MONTANA BOARD OF ALTERNATIVE HEALTH CARE
301 SOUTH PARK, 4th FLOOR
PO BOX 200513
HELENA MONTANA 59620-0513
(406) 841-2202 FAX (406) 841-2305
EMAIL: dlibsdahc@mt.gov WEBSITE: www.althealth.mt.gov

NATUROPATHIC PHYSICIAN LICENSURE IN MONTANA

THIS IS AN INFORMATION SUMMARY SHEET ONLY. THE APPLICANT IS RESPONSIBLE FOR READING THE COMPLETE STATUTES AND RULES PRIOR TO MAKING APPLICATION.

FOR A ROUTINE APPLICATION, THE AVERAGE APPROVAL TIME, AFTER RECEIPT OF ALL REQUIRED DOCUMENTATION, IS 10 DAYS. NON-ROUTINE APPLICATIONS MUST BE REVIEWED BY THE BOARD AT A BOARD MEETING. A COMPLETED APPLICATION MUST BE RECEIVED BY THE BOARD 15 BUSINESS DAYS PRIOR TO A SCHEDULED BOARD MEETING. PLEASE REFER TO OUR WEBSITE FOR BOARD MEETING DATES.

A. REQUIREMENTS FOR LICENSURE:

NATUROPATHIC PHYSICIAN LICENSURE BY EXAMINATION: Applicant must:

1) be of good moral character;
2) be a graduate of an approved naturopathic school which requires at a minimum, a 4-year, full time resident program of academic and clinical study.
3) have passed the naturopathic physicians licensing exam (NPLEX - clinical sciences exam, basic sciences exam, and minor surgery add-on exam) with a score of 75 or better or an exam endorsed by the Board;
4) have submitted a complete application accompanied by the appropriate fee and all supporting documents.

NATUROPATHIC PHYSICIAN LICENSEES FROM OTHER STATES: Applicant must:

1) have a current license in good standing from a state whose license standards at the time of application to this state are substantially equivalent to or greater than the standards in this state (i.e., meet standards 1-4 above) and;
2) provide verification from the state or states in which the applicant is licensed (past or present) that the applicant is not subject to pending charges or final disciplinary action for unprofessional conduct.

B. GENERAL INFORMATION:

The completed application and all supporting documents submitted by you must be received in the Board office before your application can be reviewed.

C. FEES: ALL FEES ARE NON-REFUNDABLE

$300.00 Application Fee
$200.00 Original License Fee (To be paid after Board Approval of Application)

** Please make check or money order payable to the Montana Alternative Healthcare Board**

D. SUPPORTING DOCUMENTS FOR NATUROPATHIC PHYSICIAN EXAMINATION CANDIDATES AND CANDIDATES FROM OTHER STATES:

1) Application fee of $300 (non-refundable) made payable to the Board of Alternative Health Care.

2) Certified copy of transcript verifying graduation sent directly to the Board office from the approved naturopathic college.
3) Documentation of good moral character consisting of three letters of reference, at least one of which must be from a licensed naturopathic physician.
4) Written, official verification received directly from another state or jurisdiction of the successful completion of licensure exam; except NPLEX scores must be verified by NABNE. NPLEX exams required are: basic sciences, clinical sciences, minor surgery add-on exam. Contact NABNE at (503) 778-7990 or www.nabne.org .
5) Applicants with licenses from other states must contact other states of licensure (past and current) and request letters of verification of license status to be sent directly to the Board office from the licensing jurisdiction. **The candidate will be responsible for contacting these jurisdictions and paying any fees that are required.**

