

License # _____

Issue Date ____/____/____

COMMITTEE ON ACUPUNCTURE

200 Harvard Mill Square, Suite 330
Wakefield, MA 01880 Telephone: (781) 876-8210 Fax: (781) 876-8383
Website: www.massmedboard.org

FULL ACUPUNCTURE LICENSE APPLICATION

Application Fee: Please enclose a check or money order in the amount of \$150.00 made payable to the Commonwealth of Massachusetts. The application fee is non-refundable.

Check One: U.S. Graduate International Graduate

Legal Name (do not use nicknames or initials, unless they are part of your legal name)

Last Name (type or print clearly) First Middle Suffix (Jr., etc.)

Male Female Indicate all degrees: _____

Other Name(s) Used - List any other name(s) you have used which may appear on your identifying documents, such as medical education and examination records. If not applicable, check here

Entire Last Name (type or print clearly) First Middle Suffix (Jr., etc.)

Date of Birth: ____/____/____ Social Security Number: _____

Month Day Year

Place of Birth: _____
City State/Province/Territory Country if not US*Mailing

*Mailing Address: _____ Telephone: _____

Number and Street

City State/Province/Territory Zip (or postal) Code

Home Address: _____ Telephone: _____

Number and Street

City State/Province/Territory Zip (or postal) Code

Business Address: _____ Telephone: _____

Number and Street

City State/Province/Territory Zip (or postal) Code

E-mail Address: _____ Fax #: _____

***All correspondence will be sent to your mailing address**

1. UNDERGRADUATE EDUCATION: List below the colleges or universities you attended. An official transcript with signature and the registrar's official seal is required to be sent **directly** to the Committee from each institution that is listed.

Name of school: _____

Complete mailing address: _____

Dates attended: From ____/____/____ To: ____/____/____ Degree
Awarded: _____

Name of school: _____

Complete mailing address: _____

Dates attended: From ____/____/____ To: ____/____/____ Degree
Awarded: _____

List below the school(s) at which you completed three semester hour courses, or the equivalent, in general biology, human physiology, and human anatomy. An official transcript with signature and the registrar's official seal is required to be sent **directly** to the Committee from each institution that is listed.

2. Human Anatomy (3 semester hour course)

Name of school: _____

3. Human Physiology (3 semester hour course)

Name of school: _____

4. General Biology (3 semester hour course)

Name of school: _____

5. ACUPUNCTURE EDUCATION: List below the acupuncture school(s) you attended. An official transcript, with signature and the registrar's official seal, is required to be sent **directly** to the Committee from each school that is listed. (If the transcript does not specify the number of classroom hours of didactic or clinical instruction, you must request your school to send information to the Committee that indicates the number of classroom hours.)

Name of school: _____

Complete mailing address: _____

Dates attended: From ____/____/____ To: ____/____/____ Degree Awarded: _____

Name of school: _____

Complete mailing address: _____

Dates attended: From ____/____/____ To: ____/____/____ Degree Awarded: _____

6. SUPERVISED PRACTICE: List

number of hours spent in the supervised diagnosis and treatment of patients for whom you were solely responsible (100 hours required) _____

7. CHINESE HERBAL THERAPY COURSES: List the number of hours of Committee on Acupuncture (COA) approved Chinese Herbal Therapy Courses (30 hours required) _____

8. ACUPUNCTURE LICENSES

Have you ever been licensed or registered to practice acupuncture in Massachusetts? YES NO

List states and countries in which you are currently or were licensed, registered or otherwise practiced acupuncture. (applicants who have been licensed in other states must have each state send **directly** to the Committee the enclosed "Verification of Licensure" form--see the "Requirements and Instructions" booklet.) None

<u>State (abb.)</u>	<u>License Number</u>	<u>Date Issued</u>	<u>Expiration Date</u>
_____	_____	____/____/____	____/____/____
_____	_____	____/____/____	____/____/____
_____	_____	____/____/____	____/____/____

9. OTHER STATE LICENSES

List states and countries in which you are or were licensed, registered or otherwise practiced a healing art other than acupuncture, such as nursing, medicine, chiropractic, dentistry, etc. (Applicants who have licenses in Massachusetts or other states must have each state send **directly** to the Committee the enclosed "Verification of Licensure" form.) None

<u>State</u>	<u>License Number</u>	<u>Date Issued</u>	<u>Expiration Date</u>
_____	_____	____/____/____	____/____/____
_____	_____	____/____/____	____/____/____
_____	_____	____/____/____	____/____/____

10. CERTIFICATION EXAMINATIONS:

List acupuncture licensure and certification examinations you have taken previously. (Include the NCCAOM written exam, the NCCAOM practical exam of point location skills (PEPLS), the CCAOM CNT/Practical course, and state and foreign licensure examinations.) Add a separate sheet of paper if necessary.

