military Spouse" *means the spouse of a service member or veteran,*

"Military Spouse" includes a surviving spouse of:

* *A veteran; or*
* *A service member who died within one year before the date on which the application for license, certification, or registration is submitted.*

"Service Member" *means an individual who is an active duty member of:*

* *The Armed Forces of The United States*
* *A reserve component of the Armed Forces of the United States; or*
* *The National Guards of any state*

Complete ONLY if You Meet the Following Criteria

Check the appropriate box.

☐ Service Member — Currently serving in the U.S. Armed Forces, a reserve component of the Armed Forces or National Guards of any state. **Provide supporting documentation.**.

☐ Veteran — Discharged from active military duty under circumstances other than dishonorable within the one year of submitting the application. **Provide supporting documentation.**

☐ Military Spouse: ***Check the appropriate box***

- ☐ Spouse is a Veteran. **Provide supporting documentation.**
- ☐ Spouse was a service member who died within one year before the date of submitting the application. **Provide supporting documentation.**
- ☐ Spouse is a Service Member currently serving in the U.S. Armed Forces, a reserve component of the Armed Forces or National Guards of any state. **Provide supporting documentation.**

_____ _____

Name of Applicant (PRINT) Military Branch

NATUROPATHIC DOCTOR LICENSURE APPLICATION 01/2017

MARYLAND BOARD OF PHYSICIANS
P.O. Box 37217 • Baltimore, MD 21297
Telephone: 410-764-4777 or 800-492-6836

NATUROPATHIC DOCTOR APPLICATION FOR LICENSURE

FOR BANK USE ONLY
Date _____
Check Number _____
Amt Paid _____
Name Code _____
App ID: 93
Fee: $790.00

Applicant ID

Please print legibly or type the required information. Do not leave any item unanswered.

1. **Your Complete Current Legal Name:** As listed on your U.S. birth/marriage certificate, U.S. passport, or most recent document issued by the INS.
   Last name and generational indicator (Jr., Sr., II, III, etc.):
   First name and middle name:
   (If applicable, please check a box and complete below) □ Complete Maiden Name OR □ Complete Former Name

Stop! If any credential you submit bears a name other than your current legal name as listed above, or if you have been licensed in another state under any name other than your current legal name, sign and date an attachment which includes each different name, an explanation of why the name differs from your current legal name, and a copy of the legal document to support the name change.

2. **Non-Public Address:** This address, usually your home, is for Board use only. However, if no public address is listed, this address will be made public.
   Street Address: (Do NOT use a P.O. Box) If you change your address prior to being licensed, immediately notify the Board in writing.
   City State Zip Code

3. **Public Address:** Your public address of record. This address, usually your place of employment, is available to the public and may be posted on the Internet.
   Street Address: If you change your address prior to being licensed, immediately notify the Board in writing.
   City State Zip Code

4. Telephone(s): Home: Office:
   Cell/Pager: E-mail Address:

5. Date of Birth: Month Day Year

6. Gender: □ Male □ Female

7. Race: Check all that apply □ American Indian or Alaska Native □ Asian □ Black or African American □ Native Hawaiian or other Pacific Islander □ White
   Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino

8. U.S. Social Security Number:

For Board Use Only	License Number:		Expiration Date:	
	Date Issued:			
	Licensed By: _____			

9. Chronology of Employment Activities: Beginning with the date you completed your naturopathic medical education, list employment activities as a Naturopathic Doctor. Also list any other health related employment. Explain any lapse over one (1) year in which you were not employed. Please write N/A below if the statements do not apply to you. Please copy this page if you need more space. Sign and date all additional pages.

Graduation Date from ND Medical School:
Month: __________ Year: ___________

Employment activities after graduation from Naturopathic Doctor Program

month	year	TO	month	year	Activity/Position:

Name and Address of Facility:

month	year	TO	month	year	Activity/Position:

Name and Address of Facility:

month	year	TO	month	year	Activity/Position:

Name and Address of Facility:

month	year	TO	month	year	Activity/Position:

Name and Address of Facility:

month	year	TO	month	year	Activity/Position:

Name and Address of Facility:

month	year	TO	month	year	Activity/Position:

Name and Address of Facility:

month	year	TO	month	year	Activity/Position:

Name and Address of Facility:

month	year	TO	month	year	Activity/Position:

Name and Address of Facility:

If you will need more space than this page allows, please photocopy this page for your use.
Please sign and date each sheet that you attach.

