Arizona Naturopathic Physicians Medical Board 1740 W Adams Ste. 3002 Phoenix AZ 85007
Annual Naturopathic Physicians Medical License Renewal Application
YOU MAY RENEW ONLINE AT www.aznd.gov (Online Payment Processing)

☐ **Renewal Fee is $165.00:** License must be renewed on or before **January 1st.** (Fees are non-refundable)
Late fee of $83.00 is required if application is post marked after **January 1st.** (Late fees cannot be waived)
Personal check or money orders are the only forms of payment accepted, payable to: State of Arizona Naturopathic Medical Board.

☐ I am requesting **RETIREMEN**T of my medical license in the State of Arizona to practice Naturopathic Medicine.

Signature_____ Date _____

PLEASE BE AWARE: you must **allow at least 30 days for processing** of your renewal. **If you wait until the end of December to renew your license**, **it will not be processed until 2018**. Licensure renewals are processed in the order they are received. Renewal forms and payment must be received together. Once your application is processed an email will be sent with the renewed license for you to copy.

LICENSE NO:_____ **DATE OF INITIAL ISSUANCE** _____

Physician
Last Name:_____ **First Name** _____ **Middle Initial** _____

EMAIL ADDRESS _____

ADDRESS: Every physician must have an address available to the public. If only one address is provided, even if it is your home address, it will be available to the public. **Primary Office Address**: This is the office/principle place of business. **Secondary Location Address**: Any other location in which you conduct business/maintain a continued activity. **Home Address**: You are required to provide a home address and phone number. They will not be released to the public unless you fail to provide an office address. **Mailing Address**: Please provide a mailing address, this will be the location the renewed license(s) will be mailed. **Email Address**: This address is optional and will not be provided to the public, however in an effort to keep Board costs at a minimum and licensing fees from increasing, the Board will be emailing appropriate Board correspondence to our licensees.

PRIMARY OFFICE: PRACTICE NAME_____

Address;_____ City_____ State _____ Zip_____

OFFICE PHONE:_____FAX:_____

SECONDARY OFFICE LOCATION(S): PRACTICE NAME: _____

OFFICE ADDRESS:_____City_____ State_____ Zip_____

OFFICE PHONE:_____FAX:_____
If you have additional locations, use a separate piece of paper to list all information required.

Home Address: _____ City_____ State_____ Zip_____

CELL PHONE:_____

Check One Mailing Address: Primary Office Address Home Address Other

Other_____

For Board Use Receipted	Entered Date	Yes Questions	Alien/Citizen proof
Deficient Email Date	Rectified Date	Complete via email/X frame	Agenda

Failure To Complete The Required CME May Be Considered Unprofessional Conduct.
I understand the above statement ☐ Check Box to Confirm

ANSWER THE ONE QUESTION THAT BEST APPLIES TO YOUR RENEWAL.

☐ In accordance with A.A.C. R4-18-205 I have completed a minimum of 30 hours of CME during 2017, 10 hours of the 30 CME hours have been in pharmacology and at least 8 hours have been from an approved naturopathic organization.

☐ My initial license was issued by the Board in 2017 I am not required to comply with the CME requirements until 2018. (This only applies to licensees who have recently graduated)
Physicians who are newly licensed by ENDORSEMENT from another state must comply with the CME requirements.)

ANSWER ALL OF THE FOLLOWING QUESTIONS

NOTE: In the event that the response to any of the questions is "yes" you must submit-explanation with this application.

Since you last license renewal	**Yes or No**
Were you arrested or charged with, convicted of, or entered into a plea of no contest to any criminal act?	
Have you had any licensing agency or board, in any state, district of the U.S. or another country initiate or take any action against any license or certificate that is or was held?	
In lieu of disciplinary action by an agency, have you ever entered a consent agreement or stipulation with a licensing agency?	
Were you a defendant in any malpractice matter that resulted in a settlement or judgment?	
Do you have a complaint in any state, district of the U.S. or another country pending before any agency or court of law?	

Submit a written supplement to this application if the answer is YES to any of the above questions.

EVIDENCE OF U.S. CITIZENSHIP, U.S NATIONAL STATUS, OR ALIEN STATUS

1. Are you a United States Citizen? Yes No

2. To be completed by applicants who are not a citizens or nationals of the United States. Attach a legible copy of the front, and the back (if any), of a current document that evidences your status. A.R.S. § 1-501.

Name of document provided _____

I hereby attest to the Board that I am the physician named on this renewal form; the answers provided and any statement submitted with the renewal form is true and correct. Signature of licensee is required

Signature_____ Date _____

LICENSURE RENEWAL CHECK LIST DID YOU:

☐ Complete the renewal form, making sure all required information is provided. **Incomplete forms will not be processed**.

☐ Include **License Renewal Fee $165.00, If postmarked after January 1, 2018**, you must include a **LATE FEE OF $83.00.**
Acceptable form of payment: Personal check or money orders are the only forms of payment accepted with this application. **DO NOT SEND CASH OR PROVIDE A CREDIT CARD NUMBER**. **THERE WILL BE A $25.00 FEE FOR RETURNED CHECKS**.

If you are being audited for CME you would have or will be notified by the board, and will need to provide proof of 30 hours of CME. (Refer to Resources on the website "CME Compliance Checklist Sheet")

If the License is not renewed within 60 days of the expiration date, your license will automatically expire.

Revised 09/052017