



E-mail address at which you wish to receive correspondence: \_\_\_\_\_

**Other State(s) licensing information:** List all states or other jurisdictions in which you are currently or have previously been licensed to practice, enclose additional sheet if necessary:

STATE:	DATE LICENSE WAS HELD	IS LICENSE CURRENT?	IF EXPIRED, REASON

**Which of the addresses listed can the Board make available to various public entities? (Choose only one)**

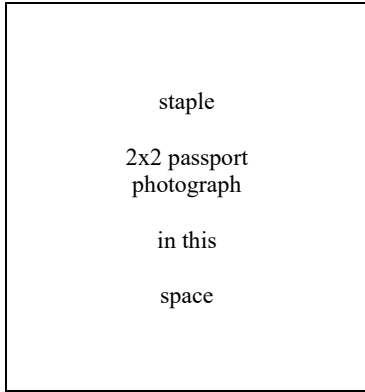
Home mailing address:       Place of Employment Mailing Address:       None:

	Yes	No
Do you have any reason to believe that you will soon be the subject of a disciplinary proceeding, settlement agreement or consent decree undertaken or issued by a professional licensing board of any state or jurisdiction?	_____	_____
Has any malpractice claim been made against you?	_____	_____
Have you, for disciplinary reasons, been put on administrative leave or had any privileges limited, suspended or revoked from any of the following settings: hospital, healthcare institution or setting, home health care agency or educational institution?	_____	_____
Have you ever been denied the privilege of taking an examination required for professional licensure?	_____	_____
Have you any physical, mental or emotional condition, or an alcohol or substance abuse problem, which could negatively affect your ability to practice the profession for which you seek licensure?	_____	_____
Do you engage in any remedial undertaking to alleviate any of the conditions listed in the Question above which could itself negatively affect your ability to practice the profession for which you seek licensure?	_____	_____
Have you committed any act(s) that would violate the laws and/or rules that govern the profession for which you are applying?	_____	_____

**NOTE...If the answer to any of the 6 questions listed above are "yes", please attach a detailed report of the relevant circumstance on a separate sheet.**

	Yes	No
Pursuant to RSA 125:25-C do you have an ownership interest in any diagnostic or Therapeutic service(s) company(s)? <b><u>If you answer "yes" you must attach a list of ALL companies.</u></b>	_____	_____

**Personal Affidavit**



State of \_\_\_\_\_

County or City of \_\_\_\_\_

I acknowledge that knowingly making a false statement on this application form is a misdemeanor under RSA 641:2, I. I certify that the information I have provided on all parts of the application form and in the documents that I have personally submitted to support my application is complete and accurate to the best of my knowledge and belief. I also certify that I have read the statute and the rules of the Board and promise that, if I am licensed, I will abide by them.

\_\_\_\_\_  
Applicant's printed name

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

Sworn to, before me, and subscribed in my presence this \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
Notary Public / Justice of the Peace

\_\_\_\_\_  
My commission expires

(seal or stamp)

**BOARD ACTION SIGN OFF PAGE**

FAST TRACK REINSTATEMENT LICENSURE OR CERTIFICATION APPROVAL:

Not Eligible

Approved: \_\_\_\_\_ Date: \_\_\_\_\_

Ratified: \_\_\_\_\_ Date: \_\_\_\_\_

BOARD APPROVAL FOR REINSTATEMENT OR CERTIFICATION APPROVAL:

Not Applicable

Approved: \_\_\_\_\_ Date: \_\_\_\_\_

BOARD APPROVAL FOR CONDITIONAL REINSTATEMENT:

Not Applicable

Approved: \_\_\_\_\_ Date: \_\_\_\_\_

Conditions: \_\_\_\_\_

\_\_\_\_\_

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