

**State of Nevada**  
**Board of Homeopathic Medical**  
**Examiners**  
**1301 Cordone Avenue**  
**Reno, NV 89502**  
**Phone: (775) 324-3353**  
**E-mail: [support@nvbhme.org](mailto:support@nvbhme.org)**

**For Office Use Only**  
Do Not Write In This Space

\_\_\_\_\_  
Date of Application

\_\_\_\_\_  
Date Application Fee Paid  
(\$200.00)

\_\_\_\_\_  
Date Fingerprint Card Fee Paid  
(\$50.00)

**APPLICATION FOR CERTIFICATION FOR**  
**HOMEOPATHIC ASSISTANT**

Applicant: \_\_\_\_\_  
(Print Full Name: Last, First, Middle)

**PLEASE READ CAREFULLY:** This application and each of the requirements set forth below must be received by the Board at the above address at least **60 days prior to the date set by the Board for examination.**

**APPLICATION REQUIREMENTS:**

1. To be eligible for certification, the applicant must answer completely all questions posed in this application. Write "NA" if a question does not apply. If further space is required to answer a question, please attach completed answer sheet to this form.
2. Type or print in ink all information requested in this application.
3. Read all questions carefully. False, misleading, inaccurate or incomplete answers are grounds for denial of certification or revocation of any certificate issued as a result of false information.
4. You are required to have one letter of recommendation from a physician licensed to practice homeopathy in Nevada, and two letters of recommendation from persons who have known you for one year or longer. Please attach to the application.
5. Attach two (2) photographs clearly evidencing the likeness of the applicant, each taken within sixty (60) days of the date of the application. The photograph must be approximately 3" x 3" and **in color**.
6. Provide documentation of all homeopathic and complementary and alternative medicine training you have had. Provide copies of any licensure or certification that may have a bearing on the qualifications for the certification for which you are applying. For example, licensure or certification as a medical assistant, physician's assistant, registered nurse, licensed practical nurse, emergency medical technician, medic in the Armed Forces, medical technician, etc. Applicants must provide documentation for:

A. Successful completion of not less than **40 credits of training in homeopathic and complementary and alternative medicine** from a program approved by the Board or the Nevada Homeopathic and Integrative Medical Association; and

B. Successful completion of not less than **160 hours of training under the supervision of a homeopathic medical doctor licensed in Nevada.**

7. You may be denied a certificate if you have been convicted on any basis of a crime. The questions asked regarding criminal record must be answered and the positive answers must be verified. **You are required to go to the Nevada Highway Patrol, Police or Sheriff's Department and inform them of the need for a criminal records check.** You will be required to **submit fingerprints** and pay a standard fee for this service. You must instruct the Highway Patrol, Police or Sheriff's Department to send the original to the board and provide you with a copy.

8. Provided there are no apparent problems with your application, you will be required to appear before the Board, or a representative of the Board, and pass a written open book examination. You may use books, notes, computer, or similar materials during the examination. The written examination will be administered at various times during the year. The applicant must receive a score of at least 70% on the written examination; or a passing score on the oral examination from a majority of the board members who are present and grading the examination, which will be graded on a pass or fail basis.

9. Send a **certified check or money order in the amount of \$200.00 made payable to the Nevada State Board of Homeopathic Medical Examiners, and an additional check for \$50.00 for fingerprint card fee.**

10. The applicant must appear personally before the Board for an oral interview and pass the required examination.

11. **PERSONAL BACKGROUND:** All applicants must answer the following questions in detail.

### **IDENTIFYING INFORMATION**

Name \_\_\_\_\_ SS# \_\_\_\_\_  
Last First Middle

Maiden Name if Applicable: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Any other names used: \_\_\_\_\_

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

Business Address (es) \_\_\_\_\_  
Street City State Zip

Mailing Address: \_\_\_\_\_  
Street City State Zip

Daytime Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

U.S. Citizen: Yes \_\_\_\_\_ No \_\_\_\_\_ Naturalized: Yes \_\_\_\_\_ No \_\_\_\_\_

Naturalized Certificate Number: \_\_\_\_\_

U.S. Military Service: Yes \_\_\_\_\_ No \_\_\_\_\_ Branch of Service: \_\_\_\_\_

Dates of Service: From \_\_\_\_\_ To \_\_\_\_\_

Rank: \_\_\_\_\_ Serial Number: \_\_\_\_\_ Type of Discharge: \_\_\_\_\_

Are you licensed to drive: Yes \_\_\_\_\_ No \_\_\_\_\_ Class \_\_\_\_\_ State of Issue \_\_\_\_\_

License Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

### **CHILD SUPPORT INFORMATION:**

Federal Welfare Reform as implemented by the 1997 Session of the Legislature by SB 356 requires that professional and occupational licensing agencies add the following questions regarding child support to all applications for new licenses and for renewals. Please mark the appropriate response. Failure to mark one of the three will result in denial of the application.