10. EDUCATIONAL PROGRAM: Please complete this section and send the attached Verification of Professional Education (ND 2) to your naturopathic medical program.

_____
Name of School/Program accredited by the CNME

_____/_____/_____ _____
Graduation Date Degree

_____
Street Address

_____
City State Zip Code

_____
Telephone Number, including area code

11. Board Examinations: To request a verification of passing board exam scores, go to the NABNE's Website (www.nabne.org) and request a written or electronic verification of the scores to be sent directly to the Board. Electronic verifications may be sent to the Board's e-mail address at dhmh.mbpcredentials@maryland.gov. Written verifications may be sent to *P.O. Box 2571, Baltimore, MD 21215*. (Please do send your application to this address.) Please do not have the NABNE send the verifications to you.

12. ORAL AND WRITTEN COMPETENCY IN ENGLISH (Check one)

_____ I graduated from a recognized English-speaking professional school; OR

_____ I graduated from a recognized English-speaking high school or undergraduate school after at least three (3) years of enrollment; OR

I achieved a passing score of at least:

_____ 26 on the spoken part and 79 on the written part of the TOEFL.

13a. Licensure as a Naturopathic Doctor. List all states or other jurisdictions in which ever held a license/certificate/registration to practice as a Naturopathic Doctor. Please complete and mail the attached Verification of Other State Licenses form (ND 3) to the appropriate state board(s). If you have never been licensed as a Naturopathic Doctor, write N/A here _____.

State	License #	Category (ND)	Year Issued	Expiration Date

13b. Licensure as another health care practitioner. List all states or other jurisdictions in which ever held a license/certificate/registration to practice in ANY other health occupation. Please complete and mail the attached Verification of Other State Licenses form (ND 3) to the appropriate state board(s). If you have never been licensed in any other health occupation, write N/A here _____.

State	License #	Category (EMT, Nurse, etc).	Year Issued	Expiration Date

14. Character and Fitness Questions (Check either YES or NO) Please answer questions "a" through "q" on pages 5 and 6.

	YES	NO	
a.	☐	☐	Has a state licensing or disciplinary board (including Maryland), a comparable body in the armed services or the Veterans Administration, ever denied your application for licensure, reinstatement, or renewal?
b.	☐	☐	Has a state licensing or disciplinary board (including Maryland), a comparable body in the armed services or the Veterans Administration, ever taken action against your license? Such actions include, but are not limited to, limitations of practice, required education admonishment or reprimand, suspension, probation or revocation.
c.	☐	☐	Has any licensing or disciplinary board in any jurisdiction (including Maryland), a comparable body in the armed services or the Veterans Administration, ever filed any complaints or charges against you or investigated you for any reason?
d.	☐	☐	Have you ever withdrawn your application for a medical license or other health professional license?
e.	☐	☐	Has a hospital, related health care institution, HMO, or alternative health care system ever investigated you or ever brought charges against you?
f.	☐	☐	Has a hospital, related health care institution, HMO, or alternative health care system ever denied your application; failed to renew your privileges, including your privileges as a resident; or limited, restricted, suspended, or revoked your privileges in any way?
g.	☐	☐	Have you ever pleaded guilty or *nolo contendere* to any criminal charge, been convicted of a crime, or received probation before judgment because of a criminal charge?
h.	☐	☐	Have you ever committed an offense involving alcohol or controlled dangerous substances to which you pled guilty or *nolo contendere*, or for which you were convicted or received probation before judgment? Such offenses include, but are not limited to, driving while under the influence of alcohol or controlled dangerous substances.
i.	☐	☐	Are there any charges pending against you in any court of law, are you currently under arrest, released pending trial with or without bond, or is there an outstanding warrant for your arrest?
j.	☐	☐	Do you currently have any condition or impairment (including, but not limited to, substance abuse, alcohol abuse, or a physical, mental, emotional, or nervous disorder or condition) that in any way affects your ability to practice your profession in a safe, competent, ethical, and professional manner?
k.	☐	☐	Have any malpractice claims or other claims for money damages ever been filed against you? Include past claims as well as any claim that is now pending, has been dismissed, has been settled, or which has resulted in a damages award against you or your medical practice.
l.	☐	☐	Are you in default of a service obligation that you incurred by receiving State or Federal funds for your medical education?

