



Governor Janice K. Brewer

State of Arizona
Naturopathic Physicians Medical Board
1400 W. Washington, Ste. 300 Phoenix, AZ 85007
Executive Director; Dr. Craig Runbeck, ND Deputy Director; Ms. Gail Anthony
Phone: 602-542-8242 Fax: 602-542-8804 Website: www.aznd.gov

APPLICATION FOR CERTIFICATE TO ENGAGE IN A CLINICAL TRAINING PROGRAM

Note: Completed application must be sent to Board's office via the Naturopathic College.

Include the following with your application:

MONEY ORDER in the amount of \$150.00 PAYABLE TO AZ. Naturopathic Medical Board (Application Fee / Certificate Fee)

MONEY ORDER in the amount of \$22.00 PAYABLE to DPS (Completed Fingerprint Card.)

One (1) passport-size photograph taken within the last 60 days, signed on back.

I, \_\_\_\_\_, hereby make application to the State of Arizona Naturopathic Physicians Medical Board (Board) for a Certificate to Engage in a Clinical Training Program in naturopathic medicine as a naturopathic medical student to diagnose and treat patients in the practice of naturopathic medicine under the supervision of a physician licensed by the Board in accordance with Arizona Revised Statutes, Title 32, Chapter 14, section 32-1501, et. Seq. and any applicable provision of Arizona Administrative Code, Title 4, Chapter 18, Section R4-18-101, et seq.

I understand: The filing of this application grants authority to the Board to obtain information from the medical school that I am attending and from any licensing agency or board in the United States or another country. That any falsification in my application to the Board is adequate cause for the Board to deny my application. The Board may also deny my application based on a felony conviction or a conviction regarding moral turpitude (A.R.S. 32-124(i)). The Board, upon notice to me, may hold a hearing to revoke the clinical training certificate that was or may be issued to me by the Board. That if I cease to be enrolled at the medical school named in this document or fail to diagnose and treat patients under the supervision of a physician licensed by this Board or by a physician licensed pursuant to Chapter 13 (M.D.), 17 (D.O) or 29 (M.D.(H)) of this title that the Board may, in accordance with statutory provisions and Board rules, cancel or revoke the certificate that is issued to me by the Board. Per R4-18-502, I understand that the Certificate to Engage in a Clinical Training Program issued to me is required to be renewed each year on or before the month and day of original issue whether or not a notice of renewal is issued. It is the responsibility of the student to know when his/her certificate expires and to renew that certificate on time. I have read and understand A.R.S 32-1560

Printed Name of Applicant: \_\_\_\_\_

Home Address: \_\_\_\_\_
Number & Street Apt. #

City: \_\_\_\_\_, State: \_\_\_\_\_, Zip: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

Cell phone number: (\_\_\_\_) \_\_\_\_\_ Email Address: \_\_\_\_\_

Place of Birth: \_\_\_\_\_
City State Country

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number \_\_\_\_/\_\_\_\_/\_\_\_\_ [ ] Female [ ] Male
(SS required)

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Hair Color: \_\_\_\_\_ Eye Color: \_\_\_\_\_

Name of School: \_\_\_\_\_

Address: \_\_\_\_\_
Number & Street City State Zip

Name of Clinical Training Program: \_\_\_\_\_

Address: \_\_\_\_\_  
Number & Street City State Zip

Anticipated Date of Clinical Entry: \_\_\_\_/\_\_\_\_/\_\_\_\_

Anticipated Date of Completing Clinical Training: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name of Supervising Physician for Clinical Training: \_\_\_\_\_

Name of Chief Medical Officer Clinical Training Program: \_\_\_\_\_

**Answer the Following Questions**

Yes  No Have you ever been arrested or charged with, convicted of, or entered into a plea of no contest to a felony or a misdemeanor?

Yes  No Have you ever had a license/certificate, including a driver's license, suspended or revoked by any agency?

Yes  No Have you ever been disciplined by any agency for any act of unprofessional conduct as defined in Arizona Revised Statutes, Section 32-1501?

Yes  No In lieu of disciplinary action by an agency, have you ever entered a consent agreement or stipulation with a licensing agency?

Yes  No Do you have a complaint pending before any agency?

Yes  No Have you ever been found guilty of being medically incompetent?

Yes  No Have you ever been a defendant in any malpractice matter that resulted in a settlement or judgment?

Yes  No Do you have any medical condition that in any way impairs or limits your ability to practice medicine?

**\*An applicant is required to submit a written supplement to this application if the answer is YES to any of the above questions. \*\* The Fact that a conviction and/or criminal offense has been pardoned, expunged or dismissed, or that your civil rights have been restored does not mean that you can answer "No" to the questions.**

\*The Criminal Justice Information Report received by the Board from the United States Department of Justice Federal Bureau of Investigation is inclusive of all arrests including juvenile arrests even when records are expunged by a court of law. In a written supplemental statement to the Board, an applicant is required to list all arrests, pleas and convictions, jail or prison time served and any probation served. Failure to provide complete information for questions answered Yes on this page may require the applicant to appear before the Board for a personal interview.

**Subscribed And Sworn To Before A Notary Public:**

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

County of \_\_\_\_\_)

**Print the Applicant's Full Name:** \_\_\_\_\_ **being**

**first duly sworn upon his or her oath deposes and says all of the following:** I am the person named in this application. I have read and understand the contents of this application. The information contained in this application is true and correct to the best of my ability and the information submitted is without fraud, deceit or misrepresentation. I hereby authorize any hospital, institution, organization, personal physician, past or present employer, past or present business or professional associate or any local, state, federal or foreign governmental agency to release any information to the State of Arizona in connection with my application and state that a photocopy of this authorization shall have the same effect as the original. I also authorize the State of Arizona Naturopathic Physicians Board of Medical Examiners, or its successor, to release any information submitted by me, upon request, to the public or to any licensing agency, or to any other person, when such request is required or permitted by Arizona Revised Statutes. I acknowledge that any falsification in my application is cause to deny my application or for the Naturopathic Physicians Board of Medical Examiners to hold a hearing to revoke any naturopathic medical student internship, preceptorship or preceptorship training registration that is issued to me by the Board. I authorize the Board to tape record any application interview that is conducted of myself in regards to this application.

**Signature of Applicant:** \_\_\_\_\_

**Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_**

**Notary Public Signature** \_\_\_\_\_

**(OFFICIAL STAMP)**

**Notary Public Commission Expires** \_\_\_\_\_