

# NATIONAL REGISTRY OF NATUROPATHIC PRACTITIONERS

## License Renewal Application

### SECTION 1. TYPE OF LICENSE- REGISTERED NATUROPATHIC DIPLOMATES

Check the box next to the type of license for which you are applying.

- |  |               |
|--|---------------|
| <input type="checkbox"/> NAT- Naturopath 2 years                     | \$ 150.00     |
| <input type="checkbox"/> NAT- Naturopath 4 years                     | \$ 250.00     |
| <input type="checkbox"/> Duplicate Licenses (limit 5) ____ x \$50.00 | \$ ____ .00   |
| <b>Total Enclosed</b>  | <b>\$ .00</b> |

Make check or money order payable to NRNP  
A charge of \$65.00 will be imposed for dishonored checks

**MAIL TO:**  
**National Registry of**  
**Naturopathic Practitioners**  
**1000 N. Green Valley Pkwy., #440-552**  
**Henderson, NV 89074**

Check \$	OFFICE USE Check #	Staff
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### SECTION 2. APPLICANT NAME/DEMOGRAPHIC INFORMATION

Enter your name exactly as it should appear on the license. If your name has changed at any point since you first attended college or university, you must provide a copy of legal name change documents for EACH time that it has changed. Complete Section 4 of this application on page 2.

<b>FIRST NAME</b>	<b>MI</b>	<b>LAST NAME</b>	<b>SUFFIX</b> (Jr, Sr, etc.)
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<b>DATE OF BIRTH</b> -      -	<b>GENDER</b> <input type="checkbox"/> Male <input type="checkbox"/> Female
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M M - D D - Y Y Y Y

Please check the correct box.

**SOCIAL SECURITY NUMBER (OPTIONAL)**

**PLACE OF BIRTH**

Provide City and State for US birthplace or security number, a sworn Country for foreign place of birth.

### SECTION 3. SUPPORTING DOCUMENTS

Please indicate the supporting documents you have included with this package or requested to be sent to the Naturopathy Registration. Keep a photocopy of all supporting documents for your records.

A.	One recent passport-type photos of the applicant's face (approx. 2"X2") with applicant's name on the back. The photo must be original photos and cannot be computer-generated copy or paper copy.	YES <input type="checkbox"/>	NO <input type="checkbox"/>
B.	Signed Naturopathy Statement.	YES <input type="checkbox"/>	NO <input type="checkbox"/>
C.	Copies of legal documents supporting all name changes.	YES <input type="checkbox"/>	NO <input type="checkbox"/>
D.	Documentation of education.	YES <input type="checkbox"/>	NO <input type="checkbox"/>

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SECTION 4. PREVIOUS NAME CHANGE

If your name has changed at any point since you first attended college or university, you must provide a copy of a legal name change documents for EACH time that it has changed. Acceptable documents for individuals are marriage certificates, divorce decrees, or court orders. Please attach additional page of information if needed.

Changed to current name by:  Marriage  Divorce  Court Order  Spouse Death Certificate

FIRST NAME MI LAST NAME SUFFIX (Jr, Sr, etc.)

Changed to current name by:  Marriage  Divorce  Court Order  Spouse Death Certificate

FIRST NAME MI LAST NAME SUFFIX (Jr, Sr, etc.)

Changed to current name by:  Marriage  Divorce  Court Order  Spouse Death Certificate

FIRST NAME MI LAST NAME SUFFIX (Jr, Sr, etc.)

SECTION 5A. HOME ADDRESS

Even if you have a PO Box, a street address should also be provided, if applicable.

APARTMENT  SUITE  FLOOR  PO BOX NUMBER\_\_\_\_\_

HOME STREET ADDRESS 1 (If applicable, use this line for additional building information. Otherwise, use this line to indicate STREET NUMBER and STREET NAME)

HOME STREET ADDRESS 2 (If additional space is needed, use this line to indicate STREET NUMBER and STREET NAME)

CITY STATE ZIP CODE

HOME PHONE NUMBER E-MAIL ADDRESS

SECTION 5B. BUSINESS ADDRESS

Please note: This information will be made available to the public unless otherwise requested.

COMPANY NAME

Even if you have a PO Box, a street address should also be provided, if applicable.

APARTMENT  SUITE  FLOOR  PO BOX NUMBER\_\_\_\_\_

BUSINESS ADDRESS 1 (If applicable, use this line for additional building information. Otherwise, use this line to indicate STREET NUMBER and STREET NAME)

BUSINESS ADDRESS 2 (If additional space is needed, use this line to indicate STREET NUMBER and STREET NAME)

CITY STATE ZIP CODE

BUSINESS PHONE NUMBER BUSINESS FAX NUMBER E-MAIL ADDRESS

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SECTION 5C. PREFERRED MAILING ADDRESS

Indicate your preferred mailing address by placing an "X" in the appropriate box. This will be the address to which all future registration documents will be mailed. The address that will appear on your registration will be your business address.  HOME  BUSINESS

SECTION 6A. PROFESSIONAL SCHOOLS ATTENDED

List all colleges and universities attended prior to and including medical/professional schools. List schools attended in reverse chronological order, with the most recent at the top.

