



State of Arizona  
Naturopathic Physicians Medical Board

"Protecting the Public's Health"  
1740 W Adams Ste 3002 Phoenix, AZ 85007 Phone:  
(602) 542-8242 Email: info@aznd.gov

**ENGAGE IN A PRECEPTORSHIP TRAINING PROGRAM**

Only complete applications are considered by the Board. Failure to provide all the requested information will delay the processing of your application. Once the application is received, allow 6 weeks to process, an email will be sent if additional information is needed.

**Application must include the following**

- Money Order in the amount of \$100.00 payable to the AZND Board
- Money Order in the amount of \$22.00 payable to DPS
- Fingerprint Card (not a clearance card)
- One (1) passport-size photograph taken within the last 60 days with your signature on the back.
- Citizenship /Alien Status Documentation Required State Law (A.R.S. § 1-501)
- If applicable, a detailed explanation and supporting documentation for affirmative questions.
- I have included the Supervisor Physician Attestation.
- I have requested an official copy of my transcript issued by my naturopathic medical school.
- Application must be notarized.

**APPLICANT INFORMATION**

Name of Applicant: Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

Former names used: \_\_\_\_\_

Email Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number \_\_\_\_\_ Gender:  Female  Male

Place of Birth \_\_\_\_\_ State \_\_\_\_\_ Country \_\_\_\_\_

Applicant Address: \_\_\_\_\_

City: \_\_\_\_\_, State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone \_\_\_\_\_

Preceptorship conducted-Practice Address  
Street: \_\_\_\_\_ Suite \_\_\_\_\_

City: \_\_\_\_\_, State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone \_\_\_\_\_

**Check One Mailing Address:**      Primary Office Address      Home Address

**APPROVED MEDICAL COLLEGE INFORMATION**

Medical School from which you graduated: \_\_\_\_\_

Address: \_\_\_\_\_

Date Graduated: \_\_\_\_\_ Transcript requested to be sent to AZND Board  Yes,  No

Have you taken and passed the Jurisprudence?  Yes  No Date Passed \_\_\_\_\_

I have read and understand 32.1561

**32-1561. Internship, clinical fellowship and preceptorship programs; duties; prohibitions**

Received	Processed	Emailed	Agenda
----------	-----------	---------	--------

ARIZONA STATEMENT OF CITIZENSHIP OR ALIEN STATUS FOR STATE PUBLIC BENEFITS  
Arizona Naturopathic Physicians Medical Board

Title IV of the federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (the "Act"), 8 U.S.C. § 1621, provides that, with certain exceptions, only United States citizens, United States non-citizen nationals, non-exempt "qualified aliens" (and sometimes only particular categories of qualified aliens), nonimmigrants, and certain aliens paroled into the United States are eligible to receive state, or local public benefits. With certain exceptions, a professional license and commercial license issued by a State agency is a State public benefit. Arizona Revised Statutes § 41-1080 requires, in general, that a person applying for a license must submit documentation to the license agency that satisfactorily demonstrates the applicant's presence in the United States is authorized under federal law.

**Directions:** All applicants must complete **Sections I, II, and IV**. Applicants who are not U.S. citizens or nationals must also complete Section III. Submit this completed form and a copy of one or more document(s) from the attached "Evidence of U.S. Citizenship, U.S. National Status, or Alien Status" with your application for license or renewal. If the document you submit does not contain a photograph, you must also provide a government issued document that contains your photograph. You must submit supporting legal documentation (i.e. marriage certificate) if the name on your evidence is not the same as your current legal name.

**SECTION I - Applicant's Name** \_\_\_\_\_

**SECTION II - CITIZENSHIP OR NATIONAL STATUS DECLARATION**

Are you a citizen or national of the United States?  Yes  No.

If you answered **yes**,

**1) Attach a legible copy of a document from the list below.**

1. An Arizona driver license issued after 1996 or an Arizona non-operating identification license.
  2. A birth certificate or delayed birth certificate issued in any state, territory or possession of the United States.
  3. A United States certificate of birth abroad.
  4. A United States passport.
  5. A foreign passport with a United States visa.
  6. An I-94 form with a photograph.
  7. A United States citizenship and immigration services employment authorization document or refugee travel document.
- See Arizona Revised Statutes § 41-1080 for a complete list. Refer to the website then forms to locate the A & B list

**2) Name of Document** \_\_\_\_\_

**3) Go to section IV. If you answered **No**, you must complete Section III and IV**

**SECTION III-ALIEN STATUS DECLARATION** To be completed by applicants who are not citizens or nationals of the United States. Indicate alien status by checking the appropriate box. Attach a legible copy of a document from the attached list or other document as evidence of your status.

