New Mexico Medical Board
2055 S. Pacheco Street, Building 400
Santa Fe, NM 87505
505-476-7220
Fax: 505-476-7233
Email: nmbme@state.nm.us

Michelle Lujan Grisham
Governor

Steve Jenkusky, MD
Chair

TO ALL APPLICANTS

Thank you for requesting an application for a license to practice naturopathic medicine in New Mexico. In New Mexico, naturopathic medicine is regulated by the New Mexico Medical Board. We look forward to working with you to process your application.

A license to practice naturopathic medicine in New Mexico is a privilege, not a right. The statutory mandate of the New Mexico Medical Board is to protect the health and safety of the citizens of the state, and the members of the Medical Board take their responsibilities very seriously. Upon completion, your application will be reviewed for quality assurance and reviewed by the medical and executive directors of the Board. You may be required to come to the Board Office in Santa Fe for an interview as part of the application process. *Please do not assume that licensure is a mere formality or that the granting of a license is automatic.*

PLEASE DO NOT: close your practice and move your family to New Mexico, enroll your children in school, begin construction of a new home, execute contracts with prospective practice partners, schedule patients, or begin practicing until you have received a license.

We will make every effort to complete the application process as quickly as possible but occasionally we encounter unanticipated questions or difficulties that may cause delay or even denial. We will not begin working on your application until we have received a completed NM Statewide application and all required fees. Please understand that much of the supporting documentation for your application has to be obtained from third parties, which can add time to the licensing process. In addition some applications, such as those with a history of disciplinary action, require in-depth investigation that may take extra time and require your cooperation.

One sure way to make certain that your application is processed as efficiently as possible is to read the directions carefully, and call (505) 476-7220 or email at nmbme@state.nm.us at the Board office if you have any questions. Our staff will be happy to assist you in any way we can.

Again, thank you for your application. *We look forward to working with you to make this process as rapid and painless as possible!*

GENERAL INFORMATION FOR NATUROPATHIC DOCTORS LICENSURE

CRIMINAL HISTORY BACKGROUND CHECK

Like other state medical boards around the country, the NM Medical Board will conduct criminal background checks in order to fulfill its statutory mandate to protect the health and safety of the NM public. The applicant is responsible for any costs associated with obtaining fingerprints.

Will the criminal background check slow down my license application?
An application for initial licensure will not be considered complete until the required fingerprinting has been completed. However, completed applications will be processed pending the outcome of the background check, and licenses may be granted while the screening is still pending. If the background check reveals a felony or a violation of the Medical Practice Act the licensee will be notified and the Board will determine if the applicant is eligible for licensure or if disciplinary action will be taken against the licensee.

The State of NM has recently partnered with Gemalto to improve the public availability of fingerprint services, shorten background check response times and increase applicant convenience.

PLEASE DO NOT SEND YOUR FINGERPRINTS TO THE BOARD. WE WILL NOT ACCEPT THEM AND THEY WILL BE RETURNED TO YOU.

