

### GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH

### HEALTH PROFESSIONAL LICENSING ADMINISTRATION

#### **ACUPUNCTURE**

#### **NEW LICENSE APPLICATION**

All applicants must complete every section of this application and submit the original application and all required supporting documents. If more space is needed to fully answer questions, attach additional sheets with typed responses. False or misleading statements will be cause for disciplinary action and could be cause for criminal prosecution pursuant to DC Code 22-2514. If you have any questions, call HPLA Customer Service at 1-888-204-6193, Monday through Friday, 8AM to 5PM EST.

SECTION 1. TYPE OF LICENSE							
Check the box next to the type of license for which you are applying.							
	Prelicensing Education  AC – Acupuncturist School Trained \$230  AC – Acupuncturist DC Licensed Physician \$230  AC – Acupuncturist Apprenticeship \$230  MAIL TO:  Department of Hea Health Professiona Board of Acupuncturist			Licensing Administration ire street,NE, First Floor			
Tota	al Enclosed	\$00	HPLA			-	
If no	ot a licensed physician, please check: I passed the NCCA examination. I wish to take the District examination.		Check \$ Check # \$00			Staff	
SEC	TION 2. APPLICANT NAME/DEMOGRAPHIC INF	ORMATION					
must	Enter your name exactly as it should appear on the license. If your name has changed at any point since you first attended college or university, you must provide a copy of legal name change documents for EACH time that it has changed. Complete Section 4 of this application on page 2.						
	Provide City and State for US birthplace or Country for foreign place of	of birth.	Please check the correc	t box.			
SEC	TION 3. SUPPORTING DOCUMENTS						
[							
	Please indicate the supporting documents you have included withotocopy of all supporting documents for your records.	vith this package	or requested to be sent to the DC Board	of Medi	cine. K	(еер а	
		nt's face (approx.	2"X2") with applicant's name printed	of Medi YES	NO	Keep a HPLA ONLY	
ŗ	shotocopy of all supporting documents for your records.  Two recent and identical passport-type photos of the applicant	nt's face (approx.	2"X2") with applicant's name printed	YES	NO	HPLA	
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<sup>\*</sup> Under the authority of Public Law 93-579, section (b), the Department of Health requests your Social Security Number/FEIN to assist in the administration of D.C. tax laws. Disclosure is not required as a part of the licensing process and will not be made available to the public.

# GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH - HEALTH PROFESSIONAL LICENSING ADMINISTRATION NEW LICENSE APPLICATION

SECTION 4. PREVIOUS NAME CHANGE	
If your name has changed at any point since you first attended college or university, you must provide a copy of a legal n documents for EACH time that it has changed. Acceptable documents for individuals are marriage certificates, divorce decrees.	
Changed to current name by: Marriage Divorce Court Order Spouse Death Certificate	
FIRST NAME  MI LAST NAME  Changed to surrout name by:  Marriage Diverge Court Order Dispuse Death Cortificate	SUFFIX (Jr, Sr, etc.)
Changed to current name by: Marriage Divorce Court Order Spouse Death Certificate  FIRST NAME  MI LAST NAME	SUFFIX
Changed to current name by: Marriage Divorce Court Order Spouse Death Certificate	(Jr, Sr, etc.)
FIRST NAME  MI LAST NAME	SUFFIX
Changed to current name by: Marriage Divorce Court Order Spouse Death Certificate	(Jr, Sr, etc.)
L   L   L   L   L   L   L   L   L   L	SUFFIX
	(Jr, Sr, etc.)
SECTION 5A. HOME ADDRESS	
Even if you have a PO Box, a street address should also be provided, if applicable.	
APARTMENT SUITE FLOOR PO BOX NUMBER	
<u> </u>	
HOME STREET ADDRESS 1 (If applicable, use this line for additional building information. Otherwise, use this line to indicate STREET NUMBER and	I STREET NAME)
HOME STREET ADDRESS 2 (If additional space is needed, use this line to indicate STREET NUMBER and STREET NAME)	
STATE ZIP (	CODE + 4
SECTION ED. BUSINESS ADDRESS	
SECTION 5B. BUSINESS ADDRESS  Please note: This information will be made available to the public.	
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ist all colleges and universilies attended prior to and including medical/professional schools. List schools attended in reverse chronological reder, with the most recent at the top.  School Name, City, State, Country  TION 6B. MEDICAL/PROFESSIONAL TRAINING AND MEDICAL/PROFESSIONAL PRACTICE  Ist all experience since medical/professional school graduation below. Include letters from employing facilities and organizations for termships, residencies, fellowships or employment. For "Description", use the letter from the key below. List experience in revers the remaining and the most recent.  Organization/Institution  Start Date  Organization/Institution  Start Date  A Fellowship  E Employment  B. Internship  E Employment  C Residency  F Private Practice  TION 6C. MEDICAL/PROFESSIONAL LICENSES IN OTHER STATES/JURISDICTIONS  re you now or have you ever been licensed in DC or any other state/jurisdiction? YES   Jurisdiction  Jurisdiction  Number of Hours  C Completed  C Completed  C Completed  C Completed  C Completed  D C Graduation  D PRACTICE  Bate of Type of Graduation  Teach or the form and organizations for reverse in reverse the number of the form the key below. List experience in reverse the number of the form the key below. List experience in reverse the number of the form the key below. List experience in reverse the number of the form the key below. List experience in reverse the number of the form the key below. List experience in reverse the number of the form the key below. List experience in reverse the number of the form the key below. List experience in reverse the number of the form the key below. List experience in reverse the number of the form the key below. List experience in reverse the number of the form the key below. List experience in reverse the number of the form the key below. List experience in reverse the number of the form the key below. List experience in reverse the number of the form the key below. List experience in reverse the number of the form the key below. List experience in r	CTION 6A.	PROFESSIONAL SCHOOLS AT	TENDED				
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# GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH - HEALTH PROFESSIONAL LICENSING ADMINISTRATION NEW LICENSE APPLICATION

