

ACUPUNCTURE CLINICAL PRACTICE AFFIDAVIT FORM

This form is required only for acupuncture applicants who did *not* graduate from an accredited, candidate, or approved equivalent program *and* are applying for licensure based on their previous licensed practice. This route to licensure requires the applicant to provide affidavits from *two* individuals who have personal knowledge of the years of practice and the number of patient visits per year. Such individuals to be office partners, clinic supervisors, accountants, or others approved by the Board.

THIS FORM MUST BE COMPLETED BY THE INDIVIDUAL VERIFYING THE APPLICANT'S CLINICAL PRACTICE.

FULL NAME:		OCCUPATION:	
COMPLETE ADDRESS:	Home	Business	PHONE NUMBER: Home Business
NAME OF ACUPUNCTURE APPLICANT WHOSE CLINICAL PRACTICE YOU ARE VERIFYING:			
DESCRIBE YOUR RELATIONSHIP TO THE APPLICANT WITH REGARDS TO HIS/HER ACUPUNCTURE PRACTICE:			

AFFIDAVIT OF CLINICAL PRACTICE

I _____, in my capacity as _____ hereby
 (Name of person verifying clinical practice) (Relationship to above named acupuncturist)
 attest that I have personal knowledge that _____ has actively
 (Name of acupuncturist whose clinical practice you are verifying)
 practiced as a **licensed** acupuncturist in the state(s) of _____,
 for a period of at least five years **prior to July 1, 1998**. Those years being _____, and has
 (Years)
 provided a minimum of 500 patient treatments per *each* year during these five years.

PRINT YOUR NAME	TITLE
Sign your name in the presence of a Notary	DATE

This portion to be completed by notary

Notary Seal or Imprint

Subscribed and sworn to before me on _____

Notary Signature _____

Notary Public for _____ Commission expires _____

IMPORTANT: This form must be sent directly from the individual verifying clinical practice to the Oregon Medical Board at the address above.