E. SUPPORTING DOCUMENTS FOR APPLICANTS FOR CHILDBIRTH SPECIALTY CERTIFICATES:

1) Documentation described in #1 through #4 above (#5 if applicable).
2) Application fee of $100 (non-refundable) made payable to the Board of Alternative Health Care.
3) Written, official verification of successful completion of the ACNO (American College of Naturopathic Obstetricians) exam, NPLEX OB Specialty Exam, or a specialty examination approved by the Board which verification is sent directly from ACNO or the jurisdiction in which the examination was taken.
4) Documentation of 100 clock hours of coursework substantiated by official college transcript with hours highlighted, or a signed supervisor statement detailing hours of internship or preceptorship.
5) A log of natural childbirth care signed by a licensed naturopathic, medical, or osteopathic physician with specialty training in obstetrics documenting that the applicant has observed and assisted in the prenatal care and delivery of 50 supervised natural childbirths (three of the births must have occurred within the 2 years immediately preceding the submission of the application and in at least one of the 3 births, the applicant must have provided continuous care), including 25 births as the primary birth attendant. The log shall contain the baby's name, date of birth, county and state of birth, the name(s) of the primary birth attendants, and the name and license number of the supervisor.

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Application for Licensure as:

☐ Naturopathic Physician
☐ Childbirth Specialty Certificate

Application by:

☐ Examination
☐ License from Another State

1. FULL NAME _____

2. OTHER NAME(S) KNOWN BY _____

3. BUSINESS NAME _____

4. BUSINESS ADDRESS _____
Street or PO Box # City and State Zip Country

5. HOME ADDRESS _____
Street or PO Box # City and State Zip Country

PREFERRED MAILING ADDRESS:
☐ Business ☐ Home EMAIL ADDRESS _____

6. TELEPHONE _____ HOME _____ FAX _____
Business

7. SOCIAL SECURITY NUMBER _____ FOREIGN ID NUMBER _____

8. DATE OF BIRTH _____ PLACE OF BIRTH _____ ◯ Male ◯ Female

9. LICENSE NAME _____
(State your name as it should appear on the license if granted.)

10. List all professional licenses you hold or ever have held.
Verification must be sent directly to Montana from each state/province/territory.

State	License#	Issue Date	Exp.Date	License Method	Requested Verification?
				◯ EXAM ◯ ENDORSE ◯ OTHER	◯ YES ◯ NO
				◯ EXAM ◯ ENDORSE ◯ OTHER	◯ YES ◯ NO
				◯ EXAM ◯ ENDORSE ◯ OTHER	◯ YES ◯ NO

11. If taking an examination, do you have any physical or mental impairment(s) requiring special accommodation(s)? If yes, attach a detailed explanation. ◯ Yes ◯ No

Please answer the following questions. If you answer yes, give specific details (names of organizations, dates, reasons, and outcome) on a Supplement Sheet.

12. Have you ever had an application for a professional or occupational license refused or denied? If yes, please attach a detailed explanation and provide supporting documentation from the source. ◯ Yes ◯ No

13. Have you ever withdrawn an application for licensure prior to the licensing agency's decision regarding your application? If yes, please attach a detailed explanation and provide supporting documentation from the source. ◯ Yes ◯ No

14. Have you ever been denied the privilege of taking an examination required for any professional or occupational license? If yes, please attach a detailed explanation and provide supporting documentation from the source. ◯ Yes ◯ No

15. Have you ever withdrawn or been suspended, placed on probation, expelled or requested to resign from any postsecondary educational program? If yes, please attach a detailed explanation and provide supporting documentation from the source. ◯ Yes ◯ No

16. Have you ever requested temporary or permanent leave of absence, been placed on probation, restricted, suspended, revoked, allowed to resign, or otherwise acted against by any professional or occupational education program (i.e., residency, internship, apprenticeship, etc)? If yes, please attach a detailed explanation and provide supporting documentation from the source. ◯ Yes ◯ No

17. Has a licensing agency initiated or completed disciplinary action against any professional or occupational license you have held? If yes, please provide agency documents including the complaint, initiating documents, orders, final orders, stipulations and consent and/or settlement agreements directly from the source. ◯ Yes ◯ No

