



OREGON BOARD OF NATUROPATHIC MEDICINE VERIFICATION OF LICENSE IN ANOTHER STATE

PLEASE TYPE OR PRINT NEATLY



APPLICANT: PLEASE COMPLETE SECTION I AND MAIL ONE FORM TO EACH STATE AGENCY OR BOARD WHERE YOU ARE NOW OR HAVE EVER RECEIVED A LICENSE TO PRACTICE NATUROPATHIC MEDICINE. PLEASE MAKE AS MANY COPIES AS NEEDED.

SECTION I – TO BE COMPLETED BY THE APPLICANT

I am applying for a Naturopathic Doctor license in the State of Oregon. The Oregon Board of Naturopathic Medicine requests that your state agency or board complete Section II of this form as part of my application for licensure. By signing this form, I give my consent to release all and any information, favorable or otherwise, to the Oregon Board of Naturopathic Medicine. Please forward the completed form as soon as possible to the Oregon Board of Naturopathic Medicine to the address listed below.

APPLICANT'S FULL NAME: _____

MY LICENSE NUMBER: _____ **ISSUE DATE :** _____

X

SIGNATURE OF APPLICANT

DATE

ADDRESS

PRINT NAME

CITY, STATE, ZIP

SECTION II – TO BE COMPLETED BY THE STATE LICENSING AGENCY OR BOARD

THE ABOVE INDIVIDUAL IS LICENSED IN THE STATE OF: _____

THE NAME OF THE LICENSEE AS SHOWN IN YOUR RECORDS: _____

THE LICENSE STATUS IS: CURRENT SUSPENDED EXPIRED REVOKED (PLEASE CIRCLE ONE)

ISSUE DATE: _____ EXPIRATION DATE: _____

IS THIS LICENSE IN GOOD STANDING? YES NO (IF NO, INDICATE REASON) _____

IS THERE ANY PAST OR PENDING DISCIPLINARY ACTIONS (INCLUDING INFORMAL OR CONFIDENTIAL DISCIPLINE, CONSENT ORDERS, OR LETTERS OF WARNING) AGAINST THE LICENSEE? YES NO (IF YES, ATTACH AN EXPLANATION)

X

SIGNATURE OF PERSON COMPLETING FORM

DATE

PRINTED OR TYPED NAME AND OFFICIAL TITLE

(AFFIX STATE AGENCY/BOARD SEAL BELOW)

AGENCY/ORGANIZATION NAME

ADDRESS

CITY, STATE, ZIP

CONTACT TELEPHONE NUMBER

**RETURN FORM TO: OREGON BOARD OF NATUROPATHIC MEDICINE
800 NE OREGON STREET, SUITE 407, PORTLAND, OREGON 97232**

QUESTIONS? CONTACT THE OREGON BOARD OF NATUROPATHIC MEDICINE: (971) 673-0193