PLEASE READ AND FOLLOW THESE INSTRUCTIONS CAREFULLY

If you are a current resident of NM, please follow the instructions below:	**If you live outside of NM, please follow the instructions below:**
ALL APPLICANTS MUST REGISTER ONLINE	
1. To register, please visit https://www.aps.gemalto.com/index.htm and click on the State of NM logo. While online registration is the preferred registration method, telephone registration can also be completed by calling 1-877-99NMAPS (1-877-996-6277) **2.** Go to the "Applicant Use" Section of the webpage **3.** Click on the Register Online for a Background Check link. (Registration is the process of collecting demographic information (name, height, eye color, etc) and collection of payment. The new fee for fingerprint service is ***$45.25.*** **4.** Once Registration and payment are complete the applicant will receive a registration ID (REG ID) that is unique to their fingerprinting record. **5.** Visit one of the NMAPS fingerprint sites. Please see attached list of approved sites in NM or go to https://www.aps.gemalto.com/index.htm > New Mexico > Print Locations and Hours. **6.** The REG ID and a valid form of identification are required at the fingerprint site. You must be registered prior to arriving at a fingerprint site. **7.** The following are required at the fingerprint site: **Valid Photo ID** (such as Driver's License or State ID card), **Registration ID** and **Money Order** (If this was your selected payment method)	**1.** All out of state applicants must request from the NM Medical Board 1 set of fingerprint cards before starting the registration process. **Fingerprint cards cannot be downloaded from the Board's web site. Blank fingerprint cards will be sent to you upon your request.** **2.** To register, please visit https://www.aps.gemalto.com/index.htm and click on the State of NM logo. While online registration is the preferred registration method, telephone registration can also be completed by calling 1-877-99NMAPS (1-877-996-6277) **3.** Go to the "Applicant Use" Section of the webpage **4.** Click on the Register Online for a Background Check link. (Registration is the process of collecting demographic information (name, height, eye color, etc) and collection of payment. The new fee for fingerprint service is ***$45.25.*** **5.** Once Registration and payment are complete the applicant will receive a registration ID (REG ID) that is unique to their fingerprinting record **6.** Applicant must mail their completed set of fingerprint cards to the following address: **Gemalto** **NM Card Receiver** **APS Department #165** **2964 Bradley Street** **Pasadena, CA 91107**
Questions? Please visit the Useful Links portion of the website and see FAQ's	
*******You will have 90 days from the time of registration to get your fingerprints completed. After 90 days, your registration will be cancelled, and you will need to begin the process once again.***	

Fees

The application fee of $320 is payable in U.S. funds by cashier's check, money order, check, MasterCard or Visa. Applications will not be processed until the application fee has been received. All fees are nonrefundable.

Education/Certification Requirements

An applicant must have graduated from an approved naturopathic medical educational program; an approved program shall offer graduate-level, full time didactic and supervised clinical training; be accredited , or shall have achieved candidacy status for accreditation, by the council on naturopathic medical education or an equivalent federally recognized accrediting body for naturopathic medical programs that is also recognized by the board; and be conducted by an institution, or division of an institution of higher education, that is accredited or is a candidate for accreditation by a regional or national institutional accrediting agency recognized by the United States secretary of education or meets equivalent standards for recognition of accreditation established in rules of the board for medical education programs offered in Canada.

An applicant must have passed NPLEX Part I (biomedical science examination), NPLEX Part II (core clinical science examination) and NPLEX clinical elective examination in minor surgery and pharmacology.

INSTRUCTIONS FOR COMPLETING THE NATUROPATHIC DOCTOR APPLICATION

Procedures for Licensure

1. Board Application
   Complete the application in its entirety. Please type or print legibly in black or blue ink. You must respond to all components of the application as instructed.

2. Curriculum Vitae (CV)
   Submit a current resume to include all education and work experience.

3. Education Certification
   Submit copies of certificates or diplomas and official transcripts from medical colleges, universities, or specialized training programs (must be accredited as defined in Subsections A of 16.10.22.7 or above in Education/Certification requirements).

4. Naturopathic Physicians Licensing Exams (NPLEX) Transcripts
   Submit certified copy of NPLEX Exam transcripts, showing results from NPLEX Part I, NPLEX Part II and NPLEX clinical elective examination in minor surgery and pharmacology. These results need to come directly from the North American Board of Naturopathic Examiners (NABNE).

5. Verification of Licensure / Registration
   Submit verification of licensure, if currently or previously licensed in another state(s) or jurisdiction, verification must come directly from the issuing state(s) or jurisdiction. The verification must include the state seal or international equivalent and must attest to the status, issue date and license number.

6. Letters of Recommendation
   Provide two letters of recommendation from individuals licensed as naturopathic doctor or

a physician licensed to practice medicine in the United States, who has worked and have personal knowledge of the applicant's moral character and competence to practice.

7. State Jurisprudence Exam
   Complete and pass the Board approved state jurisprudence exam.

8. Professional Liability Insurance
   Submit certificate of current professional malpractice liability insurance, which names you as a covered party.