18. Have you ever voluntarily surrendered, cancelled, forfeited, failed to renew a professional or occupational license in anticipation of or during an investigation or disciplinary proceeding or action? If yes, please attach a detailed explanation and provide supporting documentation from the source. ◯ Yes ◯ No

19. Has a complaint ever been made against you with a professional or occupational licensing agency? If yes, please attach a detailed explanation and provide supporting documentation from the source. ◯ Yes ◯ No

20. Have you ever been the subject of any sanction or action, denial, suspension, revocation, restriction or termination regarding hospital, facility or staff privileges; health maintenance organization participation, third party provider or Medicare/Medicaid participation; or any other privileges? If yes, please attach a detailed explanation and provide supporting documentation from the source. ◯ Yes ◯ No

21. Have you ever been censured, expelled, denied membership or asked to resign from a professional organization related to your profession or occupation? If yes, please attach a detailed explanation and provide documentation from the source. ◯ Yes ◯ No

22. Have you ever been the subject of any sanction or action, denial, suspension, revocation, restriction or termination regarding your ability to prescribe, dispense or administer drugs including controlled substances? If yes, please attach a detailed explanation and provide documentation from the source. ◯ Yes ◯ No

23. Do you have any initiated or completed action against you by any state, federal, tribal, or foreign licensing jurisdiction? (For example: Drug Enforcement Agency; Alcohol, Tobacco and Firearms; Homeland Security; Indian Health Service, etc) If yes, please attach a detailed explanation and provide documentation from the source. ◯ Yes ◯ No

24. Have any civil legal proceedings been filed against you by a (patient/client), (former patient/client) or employer/employee? If yes, attach a detailed explanation and documentation from the source including initiating document(s) and documentation of final disposition. ◯ Yes ◯ No

25. Have you ever been convicted of a misdemeanor or felony crime or do you have a pending criminal charge? "Convicted" for the purposes of this question includes a conviction under appeal, guilty plea, no contest plea, and/or forfeiture of bond. "A pending criminal charge" for the purposes of this question includes a deferred imposition of sentence and/or deferred prosecution. If you answer yes, you must submit a detailed explanation of the events AND the charging documents and final judgments or orders of dismissal. You must report but may omit documentation for: (1) misdemeanor traffic violations older than 10 years ago and that resulted in fines of less than $200; and (2) convictions prior to your 18th birthday unless you were tried as an adult. ◯ Yes ◯ No

26. Have you ever been diagnosed with chemical dependency or another addiction, or have you participated in a chemical dependency or other addiction treatment program? If yes, please attach a detailed explanation and provide documentation regarding evaluations, diagnosis, treatment recommendations and monitoring from the source. ◯ Yes ◯ No

27. Have you ever been diagnosed with a physical condition or mental health disorder involving potential health risk to the public? If yes, please provide a detailed explanation. ◯ Yes ◯ No

28. Have you ever been court-martialled or discharged other than honorably from any branch of the armed service? If yes, attach a detailed explanation and documentation from the source. ◯ Yes ◯ No

29. **PROFESSIONAL EDUCATION:**

Name of University or College	City and State/Province/ Territory	Dates Attended	Degree Earned

Name of School	City and State/Province/ Territory	Dates Attended	Degree Earned

Internship Program	City and State/Province/ Territory	Dates Attended	Diploma Received
			◯ Yes ◯ No
			◯ Yes ◯ No

Residency Program	City and State/Province/ Territory	Dates Attended	Diploma Received
			◯ Yes ◯ No
			◯ Yes ◯ No

30. **PRACTICE HISTORY:** List **all** activities after naturopathic school (other than those already set forth above) in chronological order, up to and including the present. Specify nature of activity; for example, private practice, hospital practice, vacation, school, private employment, etc. (if naturopathic practice, indicate nature of practice.) **Account for all periods of time longer than 1 month. Indicate specific month and year for each activity.** Use additional paper if necessary.