Continue to Page 6 for questions "m" through "q"

14a. Character and Fitness Questions Continued (Check either YES or NO)

	YES	NO	
m.	☐	☐	Have you ever failed to make arrangements to satisfy State or Federal loans that financed your medical education?
n.	☐	☐	Has your employment or contractual relationship with any hospital, HMO, other health care facility, health care provider, institution, armed services, or the Veterans Administration ever been terminated for disciplinary reasons?
o.	☐	☐	Have you ever voluntarily resigned or terminated a contract with any hospital, HMO, other health care facility, health care provider, institution, armed services, or the Veterans Administration while under investigation by that institution for disciplinary reasons?
p.	☐	☐	Have you ever surrendered your license or allowed it to lapse while you were under investigation by any licensing or disciplinary board of any jurisdiction, any entity of the armed services or the Veterans Administration?
q.	☐	☐	Have you ever been dishonorably discharged from any military service of the U.S. Government? If so, attach a copy of your military discharge documentation that includes type of service, date of discharge, and type of discharge.

»»» If you answered "YES" to any question, on a separate sheet of paper, please provide a signed and dated detailed explanation and attach appropriate supporting documents. Failure to provide documentation and a signed and dated explanation will delay the processing of your application.

RELEASES AND CERTIFICATION

15. Release:

I agree that the Maryland Board of Physicians (the Board) and the Naturopathic Medicine Advisory Committee may request any information necessary to process my application for initial licensure as a Naturopathic Doctor in Maryland from any person or agency, including but not limited to the NABNE, former and current employers, government agencies, the National Practitioners Data Bank, Federation of State Medical Boards, hospitals and other licensing bodies, and I agree that any person or agency may release to the Board the information requested. I also agree to sign any subsequent releases for information that may be requested by the Board.

Applicant's Name (Printed) _____ Applicant's Signature _____ Date _____

16. (OPTIONAL) Third Party Release: Although the Board encourages you to complete all aspects of your application on your own, if you plan to use an intermediary to receive information about the status of your application, please complete this release.

The Maryland Board of Physicians may release any information pertaining to the status of my application to the following person:

Name: _____

Phone: _____ Applicant's Signature _____ Date _____

17. Cooperation in an Investigation: I agree that I will cooperate fully with any request for information or with any investigation related to my practice as a licensed Naturopathic Doctor in the State of Maryland, including the subpoena of documents or records.

During the period in which my application is being processed, I shall inform the Board within 30 days of any change to any answer I originally gave in this application, any arrest or conviction, any change of address, or any action that occurs based on accusations that would be grounds for disciplinary action under Md. Code Ann., Health Occ. §14-5F-18.

Applicant's Name (Printed) _____ Applicant's Signature _____

18. Certification: To be completed by the applicant in the presence of a notary public after the applicant's picture has been attached below.

I certify that I have personally reviewed all responses to the items in this application and that the information I have given is true and correct to the best of my knowledge and that any false information provided as part of my application may be cause for the denial of my application. I also certify that I am thoroughly familiar with the statute (Md. Code Ann., Health Occ. §14-5F-01 et seq.), which governs the practice of Naturopathic Doctors in Maryland.

Applicant's Signature _____ Date _____

STATE OF _____

CITY/COUNTY OF _____

I HEREBY CERTIFY that on this _____ day of _____, 20 _____, before me, _____,
Name of Notary

a Notary Public of the State and City/County aforesaid, personally appeared the Applicant, _____, whose
(Applicant's Name)

likeness is identifiable as that of the individual in the photograph attached to this application and who has made oath in due form of law that signing the foregoing application was his/her voluntary act and deed.

AS WITNESS my hand and notorial seal. _____
Notary Public

My Commission expires: _____

SEAL

APPLICANT:

PASTE YOUR **ORIGINAL** PASSPORT- QUALITY COLOR PHOTO HERE BEFORE NOTARIZING

COPIES OF PHOTOS ARE UNACCEPTABLE.

