

State of Nevada  
Board of Homeopathic Medical Examiners  
1310 Cordone Avenue, Suite 126  
Reno, NV 89502  
Telephone: 775.324.3353

**INSTRUCTIONS FOR LICENSURE RENEWAL FOR THE YEAR 2018**

**THIS IS THE ONLY RENEWAL NOTICE THAT YOU WILL RECEIVE**

**YOUR RENEWAL IS DUE BY DECEMBER 31, 2017**

**TIMELY RENEWAL:** It is your responsibility to comply with all general and specific renewal requirements stated below and to submit your completed "Application for Licensure Renewal" promptly. If we do not receive your completed application by the due date, you will not receive a new License and will be restricted from practicing under NRS 630A.

**RENEWAL FEES:** The fees quoted herein are current at the time this renewal form was printed. If you fail to renew your Licensure by the due date your License will be suspended.

**APPLICATION APPROVAL:** Your renewal application will be approved unless it is apparent that you do not meet the renewal requirements. You may be subject to audit by the State of Nevada Board of Homeopathic Medical Examiners. Those selected for this will be notified by a separate notice. Please note that the State of Nevada Board of Homeopathic Medical Examiners reserves the right to initiate action at any time against a License Holder who did not meet the renewal requirements at the time their License was renewed.

**GENERAL REQUIREMENTS:** Please insert any missing information and correct any errors on the Application for Licensure Renewal beginning on Page 2 of this Application and sign the Application for Licensure Renewal. Return the completed form, together with the appropriate renewal fee, at least 30 days prior to the due date. Payments are accepted by check or money order and should be made payable to the "State of Nevada Board of Homeopathic Medical Examiners." **DO NOT SEND CASH**

**\*\*NOTE\*\***

If requested by the State of Nevada Board of Homeopathic Medical Examiners, each Homeopathic Physician, Advanced Practitioner of Homeopathy and Homeopathic Assistant must submit evidence that he/she has completed during the preceding year 20 credits of continuing education (CE) in courses sponsored by the Nevada Homeopathic and Integrative Medical Association (NHIMA), the Arizona Homeopathic and Integrative Medical Association (AHIMA), courses/workshops approved by the State of Nevada Board of Homeopathic Medical Examiners or courses/workshops sponsored by the following organizations wherein any of the therapies listed in NRS 630A are taught:

American Medical Association; American Institute of Homeopathy; American Osteopathic Association; American Association of Oriental Medicine, Complementary and Alternative Medicine; American Naturopathic Medical Association; Orthomolecular Medical Society; American College for Advancement in Medicine; and Courses in Thought Field Therapy.

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**APPLICATION FOR RENEWAL OF LICENSURE AS A HOMEOPATHIC MEDICAL DOCTOR**

**RENEWAL FEE: \$600.00**

**DUE DATE: DECEMBER 31, 2017**

**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 renewal 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 renewal 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 renewal 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 contendere to, a felony or to a misdemeanor involving a crime of moral turpitude since you last applied for issuance or renewal 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 \_\_\_\_

State/Territory/Country: \_\_\_\_\_ License No.: \_\_\_\_\_ MD \_\_\_\_ DO \_\_\_\_

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

\_\_\_\_\_ 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. (a) Have you ever served on active duty in the Armed Forces of the United States and separated from such service under conditions other than dishonorable?

Yes \_\_\_\_\_ No \_\_\_\_\_

(b) Have you ever been assigned to duty for a minimum of 6 continuous years in the National Guard or a reserve component of the Armed Forces of the United States and separated from such service under conditions other than dishonorable?

Yes \_\_\_\_\_ No \_\_\_\_\_

(c) Have you ever served the Commissioned Corps of the United States Public Health Service or the Commissioned Corps of the National Oceanic and Atmospheric Administration of the United States in the capacity of a commissioned officer while on active duty in defense of the United States and separated from such service under conditions other than dishonorable?

Yes \_\_\_\_\_ No \_\_\_\_\_

11. Pursuant to NAC 630A.096, 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 renewal 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 all of the information contained in this Application for Licensure Renewal 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.

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

Date: \_\_\_\_\_