9. Verification of Work Experience
   If you worked in a hospital or health facility, you must have a supervisor or administrator in every hospital or health facility where you have been employed during the past two (2) years complete the Work Experience Verification form(s) and return the completed form(s) directly to the NM Medical Board. (If you were self-employed during the past 2 years, provide verification of self-employment through documentation from your accountant, attorney, proof of business registration or license, provide dates of self-employment and describe the nature of your business.)

10. Applicants Oath
    You must complete the form entitled "Applicant's Oath" in its entirety including affixing a recent (less than 6 months) color passport-quality photograph* of yourself in the designated space.

    *Passport-quality color photograph - Approximate size is 2x2 inches, head and shoulders only, full face, front view, plain white or off-white background, standard photo stock paper. Scanned or computer-generated photographs should have no visible pixels or dots.

11. Submitting the Board Application
    Attach your payment to the front of the application. Make payment in U.S. funds to the New Mexico Medical Board. Do not send cash. Mail your application, appropriate fee, Applicant's Oath and any other supporting documents to:

    New Mexico Medical Board
    2055 S. Pacheco Street, Building 400
    Santa Fe, New Mexico 87505

NATUROPATHIC DOCTOR APPLICATION FOR LICENSURE

Date of Application: ___________________ **Application Fee:** **$320.00**

Demographics

Name			
	Last	First	Middle

Other Names Used	

Gender M F	**Place of Birth**	**Citizenship**	
Immigration Status		**INS Certification #**	
***Social Security Number**		**Date of Birth**	
***NM Tax ID# (if applicable)**		Pending ☐	
***Fed. Tax ID# (if applicable)**		Pending ☐	
Current Practice Name			
Practice Limited to: (Clinical Specialty)			
Street			
City	State	Zip Code	
Telephone Number		Email Address	
*Office Manager or Contact Person:			
Foreign Languages (spoken fluently by practitioner)			
Foreign Languages (spoken fluently at Practice)			
***Current Mailing Address** (if different from above -confidential unless no practice address indicated)			
*Street			
*City	*State	*Zip Code	
Telephone Number		*Email Address	
What are your immediate or future Practice Plans in New Mexico?			
Home Address (Required)	*Telephone Number		
Street			
*City	*State	*Zip	

*Information Confidential

Education (Please attach a separate sheet, if necessary.)

Undergraduate Education					
College or University					
City		State/Country		Zip Code:	
Dates Attended	**From:** **To:**	Degree		Graduation Date	
College or University					
City		State/Country		Zip Code:	
Dates Attended	**From:** **To:**	Degree		Graduation Date	
Graduate Medical Education					
College or University					
City		State/Country		Zip Code:	
Dates Attended	**From:** **To:**	Degree		Graduation Date	
College or University					
City		State/Country		Zip Code:	
Dates Attended	**From:** **To:**	Degree		Graduation Date	

Licensure-Registration-Certification Information

State Professional License/Certification Number							
State		Issue Date		Expiration Date		Pending ☐	
All Other State License Numbers (regardless of status - attach separate list if necessary.)							

State	Number	Issue Year	Expiration Date

***Federal Drug Enforcement Admin. (DEA) Registration**				N/A ☐
Number		Exp. Date		Pending ☐
***State Controlled Substance Registration** (CSR)				N/A ☐
Number	State	Exp. Date		Pending ☐
***National Provider Identification Number**				
Pending ☐				

Professional Liability Insurance (confidential information)

Do you have current liability insurance? ☐ Yes ☐ No

Current Carrier			Current ☐	Pending ☐
Address				
Dates Insured	From	To	Policy #	
			Coverage Limits	

Applicant Name ______________________________ **Date** ____________________

Work History Please list all previous practice experience for the last 10 years, **including military or government service**, listing the most recent first. If military service, state type of discharge and rank achieved **and attach copy of discharge or separation documents**. Attach separate page, if necessary. Please provide written explanation for any gaps in work history of 6 months or more.