<u>Name of Examination</u>	<u>Date Attempted</u>	<u>Examination Result</u>
_____	____/____/____	<input type="checkbox"/> Passed <input type="checkbox"/> Failed

12. CERTIFICATIONS

Massachusetts General Laws Chapter 62C, section 49A, requires that you complete this statement to obtain licensure to practice in Massachusetts:

I, _____
(Print name)

certify, under the pains and penalties of perjury, that I, to my best knowledge and belief, have filed all state tax returns and paid all state taxes required by state law.

Signature: _____ Date: ____/____/____

13. STATEMENT OF APPLICANT:

I hereby certify under penalty of perjury under the laws of the Commonwealth of Massachusetts that all statements made in this application and all information submitted in connection with this application are true in every respect, and that misstatements and omissions of material facts may be cause for denial of this application, or for suspension or revocation of a license, or other disciplinary action appropriate.

I hereby authorize all hospitals, institutions, organizations, my references, personal physicians, employers, and all governmental agencies and instrumentalities (local, state, federal and foreign) to release to the Massachusetts Committee on Acupuncture any information, files or records requested by the Committee.

I hereby certify that I have read the acupuncture regulations contained in 243 CMR 4.00 and 243 CMR 5.00.

Signature: _____ Date: ____/____/____

(Continued on page 6)

The primary purpose of the NPI is to uniquely identify health care providers as "health care providers" in HIPAA standard transactions. The NPI will replace all other identifiers assigned to health care providers, such as those assigned by health plans, government programs and health care purchasers for purposes of conducting these business transactions.

Under the final HIPAA NPI Rule, all individual and organization covered providers will be required to obtain an NPI by May 23, 2007.

In order for your acupuncture license to be issued you must take one of the following actions:

- Option 1: Supply the Committee on Acupuncture with your valid NPI. You can apply for an NPI directly by using the NPPES web site at www.NPPES.cms.hhs.gov.
- Option 2: Certify you have personally applied for your NPI and you have not received it yet. Once you have received your NPI Number, you must notify the Committee on Acupuncture. Please complete the NPI form at the Board's web site at www.massmedboard.org.
- Option 3: Certify another authorized institution has applied for an NPI on your behalf and you have not received it yet (supply Institution's name). Once you have received your NPI Number, you must notify the Committee on Acupuncture by completing the NPI form at the Board's website (see Option 2).
- Option 4: Authorize the Committee on Acupuncture to apply for an NPI on your behalf.
- Option 5: If your license status is INACTIVE, you may elect not to obtain an NPI number.

Check the appropriate box below, supply appropriate information, and sign the bottom of the page.

- My current NPI is:
- I have personally applied for an NPI.
- I have applied for an NPI using a third party (enter name): _____ (follow instructions for Option 3)
- By checking this option and signing the bottom of this page, I hereby authorize the Board to apply for an NPI on my behalf.
- As an *inactive* acupuncturist, I do not wish to obtain an NPI.

HIPAA TAXONOMY CODES

Please provide the HIPAA taxonomy (specialty) codes (refer to Renewal Instructions, page 13 for more information). In addition to providing the taxonomy code, please indicate your specialty in the space provided (Taxonomy Description). The primary provider taxonomy code is required if you authorize BORIM to apply for an NPI on your behalf.

	<u>Taxonomy (Specialty) Code</u>	<u>Taxonomy Description (Print)</u>
Primary Provider Taxonomy:	17110000X	Acupuncturist

NPI REQUIRED INFORMATION

In an ongoing effort to improve the quality of the information we collect, please review the following information and make corrections as necessary. **Please note:** This information is required if you authorize BORIM to apply for an NPI on your behalf.

Social Security Number: - -

State of Birth (if US): _____ Country of Birth (if outside the US): _____

Gender: Male Female

Penalties for Falsifying Information on the National Provider Identifier Application

18 U.S.C. 1001 authorizes criminal penalties against an individual who in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes any false, fictitious or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry. Individual offenders are subject to fines of up to \$250,000 and imprisonment for up to five years. Offenders that are organizations are subject to fines of up to \$500,000. 18 U.S.C. 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute.

I authorize the Board of Registration in Medicine to provide my NPI to any authorized hospital, health plan, or health organization.

Signature: _____ Date: ____/____/____

PLEASE MAKE A COPY OF ALL PAGES OF YOUR RENEWAL APPLICATION AND ALL ATTACHMENTS BEFORE MAILING YOUR RECORDS, FOR CREDENTIALING AND OTHER PURPOSES.