Name of document provided \_\_\_\_\_

Qualified Alien Status (8 U.S.C. §§ 1621(a)(1), -1641(b) and (c)), Nonimmigrant Status (8 U.S.C. § 1621(a)(2)), Alien Paroled into the United States For Less Than One Year (8 U.S.C. § 1621(a)(3)), Other Persons (8 U.S.C § 1621(c)(2)(A) and (C))

**SECTION IV - Declaration** ALL APPLICANTS MUST COMPLETE THIS SECTION

**I declare under penalty of perjury under the laws of the state of Arizona that the answers and evidence I have given are true and correct to the best of my knowledge.**

\_\_\_\_\_  
**Applicant's Signature**

\_\_\_\_\_  
**Date**

**\*An applicant is required to submit a written supplement to this application if the answer is Yes to any of the below 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 questions 1 through 9.**

**Answer the following Questions**

Yes or No

Were you arrested or charged with, convicted of, or entered into a plea of no contest to a felony or a misdemeanor?	
Did you ever have a Naturopathic Medical license/certificate, or any health profession license or certification denied, suspended, rejected, or revoked by any state, or another country?	
Were you disciplined by any agency in any state, or another country, for any act of unprofessional conduct as defined in ARS 32-1501?	
In lieu of disciplinary action by an agency, have you ever entered a consent agreement or stipulation with a licensing agency?	
Do you have a complaint pending before any agency or court of law?	
Have you ever been found guilty of being medically incompetent?	
Were you a defendant in any malpractice matter that resulted in a settlement or judgment?	
Have you ever had the authority to prescribe, dispense, or administer a natural substance, drug, or device limited, restricted, modified, denied, surrendered or revoked by a federal or state agency or court of law in any state or another country?	
Do you have any medical condition that in any way impairs or limits your ability to practice medicine?	

**I submitted a written supplement to this application if the answer is YES to any of the above questions. Yes \_\_\_ 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 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** \_\_\_\_\_

**My Notary Commission expires** \_\_\_\_\_

## SUPERVISING PHYSICIAN'S ATTESTATION

**Chief Medical Officer Name:** \_\_\_\_\_  
[CMO] License #: \_\_\_\_\_ Email Address: \_\_\_\_\_  
Practice Address: \_\_\_\_\_

**Supervising Physician Name:** \_\_\_\_\_  
Medical License #: \_\_\_\_\_ Email Address: \_\_\_\_\_  
Practice Address: \_\_\_\_\_

- I agree to be the supervising physician.
- In the event that I withdraw from supervising, I will immediately notify the board.
- In the event I am not available as supervising physician, the following has been assigned as a designated agent. [if applicable]

**Designated Physicians who will be providing supervision in the training program:** Per 32-1561 B.13,17 or 29.

Name: \_\_\_\_\_ Medical License #: \_\_\_\_\_  
Practice  
Address: \_\_\_\_\_

Name: \_\_\_\_\_ Medical License #: \_\_\_\_\_  
Practice  
Address: \_\_\_\_\_

• **I HAVE READ AND UNDERSTAND A.R.S. §32-1561.** B. If the application submitted pursuant to subsection A of this section is approved by the board, that person may engage in a board approved internship program, clinical fellowship or **preceptorship** program under the **direct supervision** (*Is physically present and within sight or sound of the person supervised and is available for consultation regarding procedures that the physician has authorized and for which the physician remains responsible.*) of a physician licensed under this chapter or by a physician licensed pursuant to chapter 13, 17 or 29 of this title. C. The board by rule may prescribe naturopathic medical treatment procedures that a person who is certified under this section may perform under the **direct supervision** (*Is physically present and within sight or sound of the person supervised and is available for consultation regarding procedures that the physician has authorized and for which the physician remains responsible.*) of a physician licensed under this chapter if the board determines that these procedures: 1. May be competently performed by the graduate. 2. Do not exceed the procedures that the supervising physician has been licensed by this state to perform. D. A person who is certified under this section may do clerical tasks without direct supervision if the tasks do not involve diagnosing or treating a patient's condition. E. If the supervising physician of a person who is certified under this section withdraws from direct supervision, the certificate to engage in the training program held by that person is automatically canceled. F. A person who is certified under this section shall not employ that person's supervising physician and shall not have any financial interest in any business owned by that person's supervising physician.

• Furthermore I have **READ** and **UNDERSTAND R4-18-108** regarding the use of title An UNLICENSED graduate of a Board approved school of Naturopathic Medicine who is certified by the Board to engage in preceptorship training SHALL use the designation **"(PRECEPTEE)"** after any of the following designations, Doctor of Naturopathic Medicine, N.M.D., Doctor of Naturopathy, N.D. Naturopath, Naturopathic Physician, or Naturopathic Medical Doctor. The PRECEPTEE SHALL also ensure that any patient treated by the preceptee signs an informed consent treatment form stating clearly that the preceptee is undergoing training, is not licensed, and identifying the name of the supervising physician. The preceptee must not in any way lead the public to believe that he or she is a licensed naturopathic physician.

**I declare under penalty of perjury under the laws of the state of Arizona that the answers I have given are true and correct to the best of my knowledge.**

**Signature of Supervising Physician:** \_\_\_\_\_ **Date** \_\_\_\_\_