Location		From		To	
Street		Phone Number			
City		State		Zip Code	
Type of Practice		Contact Person			
Type of Discharge		Rank Achieved			
Location		From		To	
Street		Phone Number			
City		State		Zip Code	
Type of Practice		Contact Person			
Type of Discharge		Rank Achieved			
Location		From		To	
Street		Phone Number			
City		State		Zip Code	
Type of Practice		Contact Person			
Type of Discharge		Rank Achieved			
Location		From		To	
Street		Phone Number			
City		State		Zip Code	
Type of Practice		Contact Person			
Type of Discharge		Rank Achieved			

Professional References Please list three professional peers familiar with your professional performance in the past 5 years, (not including current or impending partners or associates in practice).

(1) Name and Title					
Address					
City		State		Zip Code	
Telephone Number			Email		
(2) Name and Title					
Address					
City		State		Zip Code	
Telephone Number			Email		
(3) Name and Title					
Address					
City		State		Zip Code	
Telephone Number			Email		

Naturopathic Physicians Licensing Exams:

NPLEX Part I: Date Passed Exam: ____________________
Month/Year

NPLEX Part II: Date Passed Exam: ____________________
Month/Year

NPLEX Elective Minor Surgery: Date Passed Exam: ____________________
Month/Year

NPLEX Elective Pharmacology: Date Passed Exam: ____________________
Month/Year

Professional Practice Questions Please answer all of the following Yes or No questions. If you answer YES to any question, please give details including name, address, and telephone number of significant parties on a separate sheet of paper.

Question	Yes	No
1. Has your professional liability coverage ever been terminated by action of the insurance company except as a result of the company ceasing to offer insurance to physicians?	Yes ☐	No ☐
2. Have you ever been denied professional liability insurance coverage?	Yes ☐	No ☐
3. Has your professional liability carrier ever excluded any specific procedures from your coverage?	Yes ☐	No ☐
4. Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any professional organization?	Yes ☐	No ☐
5. Have you ever been excluded from or sanctioned by Medicare and/or Medicaid?	Yes ☐	No ☐
6. Have you ever been arrested? If so explain the circumstance, regardless of the outcome (i.e. expunged, dismissed, sealed, vacated).	Yes ☐	No ☐
7. Have you ever been named as a defendant in any criminal proceedings?	Yes ☐	No ☐
8. Have you ever been subject to investigation by a governmental entity or Board that either could have resulted or did result in licensure sanction or other adverse actions, irrespective of the outcome?	Yes ☐	No ☐
9. Have you ever been named in any formal requests for corrective actions filed by any healthcare entity where you have had an appointment (a request which could result in either formal or informal proceedings).	Yes ☐	No ☐
10. a. Have your privileges at any healthcare entity ever been voluntarily or involuntarily suspended, restricted, diminished, revoked, surrendered, or not renewed, for any reason, except for medical records delinquency unrelated to your professional competence or conduct?	Yes ☐	No ☐
b. Have you ever agreed not to exercise your clinical privileges while under investigation?	Yes ☐	No ☐
c. Have you ever been investigated and/or terminated by a healthcare entity for cause, or without cause, related to your clinical competence or conduct, which could impact patient safety/care or allowed to resign in lieu of termination for such reason?	Yes ☐	No ☐
11. Have you ever resigned from a healthcare entity to avoid modification, suspension, or termination of privileges, or while under investigation?	Yes ☐	No ☐
12. a. Has your application for licensure or license to practice in any jurisdiction ever been investigated, voluntarily or involuntarily limited, suspended, revoked, surrendered or denied?	Yes ☐	No ☐
b. Are any currently held licenses pending investigation or being challenged?	Yes ☐	No ☐
13. Have you ever been notified to appear before any licensing agency for a hearing or complaint of any nature?	Yes ☐	No ☐
14. Has your federal or state narcotics registration certificate in any jurisdiction ever been investigated, voluntarily or involuntarily limited, suspended, revoked, or restricted?	Yes ☐	No ☐