Table with 4 columns: School Name, City, State, Country; Number of Hours Completed; Date of Graduation; Type of Degree/Certification.

SECTION 6B.

MEDICAL/PROFESSIONAL TRAINING AND MEDICAL/PROFESSIONAL PRACTICE

List all experience since medical/professional school graduation below. Include letters from employing facilities and organizations for internships, residencies, fellowships or employment. For "Description", use the letter from the key below. List experience in reverse chronological order, beginning with the most recent.

Table with 4 columns: Organization/Institution; Start Date; End Date; Description (Use Key Below)\*

\* TRAINING AND PRACTICE DESCRIPTIONS

- A. Fellowship B. Internship C. Residency D. Apprenticeship E. Employment F. Private Practice G. Certifications H. Other (Attach a typed explanation on a separate sheet of paper to this form.)

SECTION 6C. MEDICAL/PROFESSIONAL LICENSES IN OTHER STATES/JURISDICTIONS

Are you now or have you ever been licensed in DC or any other state/jurisdiction?  YES  NO (If "Yes", be sure to complete section 6C of this form.) You must request verification of licensure for all of these licenses, past and/or present.

Table with 3 columns: Jurisdiction; Date License Was First Obtained; License Number

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**SECTION 7. SCREENING QUESTIONS – Applicants MUST answer all of the following questions.**

All applicants must complete ALL questions. **If you answer "Yes" to any of the questions B through J below, please provide a complete explanation on a separate sheet of paper and attach with this application form.**

**A. I have read, understand and agree to abide by this naturopathic statement:**  
 (initial each line)

\_\_\_ The Code of Ethics for Registered Naturopathic Diplomates

\_\_\_ All of the state's laws and regulations where I plan to practice as laws vary from one state to another.

\_\_\_ Naturopaths help prevent disease, but they do not cure disease.

\_\_\_ Never falsely lead any person to believe you (the practitioner) practice anything other than naturopathy.

\_\_\_ Practitioners may counsel and treat individuals through the use of naturally occurring substances and the use of natural and non-invasive therapies.

\_\_\_ This is strictly a naturopathic registration

\_\_\_ Never instruct a client to discontinue any medications prescribed by any doctor.

\_\_\_ Naturopathic practitioners do not take x-rays, inject any substance by needle, remove blood by needle, perform any surgical procedures, or deliver infants.

Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

B.	Have you ever been convicted or arrested for a crime or misdemeanor (other than minor traffic violations) not previously reported to the Board?	<input type="checkbox"/> Yes <input type="checkbox"/> NO	<input type="checkbox"/>
C.	Are you now or have you ever been licensed in the District of Columbia or any other state/jurisdiction? (If "Yes," be sure to complete section 6C of this form.)	<input type="checkbox"/> Yes <input type="checkbox"/> NO	<input type="checkbox"/>
D.	Have you ever been accused of practicing medicine without a license?	<input type="checkbox"/> Yes <input type="checkbox"/> NO	<input type="checkbox"/>
E.	Have you ever voluntarily surrendered a license after formal charges have been filed against you or while under investigation?	<input type="checkbox"/> Yes <input type="checkbox"/> NO	<input type="checkbox"/>
F.	Have you ever been terminated from or resigned from a clinical or professional training program?	<input type="checkbox"/> Yes <input type="checkbox"/> NO	<input type="checkbox"/>
G.	Do you have a physical or medical condition that currently impairs your ability to practice your profession?	<input type="checkbox"/> Yes <input type="checkbox"/> NO	<input type="checkbox"/>
H.	Has the use of drugs and/or alcohol resulted in an impairment of your ability to practice your profession?	<input type="checkbox"/> Yes <input type="checkbox"/> NO	<input type="checkbox"/>
I.	(1) Have you withdrawn an application (in D.C. or any other state/jurisdiction) to practice your profession? (2) Has any authority or peer review board taken adverse action against your license or privileges? (3) Are you currently under investigation or were you investigated by any authority or peer review board for any violation of state, federal, or local law? (4) Has any authority or peer review board informed you of any pending charges(s) or investigation not previously reported to this Board?	<input type="checkbox"/> Yes <input type="checkbox"/> NO	<input type="checkbox"/>
J.	Have you ever been terminated or asked to resign from employment since obtaining your (professional) license?	<input type="checkbox"/> Yes <input type="checkbox"/> NO	<input type="checkbox"/>

**Please complete the affidavit of application below.**

*All applications that are unsigned by the applicant will be returned unprocessed.*

**SECTION 8. LICENSEE AFFIDAVIT**

I hereby attest that the information given in this application, including all writings and exhibits attached hereto, is true and complete to the best of my knowledge. I understand that the making of a false statement on this application, including all writings and exhibits attached hereto, is punishable by criminal penalties and the revocation of national license.

\_\_\_\_\_  
REGISTRATION SIGNATURE

\_\_\_\_\_  
NAME (Please Print)

\_\_\_\_\_  
DATE