

**STATE OF NEW HAMPSHIRE  
NATUROPATHIC BOARD OF  
EXAMINERS STAFF CHECKLIST**

**Applicant Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**PLEASE FILL OUT AND RETURN THIS CHECK LIST  
WITH YOUR APPLICATION**

- Payment:  \$300 check made payable to "Treasurer State of New Hampshire"
- Signed, completed application form
- 3"x 4" untouched photo of applicant
- Two (2) letters of professional character from any of the following:
- Medical Doctor
  - Osteopathic Doctor
  - Naturopathic Doctor
- Official Transcript(s) from Naturopathic College or University, Notarized true photocopy attest if in category described in RSA 328-E:9, I (b).
- Certification of Naturopathic Medical diploma or degree. (Not required if in category described under RSA 328-E:9, I (b))
- Proof of NPLEX Exam - unless applying under Exemption or in category described under RSA 328-E:9, I (b).
- Proof of ACNO Exam - if applying for certification of natural childbirth
- Proof of 500 hours acupuncture training - if applying for Acupuncture Specialty

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**STATE OF NEW HAMPSHIRE  
NATUROPATHIC BOARD OF  
EXAMINERS**

**ADDITIONAL**

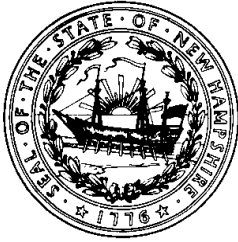
- RECIPROCITY  
 EXEMPTION

**RECIPROCITY**

- Current certificate of good standing from all jurisdictions where you currently hold a license.
- Name/address/description of current practice
- Credentials from specialty or certification board (if applicable)
- Diploma
- Two Recommendation Letters
- Transcripts

**EXEMPTION per RSA 328-E:5, I (e)**

- Enclose a statement that applicant is not currently licensed as health care provider in NH
- Proof of income - copy of IRS Income Tax Return Statement for 1990
- Document to demonstrate current NH residency and NH residency for at least twelve consecutive months prior to July, 1991.



**STATE OF NEW HAMPSHIRE**  
**OFFICE OF PROFESSIONAL LICENSING**  
**NATUROPATHIC BOARD OF EXAMINERS**  
121 South Fruit Street, Suite 303, Concord, NH 03301  
603-271-9254

Dear Applicant:

Thank you for contacting the New Hampshire Naturopathic Board of Examiners. This letter explains the Board's procedure for screening and processing applications. Please review this information carefully prior to beginning the application process.

Enclosed is the application for licensure that you requested. Applications are processed in the order that the Board receives them. The Board will not accelerate processing of one applicant at the expense of others for any reason. Upon receipt of the application, the Board will initiate background verification. If you have any malpractice or disciplinary history, it may take additional time for all pertinent documentation to be received.

Once your application is complete, including all outside verifications, it will be forwarded to the Board for review, at the next regularly scheduled Board meeting. If your license is approved, it will be mailed to the address you furnished on the application. Please remember that you are responsible for notifying the Board, in writing, of any address changes in the interim period.

Please visit the Board's website at <http://www.oplc.nh.gov/naturopathic-examiners/index.htm> to obtain a copy of the naturopathic law, rules and regulations.

If you have questions or wish to inquire as to the progress of your application, please contact the Board's assistant, Roberta MacLean at (603) 271-9254. We understand that the application process can be complicated, and will be glad to answer any questions.



**OFFICE OF PROFESSIONAL LICENSING  
NATUROPATHIC BOARD OF EXAMINERS  
APPLICATION FOR LICENSE**

**Part I**

Name: \_\_\_\_\_  
First
Middle Initial
Last

Date and Place of Birth: \_\_\_\_\_  
Date
Place

**Business Information**

Name of Business (if any): \_\_\_\_\_ Telephone: \_\_\_\_\_

Business/Mailing Address: \_\_\_\_\_  
Street Number, Street Name
PO Box

\_\_\_\_\_ City or Town State  
Zip Code

**Naturopathic Medical Education**

<i>Name &amp; Location of Institution(s)</i>	<i>Dates Attended</i>	<i>Degree Awarded</i>
1. _____		
_____		
2. _____		
_____		
3. _____		
_____		

**Other Information**

Yes No Check Yes or No to indicate whether:

		1) You have been licensed or otherwise authorized to practice naturopathic medicine in any state, the District of Columbia, any territory or foreign country.
		2) You have been refused a professional license or other authorization to practice naturopathic medicine by a regulatory body of any state, country or other regulatory jurisdiction.
		3) You have had a professional license or other authorization to practice naturopathic medicine revoked or suspended by a regulatory body of any state, country or other regulatory jurisdiction.
		4) You have had disciplinary action other than action reportable under (2) and (3) above taken against you by any state, country or other regulatory jurisdiction.
		5) You have entered into a settlement agreement or consent decree to resolve a complaint of misconduct or a disciplinary charge.
		6) Any of your professional licenses are presently the subject of a disciplinary proceeding, settlement agreement or consent

	decree undertaken or issued by any professional licensing authority in any jurisdiction.
	7) In the past ten years, any disciplinary action has been taken against you by any hospital or other health care facility, or international, national, state or local professional association.
	8) A malpractice claim or a malpractice law suit has been brought against you within the last ten years.
	9) You have ever been denied certification by NCCAOM or ACNO.
	10) Your NCCAOM or ACNO certification has ever been suspended or revoked.
	11) You have ever been convicted of a felony or misdemeanor.