Question	Yes	No
15. Have you ever been involved in a settlement, medical malpractice claim or suit, or have you ever received written notice of intent to file such a suit? **If yes, please provide the following information on the attached Malpractice History form for each case:** • Name, age, sex of patient/claimant. • Date(s) and type of treatment and/or surgery, which led to the allegations against you. • Nature of allegations in claims/suits. Specify whether a suit was ever filed. • Names of other practitioners and hospital, if any, involved in claims or suit. • Disposition or current status of claim or suit (be specific). • Name of insurance carrier defending you. • Name of defense attorney.	Yes ☐	No ☐
16. Have you ever been reported to the National Practitioner Data Bank?	Yes ☐	No ☐
17. Are you now, or were you in the past, addicted to, abusive of, or in treatment for abuse of any controlled substances, habit-forming drugs, illegal drugs, prescription medication or alcohol?	Yes ☐	No ☐
18. Do you have or have you been diagnosed with an illness or condition which impairs your judgment or affects your ongoing ability to practice medicine in a competent, ethical and professional manner? **If yes, please have your treating physician send the NM Medical Board a letter regarding your diagnosis, treatment, and current status.**	Yes ☐	No ☐
19. Have you ever, for any reason:		
a) Resigned from a naturopathic medical education program?	Yes ☐	No ☐
b) Withdrawn from a naturopathic medical education program?	Yes ☐	No ☐
c) Been suspended, dismissed, or expelled from naturopathic medical education program?	Yes ☐	No ☐
d) Been placed on probation or remediation, including academic probation or remediation, by a naturopathic medical education program?	Yes ☐	No ☐
e) Taken a leave of absence or break from, or had any interruptions or extensions in, a naturopathic medical education program for any personal or professional reason (including illness or disability, pregnancy or maternity, any academic issue, etc)?	Yes ☐	No ☐
20. Are you currently in arrears in payments of amounts required to be paid pursuant to an outstanding judgement and order for child support in New Mexico or in any other state?	Yes ☐	No ☐

If you answer “Yes” to any question, please give details including name, address, and telephone number of significant parties on a separate sheet of paper.

Applicant Name ______________________________ **Date**____________________

New Mexico Medical Board
2055 S. Pacheco St.
Building 400
Santa Fe, NM 87505
(505) 476-7220

APPLICANT'S OATH

I, ____, hereby certify that I am the person pictured below and named in this application for a license to practice as a Naturopathic Doctor in the State of New Mexico; that all statements I have made herein are true; that I am the original and lawful possessor and person named in the various forms and credentials furnished to the New Mexico Medical Board (Board) with my application.

I acknowledge and state that I have read the Information and Instructions that accompanied this application and I have answered all questions truthfully. I understand that the fee I submitted is not refundable.

I authorize and request every person, hospital, clinic, community, governmental agency, court, association, institution or other organization having control of any documents, records, and other information pertaining to me, to furnish to the Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the Board or their agents or representatives to inspect and make copies of such documents, records and other information, in connection with this application.

I hereby release, discharge, and exonerate the Board, and their agents or representatives, and any person furnishing information, from any and all liability of every nature and kind arising out of the furnishing or inspection of such documents, records, other information, or the investigation made by the Board. I authorize the Board to release information, material, documents, orders, or the like relating to me or to this application to any other agency of the State of New Mexico or the appropriate licensing agency of any other state or Territory of the United States or any agency of the United States government.

ATTACH RECENT PASSPORT-QUALITY* PHOTOGRAPH THAT WILL FIT IN THIS SPACE

____
Applicant Signature Date

*Passport-quality color photograph taken within six months prior to filing the application, approximate size 2 x 2 inches, head and shoulders only, full face, front view, plain white or off-white background, standard photo stock paper, scanned or computer-generated photographs should have no visible pixels or dots.

Applicant Name ____________________________________ **Date** ______________________

New Mexico Medical Board
2055 S. Pacheco St.
Building 400
Santa Fe, NM 87505
(505) 476-7220

NATUROPATHIC MEDICAL EDUCATION CERTIFICATION

APPLICANT INSTRUCTIONS: Please complete the waiver for release of information and forward this form to your Naturopathic Medical Education Program of graduation for verification.

Waiver for Release of Information

I authorize the Naturopathic Medical Education Program listed below to provide any and all information pertaining to my medical education at your institution.

