PHOTOGRAPH	NMC Use Only

Photograph

Affix a 2" X 2" Photo Here

Photo Must Be Recent and Must Be of your Head and Shoulder Area Only

Altered Photographs are NOT Acceptable

INFORMATION COLLECTION AND ACCESS

Agency requesting information: California Department of Consumer Affairs, California Board of Naturopathic Medicine, 1300 National Drive, Suite 150, Sacramento, CA 95834-1991, (916) 928-4785.

All items in this application are mandatory; none are voluntary. Failure to provide any of the requested information will delay the processing of your application. The information provided will be used to determine your qualifications for licensure per Sections 3630-3637 of the California Business and Professions Code, which authorizes the collection of this information. The information on your application may be transferred to other medical licensing authorities, the Federation of State Medical Boards, or other governmental or law enforcement agencies. You have the right to review your application subject to the provisions of the Information Practices Act. The Executive Officer of the California Board of Naturopathic Medicine is the custodian of records.

Photograph ☐

DECLARATION

The applicant, ______________________________, ________________,
Please print full name (First, Middle, Last) Date of Birth (mm/dd/yyyy)

Applicant Name & DOB ☐

Certify that I am the person herein named subscribing to this application; that I have read the complete application, know the full content thereof, and declares under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; that I am the lawful holder of the degree of Doctor of Naturopathic Medicine as prescribed by this application, that the same was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted, were produced without fraud or misrepresentation or any mistake of which I am aware and that I am the lawful holder thereof. Further, I hereby authorize all hospitals, institutions, schools, and/or organizations my references, employers (past, present, future), business and professional associates (past, present, future), and all government agencies (local, state, federal, or foreign), to release to the California Board of Naturopathic Medicine of the California Department of Consumer Affairs or its successors any information, pertinent files or records, including educational records, requested by the Board in connection with this application, or any further or future investigation by the Board necessary to determine my medical competence, professional conduct, or physical or mental ability to safely engage in the practice of Naturopathic Medicine. I further authorize the Board or its successors to release to the organizations, individuals, or groups listed above any information, which is material to this application, or any subsequent licensure. **I UNDERSTAND THAT FALSIFICATION, OMISSION OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS APPLICATION OR ANY ATTACHMENT HERETO IS A SUFFICIENT BASIS FOR DENYING OR REVOKING A LICENSE.**

SIGNATURE:______________________________ **DATE:**________________

Applicant Signature & Date ☐

NOTARY SECTION

SIGNATURE OF APPLICANT:______________________________
(DO NOT SIGN EXCEPT IN THE PRESENCE OF NOTARY – Please sign full name)

Applicant Signature ☐

State of ________________

County of ________________

Subscribed and sworn to (or affirmed) before me on this ________ day of ________________, 20________,

Applicant Name & Notary Date ☐

by, ______________________________ proved to me on the basis of satisfactory evidence to
(Print applicant's name)

be the person who appeared before me.

NOTARY SEAL

____
SIGNATURE OF NOTARY PUBLIC

Notary Signature & Seal ☐