**The information provided on both parts of the application and the documentation provided to support the application is true, accurate, complete and unaltered. I acknowledge that, pursuant to RSA 641:3, the knowing making of a false statement on the application form is punishable as a misdemeanor.**

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

## Part II

Home Address: \_\_\_\_\_  
Street Number, Street Name
PO Box  


---

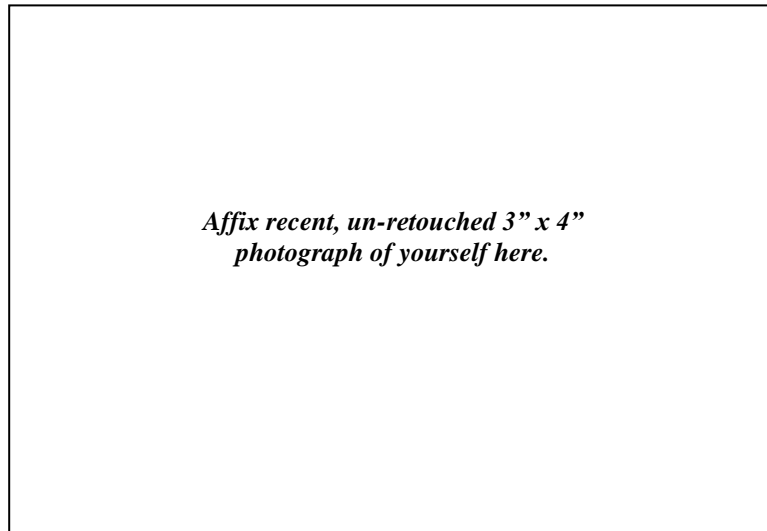
City or Town
State
Zip Code

Home Telephone: (\_\_\_\_) \_\_\_\_\_

Yes No Check Yes or No to indicate the following, attaching additional sheets to explain any “yes” answer provided:

		1) You are now being, anticipate being, or have ever been, investigated for possible misconduct by a regulatory body of any state or country or other regulatory jurisdiction.
		2) You anticipate that any of your professional licenses soon will be the subject of a disciplinary proceeding, settlement agreement or consent decree undertaken or issued by any professional licensing authority in any jurisdiction.
		3) You have ever voluntarily surrendered a license or other authorization to practice naturopathic medicine, or allowed such a license or authorization to laps, to avoid disciplinary investigation or action.
		4) You are now being, or have in the past 10 years been, investigated for possible misconduct by a hospital or other health care facility, or international, national, state or local professional association.
		5) You have any physical, mental, addictive or other condition that negatively affects your ability to practice naturopathic medicine.
		6) You have any physical, mental, addictive or other condition for which continuing remedial or therapeutic action is required to ensure your continuing ability to practice naturopathic medicine..
		7) You have, since graduation from highschool, ever been denied the privilege of taking or finishing an examination, or been accused of cheating or improper conduct during an examination.

**Please enclose \$300 license fee. Checks must be made payable to “Treasurer, State of New Hampshire”.**



↓ <b>For Office Use Only</b> ↓	
Date Received: _____	Fee \$300 - Check/M.O. # _____
Effective Dates: _____	

**Information About the Request for Your Social Security Number**

The Naturopathic Board of Examiners is required by law to ask for your social security number. The number will be held confidential by the Board and used only for enforcement of the laws governing child support. (42 USC 666(a)(13); RSA 161-B:11).

Name: \_\_\_\_\_  
                                    (first)                                    (middle initial)                                    (last)

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**TO BE COMPLETED BY NATUROPATHIC MEDICAL SCHOOL**

**Certificate of naturopathic medical degree:**

It is hereby certified that \_\_\_\_\_ matriculated in  
\_\_\_\_\_ at \_\_\_\_\_ on  
\_\_\_\_\_ and received a diploma from this institution conferring the degree of  
**Doctor of Naturopathic Medicine.**

\_\_\_\_\_  
**President, Secretary or Dean**

**SCHOOL SEAL**

.....  
**Please return to the following address:**

**OFFICE OF PROFESSIONAL LICENSING  
NATUROPATHIC BOARD OF EXAMINERS**  
121 South Fruit Street, Suite 303  
Concord, NH 03301