Applicant's Signature:____ Date of Birth _______/_______/______

Print or Type Name: ____

Other Name(s) Used: ____

Naturopathic Medical Education Program Name: ____

Address: _____________________________________City _____________________State_______ Zip___________

Please complete this form and forward it DIRECTLY to NMMB, 2055 S. Pacheco St., Bldg. 400, Santa Fe, NM 87505.

I hereby certify that the Naturopathic Medical Degree issued by ____
Naturopathic Medical Education Program Name

____
Program Address City/State/Zip

was conferred upon ____on ______________________.
Applicant's Name Date of Graduation

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education. ***All questions must be answered***. ***If you answer "YES" to any of the questions below, please enclose an explanation.***

1. Did the applicant take any leaves of absence or breaks from his/her naturopathic medical education? ___Yes ___No
2. Was the applicant ever placed on probation or remediation? ___Yes ___No
3. Was the applicant ever disciplined or under investigation? ___Yes ___No
4. Were any negative reports ever filed by instructors regarding the applicant? ___Yes ___No
5. Is this naturopathic medical education program accredited? ___Yes ___No

Affix School Seal Here

____
Program Director/Administrator (Type or Print)

____
Program Director/Administrator Signature Date

<u>INSTRUCTIONS TO NATUROPATHIC MEDICAL EDUCATION PROGRAM OFFICIAL</u>

This form will not be accepted if returned by the applicant.
Please complete this certification, including affixing the school seal in the space provided and return **<u>directly</u>** to the above address.
Thank you for your cooperation.

New Mexico Medical Board
2055 S. Pacheco St.
Building 400
Santa Fe, NM 87505
(505) 476-7220

VERIFICATION OF LICENSURE

I am applying for naturopathic medical licensure in the State of New Mexico. The New Mexico Medical Board requires that your Board complete this form or its equivalent so that I may be considered for licensure. This is my authorization to release all information in your files, favorable or otherwise, to the NMMB, **2055 S. Pacheco St., Bldg. 400, Santa Fe, NM 87505**

Print/Type Full Name	Signature / Date
License Number / Date Issued	Address
	City / State / Zip Code

THE SECTION BELOW SHOULD BE COMPLETED BY THE LICENSING BOARD

Name of Licensing Authority: ______________________________

Name of Licensee: ______________________________

License Number: ____________ Issue Date: ____________ Expiration Date: ____________

1. Is license current? ___Yes ___No If "No" why not? ______________________________
2. Has licensee ever been disciplined by your Board? ____Yes ____No

   If "Yes": Revoked ___Yes ___No Suspended ___Yes ___No

   Stipulated ___Yes ___No On Probation ___Yes ___No

   Dates:______________________________

3. Has his licensee's license ever been:
   - Allowed to lapse for non-payment of fees? ___Yes ___No
   - Placed on Retired or Inactive status? ___Yes ___No
   - Surrendered Voluntarily? ___Yes ___No
4. Are there any formal charges pending against this license? ___Yes ___No
5. Has licensee ever been investigated or requested to appear before your Board for any serious matter? ___Yes ___No

If you answered "YES" to questions 3-6 please provide a written explanation below, and attach a copy of all supporting documentation (e.g., Board order, complaint, etc.).

Please Affix
Board Seal Here

______________________________ ______________
Signature of Board Official Date

______________________________ ______________
Title Phone Number

New Mexico Medical Board
2055 S. Pacheco St.
Building 400
Santa Fe, NM 87505
(505) 476-7220 Fax (505) 476-7233

PROFESSIONAL RECOMMENDATION

The New Mexico Medical Board requires the completion of this Professional Recommendation by a Naturopathic Doctor, Physician, Program Director or the Director's designee who have personal knowledge of my moral character and competence to practice as a Naturopathic Doctor. This form is required as part of my application for licensure. ***All*** elements in the section below ***must*** be completed. The lower half of the form may be used for narrative comment. This is my authorization to release all information in your files, favorable or otherwise, DIRECTLY to the NMMB, 2055 S. Pacheco St., Bldg. 400, Santa Fe, NM 87505.

Applicant's Name:______________________________ Date of Birth _____/_____/_____

Applicant' Signature: ______________________________ Date:______________

Address: ______________________________ City ______________ State________

ALL ELEMENTS IN THIS SECTION MUST BE COMPLETED BY THE RECOMMENDING INDIVIDUAL
The information on this form is NOT a public document.

