State of Nevada
Board of Homeopathic Medical Examiners
1301 Cordone Avenue, Suite 126
Reno, NV 89502
Telephone: 775.324.3353
Email: support@nvbhme.org

APPLICATION FOR REGISTRATION OF LICENSURE AS A HOMEOPATHIC MEDICAL DOCTOR

REGISTRATION FEE: $600.00 DUE DATE: DECEMBER 31, 2018

PLEASE PRINT OR TYPE

Name of License Holder: _____ License No.: _____

Social Security No.: _____ Date of Birth: _____

Drug Enforcement Administration No.: _____

Nevada State Board of Pharmacy No.: _____

Office Mailing Address: _____

City / State / Zip Code: _____

Office Telephone No.: _____ Office Facsimile No.: _____

Home Mailing Address: _____

City / State / Zip Code: _____

Home Telephone No.: _____ Cellular Telephone No.: _____

Email Address: _____

1. Has any disciplinary action, including the voluntary surrender, revocation, limitation or restriction, been taken against your license since you last applied for issuance or registration of your license?

Yes _____ No _____

If yes, attach a certified copy of the final order, stipulation or consent agreement.

2. Has any disciplinary action, including the voluntary surrender, revocation, limitation or restriction, been taken against any license you hold from another licensing authority since you last applied for

issuance or registration of your license?

Yes _____ No _____

If yes, attach a certified copy of the final order, stipulation or consent agreement.

3. Has any malpractice or any other lawsuit or settlement, award, or judgment been made against you or your practice since you last applied for issuance or registration of your license?

Yes _____ No _____

If yes, attach a certified copy of the court action or settlement.

4. Have you been convicted of, or pled nolo contendre to, a felony or to a misdemeanor involving a crime of moral turpitude since you last applied for issuance or registration of your license?

Yes _____ No _____

If yes, attach a certified copy of the court records showing the court's decision and sentence.

5. List all States, United States Territories and/or Foreign Countries where you currently hold an active license in good standing to practice medicine and the corresponding license number and type of license.

State/Territory/Country: _____ License No.:_____ MD _____ DO _____

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State/Territory/Country: _____ License No.:_____ MD _____ DO _____

State/Territory/Country: _____ License No.:_____ MD _____ DO _____

6. Check all modalities that you intend to offer under your supervision to 25% or more of your patients.

_____ Herbal Therapy
_____ Accupuncture-electrodiagnosis
_____ Classical (Kentian) Homeopathy
_____ Complex Homeopathy and Electrotherapeutics (EAV related)
_____ Orthomolecular Therapy
_____ Bio-Oxidative Therapies
_____ Neuromuscular Integration
_____ Chelation Therapy (see 7 below)
_____ Nutrition, including Parental Therapy
_____ Neural Therapy
_____ Other (specify) _____

7. Do you intend to offer Intravenous Chelation Therapy and/or Intravenous Bio-Oxidative Therapies as part of your practice?

_____ Yes, I intend to offer Intravenous Chelation Therapy.
_____ Yes, I intend to offer Intravenous Bio-Oxidative Therapy.
_____ Yes, I follow ACAM and/or IBOM protocols, including signed informed patient consent.
_____ Yes, my therapy protocol(s) are already on file with the Board and have not changed since last year.
_____ No, I do not intend to offer Chelation Therapy.
_____ No, I do not intend to offer Intravenous Bio-Oxidative Therapy.

8. 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 responses will result in denial of the Application or registration.

_____ 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.

9. Do you have any medical condition, chemical dependency or are you suffering from any physical, emotional or psychiatric impairment that adversely affects, or in any way impairs, your ability to practice medicine?

Yes _____ No _____

If yes, attach a detailed explanation of your condition.

10. Pursuant to NAC 630A.095, you are required to obtain at least 20 continuing education credits of courses approved by the Board. Have you fulfilled this requirement?

Yes _____ No _____

I hereby certify that I have completed, or will complete, all registration requirements before the expiration of my current certificate. I understand and acknowledge that I may be subject to an audit of these requirements by State of Nevada Board of Homeopathic Medical Examiners.

I hereby certify that the information contained in this Application for Licensure Registration is true, correct and complete. I understand that I will be subject to disciplinary action including, but not limited to, the revocation of my License to Practice Homeopathic Medicine for violating NRS 630A.350 (3) by providing false, incomplete or misleading information.

_____ Date: _____

Signature of Applicant