Name and Location of Practice	Activity/Position	Inclusive Dates	Reason for Leaving

COMPLETE QUESTIONS 31 AND 32 ONLY IF APPLYING FOR CHILDBIRTH SPECIALTY CERTIFICATE

31. Montana Naturopathic Physician License Number (or submit photocopy of completed, concurrent Montana Naturopathic Physician License Application):

_____

32. Indicate below how the 100 hours required in 37-36-304, MCA were completed:

Hours	Internship	Location	Supervisor Name and License Number

Hours	Preceptor	Location	Supervisor Name and License Number

Hours	Course Work	Location	Submit transcript with hours highlighted

DECLARATION

I authorize the release of information concerning my education, training, record, character, license history and competence to practice, by anyone who might possess such information, to the Montana Board of Alternative Health Care.

I hereby declare under penalty of perjury the information included in my application to be true and complete to the best of my knowledge. In signing this application, I am aware that a false statement or evasive answer to any question may lead to denial of my application or subsequent revocation of licensure on ethical grounds. I have read and will abide by the current licensure statutes and rules of the State of Montana governing the profession. I will abide by the current laws and rules that govern my practice.

_____ _____

Signature of Applicant Date

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VERIFICATION OF MORAL/PROFESSIONAL CHARACTER

APPLICANT: Complete the upper portion of this form and mail to each of the character references you have listed in your application (page 5).

_____ _____
Legal Signature of Applicant Date

(Please Type or Print)
Name of Applicant: _____

Address: _____

This verification sent to: _____

CHARACTER REFERENCE: Please answer the following questions concerning the applicant's moral and professional character. This document is your authorization to release any and all information and opinions you have, favorable or otherwise, directly to the Montana Board of Alternative Health Care. Your response will be kept confidential.

Name of reference: _____ Daytime phone: _____

Address: _____

Title/profession/position: _____

How long have you known the applicant? _____ In what capacity? _____

To your knowledge, does the applicant have any habits or practices that would adversely affect his/her professional activities? If your answer is "yes", please explain:

Do you consider this applicant worthy of approval to practice as a _____ in Montana?

Please comment on the applicant's professional character, morals and ethics (attach additional sheet as needed):

_____ _____
Signature of Reference Date

The Applicant and the Board thank you for your assistance.

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REQUEST FOR OFFICIAL VERIFICATION OF LICENSURE

(THIS IS NOT AN ENDORSEMENT CERTIFICATION)

APPLICANT: Do **NOT** send this form in with your application. This is to be used as necessary to request official license verification from states or licensing entities in which you currently hold, or ever have held a license.

COMPLETE THE FORM AND MAIL IT TO ANY STATE BOARD IN WHICH YOU ARE REQUESTING OFFICIAL LICENSE VERFICATION BE SENT TO THE MONTANA ALTERNATIVE HEALTHCARE BOARD. YOU MAY COPY THIS FORM AS MANY TIMES AS NEEDED. BE ADVISED THAT SOME BOARDS REQUIRE A FEE FOR THIS SERVICE. IT IS RECOMMENDED YOU CONTACT THE BOARDS BY PHONE PRIOR TO MAILING IN THIS FORM TO SEE IF YOU NEED TO INCLUDE PAYMENT.

LICENSEE INFORMATION

To Whom It May Concern:
I am applying for a license to practice _____ in the State of Montana and the Alternative Healthcare Board requires official license verification.This is your authority to release any information in your files, favorable or otherwise, **DIRECTLY** to:

Montana Alternative Healthcare Board
PO Box 200513
Helena, MT 59620-0513.

Your prompt response is appreciated.

Name (Please Print) _____ Signature _____

Address: _____

_____
Street or PO Box # City State Zip

My License Number from your State is: _____ License Type: _____

This form is to be used to request official verification from states where you hold or have ever held a license. Please **DO NOT** return this form to our office.