1. Date and type of service: This individual served with me as______________________________

   from ______________ to ______________ at ______________________________
   Month/Year Month/Year Location

2. Please evaluate:

(Please indicate with check mark)

		Poor	Fair	Good	Superior
Professional knowledge					
Clinical judgment					
Relationship with patients					
Ethical/professional conduct					
Ability to communicate					
Clinical skills					

3. Recommendation: (please indicate with a check mark)
   1. Recommend highly and without reservation ______________
   2. Recommend as qualified and competent ______________
   3. Recommend with some reservation (explain) ______________
   4. Concerns (explain) ______________

4. Of particular value in evaluating the candidate is information regarding any notable strengths and weaknesses (including personal demeanor). We would appreciate your comments.

____

____

5. The above report is based on: (please indicate with check mark)
   1. Close personal observation __________ 3. A composite of evaluations __________
   2. General impression __________ 4. Other __________

Name (Please Print): ______________________________

Title: ______________________________ Phone:______________

Signature: ______________________________ Date: ______________

New Mexico Medical Board
2055 S. Pacheco St.
Building 400
Santa Fe, NM 87505
(505)476-7220 Fax (505)476-7233

WORK EXPERIENCE VERIFICATION

I am applying for a naturopathic medical license in the State of New Mexico. The New Mexico Medical Board requires this form to be completed by the Chief of Staff or facility's administrative staff. I hereby authorize release of all information in your files, favorable or otherwise, DIRECTLY to the NMMB, **2055 S. Pacheco St., Bldg. 400, Santa Fe, NM 87505**.

______________________	______________________
Applicant Name	Applicant Signature
Address	***Dates of Employment mm/yy to mm/yy (must be provided)**
City/State/Zip	Telephone Number

The section below should be completed by the chief of staff or facility's administrative staff.
Letters of Recommendation are ***NOT*** accepted in lieu of this form.

____
Type or Print Name of person completing this form

____
Title

____
Name of Institution

____
Address

____
City / State / Zip

1. This evaluation is based on: ___Observation of applicant ___Review of personnel file
2. In your estimation, is there any reason why this applicant should not be licensed to practice? ___Yes ___No
3. To your knowledge, is there any mental or physical reason why this applicant should not be licensed? ___Yes ___No
4. To your knowledge, is there any derogatory/disciplinary information regarding this applicant? ___Yes ___No
5. Are the dates of privilege/employment provided by the applicant on this form accurate?* ___Yes ___No

***If not, please provide correct dates**: Beginning ______________ Ending ______________
Month/Year Month/Year

If you answered "YES" to questions 2, 3, and/or 4, please provide a written explanation and/or any supporting documentation that may be relevant.

____
Signature of person completing this form Date

Please affix hospital or notary seal here

____
Signature of Notary (if applicable) Date

My commission expires:______________________

Please note on this form if there is no hospital or notary seal available.

Please return this form directly to the address above
Thank you for your cooperation.

Malpractice History

Provider Name: ____

Please DUPLICATE this form and complete for EACH case.

1. **Patient Name:____**
2. **Diagnosis:**
   ____
   ____
   ____
3. **Your involvement in the case, i.e... Attending, Consulting, Etc.:**
   ____
4. **Allegation(s):**
   ____
   ____
5. **Clinical Case Summary:**
   ____
   ____
   ____
   ____
   ____
6. **Patient Outcome: ____**
7. **Other pertinent details:**
   ____
   ____
   ____
8. **Date of incident: ___________________ Date filed: _______________________**
   Date closed: _______________________
9. **Resolution of case, i.e. Dismissed, Settled Out of Court, Litigated, Pending, Other:**
   ____
   ____
10. **Settlement amount paid on your behalf (if any):**
    ____
11. **Professional liability insurer involved: __________________________________**
    a. **Name of Insurer: ____**
    b. **Address of Insurer: _______________________________________**
12. **Defense attorney: ____**

_____________________________________ ____________

Signature **Date**