SEC	TION 7. SCREENING QUESTIONS – App	licants MUST answer all of the followin	g questions.				
Please answer all of the following questions by placing an "X" in the appropriate boxes. If you answer "Yes" to questions B through J below, you must provide full information and complete details <b>on a separate sheet of paper, including copies of relevant court documents,</b> and attach to this application.							
A.	Clean Hands Before Receiving a License or Permit Act of	f 1996 Certification Form Requirement.					
	Please read the information below carefully before responding to this yesor no question, as any false information provided requires that the Department of Health proceed immediately to revoke your License or Permit for which you are now applying, and fine you one thousand dollars (\$1,000.00), pursuant to D.C. Official Code § 47-2864 (2001).						
	IF YOU ANSWER "YES" TO THIS QUESTION, PLEAS PAY THE OUTSTANDING DEBT. IF YOU DO NOT YOU OWE OR IF NO APPEAL IS PENDING, THE LAW	HAVE AN APPROVED PAYMENT SCHEDULE					
	As of this date, do you owe more than one hundred dollars following:  Yes  No	(\$100.00) to the District of Columbia Government as	s a result of any of the				
	<ol> <li>Fines, penalties, or interest assessed pursuant to Act of 1985);</li> </ol>	D.C. Official Code Title 8, Chapter 8 (LitterControl	Administrative		YES NO		
	1	al Code Title 8, Chapter 9 (Illegal Dumping Enforcer D.C. Official Code Title 2, Chapter 18 (Civil Infracti	· · · · · · · · · · · · · · · · · · ·				
	5. Past due District of Columbia Water and Sewer	Authority service fees; or cial Code Title 50, Chapter 23 (Traffic Adjudication)	?				
	The information presented above is in compliance with th Clean Hands Before Receiving a License or PermitAct of						
В.	Have you ever been convicted or arrested for a opreviously reported to the Board?	crime or misdemeanor (other than minor traffic	violations) not	YES NO			
C.	Are you now or have you ever been licensed in DC section 6C of this form.)	or any other state/jurisdiction? (If "Yes," be so	ure to complete	YES NO			
D.	Have you ever been party to a malpractice action or	had a malpractice action brought against you?		YES NO			
E.	Have you ever voluntarily surrendered a license afte investigation?	r formal charges have been filed against you	or while under	YES NO			
F.	Have you ever been terminated from or resigned from	n a clinical or professional training program?		YES NO			
G.	Do you have a physical or medical condition that cur	rently impairs your ability to practice your profess	sion?	YES NO			
H.	Has the use of drugs and/or alcohol resulted in an im	pairment of your ability to practice your profession	on?	YES NO			
I.	(1) Have you withdrawn an application (in D.C. or a any authority, health facility or peer review board (3) Are you currently under investigation or were you board for any violation of state, federal, or local law? informed you of any pending charges(s) or investigation.	taken adverse action against your license or p a investigated by any authority, health facility or (4) Has any authority, health facility or peer rev	rivileges? peer review	YES NO			
J.	Have you ever been terminated or asked to resign from	om employment since obtaining your (profession	al) license?	YES NO			
Please be sure to complete the affidavit of application below.  All applications that are unsigned by the applicant will be returned unprocessed.							
SECTION 8. LICENSEE AFFIDAVIT							
I hereby attest that the information given in this application, including all writings and exhibits attached hereto, is true and complete to the best of my knowledge. I understand that the making of a false statement on this application, including all writings and exhibits attached hereto, is punishable by criminal penalties.							
	LICENSEE SIGNATURE	NAME (Please Print)	DATE				