State of Arizona Naturopathic Physicians Medical Board
"Protecting the Public's Health"
1400 W. Washington, Ste. 230, Phoenix, AZ 85007 , www.aznd.gov

APPLICATION FOR SPECIALIST CERTIFICATE

THIS APPLICATION AND ANY DOCUMENT SUBMITTED WITH THIS APPLICATION BECOMES THE PROPERTY OF THE STATE OF ARIZONA AND IS NOT RETURNED TO THE APPLICANT. FEES ARE NONREFUNDABLE. INCOMPLETE OR UNREADABLE APPLICATIONS WILL DELAY PROCESSING. TYPE OR PRINT LEGIBLY.

Pursuant to A.R.S. § 41-1030 (B) An agency shall not base a licensing decision in whole or in part on a licensing requirement or condition that is not specifically authorized by statute, rule or state tribal gaming compact. A general grant of authority does not constitute a basis for imposing a licensing requirement or condition unless a rule is made pursuant to that general grant of authority that specifically authorizes the requirement or condition. **Pursuant to A.R.S. §41-1030 (D)** This section may be enforced in a private civil action and relief may be awarded against the State. The Court may award reasonable attorney fees, damages and all fees associated with the license application to a party that prevails in an action against the State for violation of this section. **Pursuant to A.R.S. §41-1030 (E)** A State employee may not intentionally or knowingly violate this section. A violation of this section is cause for disciplinary action or dismissal pursuant to the Agency's adopted personnel policy. **Pursuant to A.R.S. §41-1030 (F)** This section does not abrogate the immunity provided by Section 12-820.01 OR 12-820.02.An individual with a disability who, as a result of that disability, requires this application in an alternative format may contact the Board's Americans with Disability coordinator at Voice Telephone Number (602) 542-3095, or through Voice Replay Service at (800) 842-4681 or the TTY Service at (800) 367-8939 to make the need known.

$225.00 APPLICATION FEE. MONEY ORDER OR CASHIERS CHECK ONLY: PAYABLE TO THE AZND BOARD SEND COMPLETE APPLICTION, ALONG WITH FEE TO THE ADDRESS ABOVE

APPLICANT INFORMATION

Applicant's Legal Name: _____N.M.D.___ N.D._____
Designation Used

Applicant's Current State of Arizona Naturopathic Medical License No:_____-_____

Applicant's Contact Information: _____ _____
Email Phone

Applicant's Mailing Address:_____

APPROVED SPECIALTY COLLEGE OR PROGRAM

Name and address of the approved specialty college or program at which you completed postdoctoral specialty training.

Name of Specialty College or Program:_____

Address of Specialty College or Program:_____

Phone Number: _____Website address of Specialty College or Program_____

WHAT SPECIALTY DID YOU RECEIVE TRAINING IN

☐ Oncology ☐ Pediatrics ☐ Environmental ☐ Family Medicine ☐ Other _____

Date postdoctoral training in specialty was completed**:**_____/_____/_____

THE SPECIALTY COLLEGE OR PROGRAM MEETS THE DEFINITION OF R4-18-101 AND WAS APPROVED BY

☐ The Council on Naturopathic Medical Education

☐ The American Association of Naturopathic Physicians

☐ The Arizona Naturopathic Medical Association

☐ Other:_____

I HAVE REQUESTED THE COLLEGE OR PROGRAM TO SEND VERFICIATION OF MY SPECIALTY CERTIFICATION DIRECTLY TO THE NATUROPATHIC BOARD.

Date requested_____

- Do you have any medical condition that in any way impairs or limits your ability to practice medicine?

  ☐ Yes - Submit Explanation ☐ No

- Have you ever been found guilty of any act of unprofessional conduct or any other conduct that would be grounds for refusal, suspension or revocation of a license

  ☐ Yes - Submit Explanation ☐ No

- Have you ever had any license to practice any profession refused, revoked or suspended by any other state, district or territory of the United States or another country for reasons that relate to your ability to skillfully and safely practice as a physician in this State.

  ☐ Yes- Submit Explanation ☐ No

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, correct 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 Medical Board, 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 Medical Board to hold a hearing to revoke any naturopathic medical license or certificate 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 _____, 200_____
(OFFICIAL STAMP)

_____
Notary Public Signature

Office Use Receipted	*Processed*	*Emailed*	*Agenda*

Revised 7/2015