



**NEVADA STATE BOARD OF HOMEOPATHIC MEDICAL EXAMINERS**  
 1301 Cordone Avenue Suite 126, Reno, NV 89502  
 TEL: (775) 324-3353

**LICENSE REGISTRATION RENEWAL/HMD**  
 (Please print or type)

**Name:**

**License Number:**

**Office Address: 1.** \_\_\_\_\_ **2.** \_\_\_\_\_  
 (Street) (Street)

\_\_\_\_\_ (City) \_\_\_\_\_ (City)

**Home Address:** \_\_\_\_\_  
 (Street)

**Office Phone:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_

**Cell Phone:** \_\_\_\_\_

**E-Mail Address:**

**Fax:**

**REGISTRATION RENEWAL DEADLINE AND FEE**

Fee must be received on or before December 31

1. Has any disciplinary action (including surrender), limitation, or restriction been taken against any license you hold from another licensing authority since you last applied for issuance or renewal of this license?  
**YES** \_\_\_\_\_ **NO** \_\_\_\_\_ If yes, attach a certified copy of the final order, stipulation or consent agreement.

2. Has any malpractice or any other lawsuit or settlement, award, or judgment been made against you or your business in any jurisdiction since you last applied for issuance or renewal of this license?  
**YES** \_\_\_\_\_ **NO** \_\_\_\_\_ If yes, attach a certified copy of court action or settlement.

3. Have you been convicted of or pled nolo contendere to a felony, or to a misdemeanor involving moral turpitude since you applied for issuance or renewal of this license?  
**YES** \_\_\_\_\_ **NO** \_\_\_\_\_ If yes, attach certified copies of court records showing court's decision and sentence.

4. List ALL states and/or United States territories with their license numbers where you CURRENTLY HOLD A LICENSE to practice:

State/Territory	License Number	M.D	D.O.
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

5. Check all modalities that you intend to offer under your supervision to 25% or more of your patients:  
 12-27-11

- |   |   |
|---|---|
| Herbal Therapy  | _____ Bio Oxidative therapies                 |
| Acupuncture-electrodiagnosis  | _____ Neuromuscular Integration               |
| Classical (Kentian) homeopathy                                      | _____ Chelation Therapy (see# 8 below)        |
| _____ Complex homeopathy and electro-therapeutics (EAV and related) | _____ Nutrition, including parenteral therapy |
| _____ Orthomolecular therapy  | _____ Neural Therapy                          |
|   | _____ Other (specify) _____                   |

6. Do you intend to offer intravenous chelation 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 the 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.

7. Child Support: Federal Welfare Reform Act of 1997 (SB356) **requires** all licensing agencies to add the following questions to all license applications.

- I am not subject to a court order for child support.  
 \_\_\_\_\_ I am subject to a court order for child support and am in compliance or in compliance with plan approved by the District Attorney or other public enforcement agency.  
 \_\_\_\_\_ I am subject to a court order for child support and am **NOT** in compliance with the order or a plan approved by the district attorney or other public enforcement agency.

8. 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 or limits your ability to practice medicine. **Yes** \_\_\_\_\_  
 If "Yes" please attach an explanation when returning this application.  
**No** \_\_\_\_\_

9. Your Social Security Number **IS REQUIRED**. The Board may use it for identification purposes in establishing your credentials to be issued or to renew this license. The Board **must** release it to proper legal authorities such as NV Attorney General's Office: SS# \_\_\_\_\_

10. Drug Enforcement Administration Number:

11. Pursuant to NAC 630A.095 you are required to obtain **20 continuing education credits** through the Nevada Homeopathic and Integrative Medical Association or courses approved by the board. Have you fulfilled this requirement? Yes \_\_\_ No \_\_\_. You may be required by the board to produce evidence of your compliance.

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**ATTESTATION**

**I, the undersigned, attest that the information contained in this license registration renewal form is true, correct, and complete. I understand I will be subject to disciplinary action including, but not limited to, the revocation of my Homeopathic License for violating NRS 630A.350(3) by providing false, incomplete or misleading information.**

\_\_\_\_\_  
 Signed

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 Date

***Make check payable to "Homeopathic Physicians Board." All payments must be in U.S. funds. Do not postdate your check. If you wish for the board to maintain a copy of your various consent forms, you may also enclose them.***