NATUROPATHIC DOCTOR APPLICATION FOR LICENSURE

Supplemental Forms

ND 1—Written Attestation Consultation and Collaboration Agreement

ND 2—Verification of Professional Education (Accredited ND Educational Program)

ND 3—Verification of Other State Licenses

REMINDER NOTICE FOR NATUROPATHIC DOCTORS

In order to practice as a Naturopathic Doctor (N.D.) in Maryland, an N.D. must have a Written Attestation *(See the ND 1 form)* that confirms a Collaboration and Consultation Agreement.

The agreement must be completed by the N.D. and submitted with the application to the Board for approval.

ND 1
Written Attestation
Supplemental Form

MARYLAND BOARD OF PHYSICIANS
P.O. Box 37217
Baltimore, Maryland 21297
Telephone: 410-764-4777 or 800-492-6836

WRITTEN ATTESTATION
NATUROPATHIC DOCTOR AND MARYLAND PHYSICIAN CONSULTATION AND COLLABORATION AGREEMENT

Please submit this completed form with your application.

Part 1 NAME OF NATUROPATHIC DOCTOR

Name: _____
Last First Middle

Part 2 COLLABORATING PHYSICIAN

Name: _____
Last First Middle

Maryland Medical License Number of the Collaborating Physician: _____

Collaborator's Primary Field of Practice or Specialty: _____

Part 3 AFFIRMATION

PLEASE READ CAREFULLY AND INITIAL EACH STATEMENT:

_____ I will require patient to sign a consent in plain language that the naturopathic doctor's practice of naturopathic medicine is limited to the scope of practice identified in Health Occupations Article, Section 14-5F-14 and describes the differences in scope of practice between naturopathic doctors and physicians;

_____ I shall refer patients to and consult with physicians and other health care providers licensed or certified under the Health Occupations Article as needed; and

_____ In cases where I diagnose a patient with a life threatening condition, I shall counsel and discuss with the patient the potential benefits offered by other physicians or other healthcare professionals and shall attempt to make the appropriate referral.

_____ I have informed the collaborating physician listed above that he/she has been named as my collaborating physician.

The undersigned applicant solemnly swears and affirms that the applicant is in full compliance with Health Occupations Article, §§14-5F-01—14-5F-32, *including the requirement to collaborate with a Maryland licensed physician.*

_____ _____
Signature of Naturopathic Doctor Date

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 complete this form and mail it to the above address.

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

ND 3
Verification of Other
State Licenses
Supplemental Form

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

VERIFICATION OF OTHER STATE LICENSES

Part 1

APPLICANT: Complete and sign Part 1 and send a copy of this form to each state board that ever issued you a license/certificate/registration to practice as a Naturopathic Doctor. Also use this form to send to each state board, including Maryland, that ever issued you a license/certification/registration to practice as ANY other health care practitioner. Please copy this form if you need to send it to more than one state board.

License Type: _____

State of Licensure: _____ License Number: _____

Date: _____ Expiration Date: _____

Name: _____
(Print) Last (Generational Indicator, Jr., III) First Middle Maiden

Social Security Number: _____ Date of Birth: _____/_____/_____

Professional School of Graduation: _____ Year: _____

Signature: _____ Date: _____

Part 2

AUTHORIZED OFFICIAL OF STATE MEDICAL BOARD: Please certify the following information regarding the above-listed individual and send this form directly to the Maryland Board of Physicians at the above address.

License Type	License Number	Date Issued	Expiration Date

Is/was the license in good standing? ☐ Yes ☐ No

If not in good standing is/was it: ☐ Reprimanded ☐ Suspended ☐ Revoked ☐ Surrendered ☐ Other

Was the license administratively revoked, suspended, or surrendered because the licensee did not renew? ☐ Yes ☐ No

If yes, please explain: _____

_____

Other Derogatory Information or Pending Charges: _____

_____

Printed Name of Authorized Official

Direct Telephone Number

Title of Authorized Official

Printed Name of State

Signature of Authorized Official

Date

State Board Seal