\_\_\_\_\_ I am not subject to a court order for the support of my child.

\_\_\_\_\_ I am subject to court order for the support of one or more children and am in compliance with the order or am in compliance with a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order; or

\_\_\_\_\_ I am subject to a court order for the support of one or more children and am **not** in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

### **CRIMINAL RECORD**

Have you ever been convicted of a crime? (Traffic violations involving a fine of \$150.00 or less or any juvenile offense that was not prosecuted as an adult are not considered crimes for these purposes)

Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, provide information for each incidence: Date; Charge; Disp. of Charges.

### **EDUCATIONAL BACKGROUND:**

Please provide the following information:

Graduated from High School: Yes \_\_\_\_\_ No \_\_\_\_\_

Location: \_\_\_\_\_ When: \_\_\_\_\_

Technical School: Name: \_\_\_\_\_

Course or Program: \_\_\_\_\_

Date of Completion: \_\_\_\_\_ Diploma: \_\_\_\_\_ Certificate: \_\_\_\_\_  
(Attach a copy of all Degrees, Diplomas or Certificates)

College/University: \_\_\_\_\_

Course or Program: \_\_\_\_\_

Date of Completion: \_\_\_\_\_ Diploma: \_\_\_\_\_ Certificate: \_\_\_\_\_  
(Attach a copy of all Degrees, Diplomas or Certificates)

Professional or Graduate School: \_\_\_\_\_

Address: \_\_\_\_\_ Phone # \_\_\_\_\_

Date of Completion: \_\_\_\_\_ Degree: \_\_\_\_\_  
(Fill out and sign the attached Professional or Graduate School Transcript authorization)

Homeopathic Training Program: \_\_\_\_\_

Address of School \_\_\_\_\_ Phone # \_\_\_\_\_  
(Attach copies of Diploma or Certificate)

Naturopathic Training Program: \_\_\_\_\_

Address of School \_\_\_\_\_ Phone # \_\_\_\_\_  
(Attach copies of Diploma or Certificate)

Preceptorship Training: Location: \_\_\_\_\_

Preceptor: \_\_\_\_\_  
(Attach a copy of Certificate from the Preceptor showing the number of credits and subject matter)

Have you ever been licensed or certified to perform any medical services? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what service(s) and where? \_\_\_\_\_

Has any professional license or certificate ever been revoked or limited as a result of disciplinary action by a state, country, or territory licensing authority? Yes \_\_\_\_\_ No \_\_\_\_\_. If yes, give details on a separate sheet, including name of licensing authority, place, and date of action.

Staple one photograph here

Include a 2<sup>nd</sup> photograph with application, unattached.

**Place signature on both photos**

STATE OF NEVADA

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COUNTY OF \_\_\_\_\_

**AFFIDAVIT**

(To be signed by Applicant and notarized)

I, \_\_\_\_\_, being duly sworn, upon oath and under penalty of perjury do depose and state: That I am the individual named in the foregoing document; that I have answered all questions truly and accurately to the best of my ability.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Printed name of Applicant

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 200\_\_\_\_.

\_\_\_\_\_  
Notary Public

\_\_\_\_\_  
My Commission Expires

## **Statement of Supervising Homeopathic Physician**

The supervising Homeopathic Physician must be currently licensed with the State of Nevada Board of Homeopathic Medical Examiners. The supervising Homeopathic physician must provide the following information:

1. Supervising Homeopathic Physician's Name: \_\_\_\_\_
2. Current physical address and phone number of each location where the Homeopathic Assistant will provide medical services (general office hours that apply):  
  
Address/Phone: \_\_\_\_\_  
  
Address/Phone: \_\_\_\_\_
3. Date and time the supervising Homeopathic Physician will be present at each location to consult with and monitor the medical services provided by the Homeopathic Assistant:  
Dates and Times: \_\_\_\_\_  
\_\_\_\_\_
4. As the Supervising Homeopathic Physician, I have read and will implement all necessary procedures to be in accordance with NAC.

STATE OF NEVADA

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COUNTY OF \_\_\_\_\_

### **AFFIDAVIT**

I, \_\_\_\_\_, being duly sworn, upon oath and under penalty of perjury do depose and state: That I am the individual named in the foregoing document; that I have answered all questions truly and accurately to the best of my ability.

\_\_\_\_\_  
Signature of Supervising Physician

\_\_\_\_\_  
Printed name of Supervising Physician

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 200\_\_.

\_\_\_\_\_  
Notary Public

\_\_\_\_\_  
My Commission Expires