



State of Maine

BOARD OF COMPLEMENTARY HEALTH CARE PROVIDERS

Applicant information to assist in completing your application

Certificate for Custom-made Chinese Herbal Formulations

Do not return the following informational pages with your application; it is for your information only

Department of Professional and Financial Regulation
Office of Professional and Occupational Regulation
(Mailing address) 35 State House Station, Augusta, ME 04333
(Office location) Gardiner Annex, 76 Northern Avenue, Gardiner, Maine 04345

Office Direct Line (207) 624-8689 or Main Receptionist (207) 624-8603
TTY/Hearing Impaired 1-888-577-6690
FAX (207) 624-8637

Web address: www.maine.gov/professionallicensing
Email: comphealth.lic@maine.gov

APPLICATION INSTRUCTIONS

CUSTOM-MADE CHINESE HERBAL FORMULATIONS CERTIFICATE

Information checklist for documents to be submitted to the Board in one package at time of application. (This is an abbreviated checklist and does not replace the requirements outlined in the Complementary Health Care Providers Laws and Rules. Please review them carefully for more detailed and clarifying information.)

Fax submissions of applications and supporting documentation will not be accepted.

One of the Two methods described below may be used to achieve licensure:

Method #1 -- CHAPTER 3.1 Applying With Baccalaureate Degree

- Baccalaureate Degree;
- Official Acupuncture School Transcript of 1,000 acupuncture classroom hours;
- Official verification of 300 acupuncture hours of clinical experience; and
- Official copy of the NCCAOM Certification.

Method #2 -- CHAPTER 3.2 Applying As Registered Nurse Or Physician's Assistant

- Verification of Licensure as Registered Professional Nurse, or
- Verification of Completion of Training Program and Examination as Physician's Assistant, and
- Official Acupuncture School Transcript of 1,000 acupuncture classroom hours
- Official verification of 300 acupuncture hours of clinical experience
- Official copy of the NCCAOM Certification

CUSTOM-MADE CHINESE HERBAL FORMULATIONS

You may apply for certification by using at least one of the following methods. Please refer to the law and board rules for more detailed information.

- Method 1 - NCCAOM Certification with Chinese Herbology; OR
- Method 2 - Master Degree or Equivalent; OR
- Method 3 - Herb Certificate Training Program

You must hold a valid Maine Acupuncture license to be eligible for this certification.

□ **Completed Application**

Complete, sign the application and submit with the appropriate fees and documentation.

□ **Proof of age**

A copy of your official birth certificate or other official legal document is acceptable.

□ **Any other supporting documentation such as: verification of licensure or criminal conviction information**

Submit verification from every state in which you currently hold or have ever held any type of professional license (except Maine).

Court judgment and decision of any criminal conviction and a written statement regarding the crime.

CONTINUING EDUCATION

As an Acupuncturist you will be required to satisfy the Continuing Education requirements identified in Chapter 5 of the Board's rules. Please be sure to review this chapter carefully.

INITIAL EACH PAGE OF YOUR APPLICATION WHERE NOTED. Be sure to initial the bottom of each page where noted on your application. This is critical to insuring that each page of your application is intact with the correlating application and will help us with expediting your application review.

The Board of Complementary Health Care Providers requires that all supporting documents and fees be submitted with the filing of your application. **Your application will be considered incomplete and will be returned if supporting documents and/or fees are omitted.** Documents that have been modified or altered in any way will not be accepted.

PROCESSING TIME

- ✓ Please do not call our office regarding the status of your application as numerous calls causes delays with processing applications. Information regarding the status of applications may be found at the Office of Professional and Occupational Regulation's website www.maine.gov/professionallicensing We appreciate your thoughtful attention to this request.
- ✓ Once your license is issued it is immediately visible online. Licenses are printed off site and require at least 14 days for delivery.

STATE OF MAINE DEPARTMENT OF PROFESSIONAL & FINANCIAL REGULATION
OFFICE OF PROFESSIONAL AND OCCUPATIONAL REGULATION

Mailing Address: 35 State House Station, Augusta, Maine 04333 **Courier/Delivery address:** 76 Northern Avenue, Gardiner, Maine 04345
Phone: (207) 624-8603 Fax: (207) 624-8637 Hearing Impaired: (888) 577-6690 web: www.maine.gov/professionallicensing

Frequently Asked Questions:

- **Where do I send my application?** Our mailing address is 35 State House Station, Augusta, Maine 04333-0035
- **Where are you located?** 76 Northern Avenue, Gardiner, Maine.
- **What hours are you open?** 8:00 AM to 5:00 PM weekdays
- **Can I come to Gardiner to drop off my application?** Yes. You will not leave with a license, though.
- **Can I come to Gardiner to pick up my license?** No. Your license will be mailed to you.
- **How long does it take to process an application?** You can check our website: www.maine.gov/professionallicensing. Your license will show up as PENDING at first; as soon as your status is ACTIVE you are authorized to practice.
- **How far back do I go answering the criminal question?** Any conviction, ever.

NOTICES

BACKGROUND CHECK: Pursuant to 5 MRS §5301 - 5303, the State of Maine is granted the authority to take into consideration an applicant's criminal history record. The Office of Professional and Occupational Regulation requires a criminal history records check as part of the application process for all applicants.

PUBLIC RECORD: This application is a public record for purposes of the Maine Freedom of Access Law (1 MRS §401 et seq). Public records must be made available to any person upon request. This application for licensure is a public record and information supplied as part of the application (other than social security number and credit card information) is public information. Other licensing records to which this information may later be transferred will also be considered public records. Names, license numbers and mailing addresses listed on or submitted as part of this application will be available to the public and may be posted on our website.

SOCIAL SECURITY NUMBER: The following statement is made pursuant to the Privacy Act of 1974 (§7(B)). Disclosure of your Social Security Number is mandatory. Solicitation of your Social Security Number is solely for tax administration purposes, pursuant to 35 MRS §175 as authorized by the Tax Reform Act of 1975 (42 USC §405(C)(2)(C)(1)). Your Social Security Number will be disclosed to the State Tax Assessor or an authorized agent for use in determining filing obligations and tax liability pursuant to Title 36 of the Maine Revised Statutes. No further use will be made of your Social Security Number and it shall be treated as confidential tax information pursuant to 36 MRS §191.

Before you seal the envelope, did you:

- Complete every item on the application (incomplete applications may be returned)
- Answer the criminal background disclosure questions
- Sign and date your application
- Include correct amount (payable to Maine State Treasurer) or credit card information (plus signature)
- Include any required transcripts or exam results
- Make a copy of your application to keep for your records
- DO NOT SEND CASH.



**STATE OF MAINE
DEPARTMENT OF PROFESSIONAL
AND FINANCIAL REGULATION
OFFICE OF PROFESSIONAL AND OCCUPATIONAL REGULATION
INDIVIDUAL LICENSE APPLICATION**

APPLICANT INFORMATION (please print)			
FULL LEGAL NAME	<i>FIRST</i>	<i>MIDDLE INITIAL</i>	<i>LAST</i>
ANY OTHER NAMES EVER USED:			
DATE OF BIRTH	<i>mm / dd / yyyy</i>	SOCIAL SECURITY NUMBER	- -
MAILING ADDRESS			
CITY	STATE	ZIP	COUNTY
PHONE # ()	FAX # ()	E-MAIL	
CRIMINAL BACKGROUND DISCLOSURE			
<i>NOTE: Failure to disclose criminal convictions may result in denial, fines, suspension and/or revocation of a license.</i>			
1. Have you ever been convicted by any court of any crime? (circle one) NO YES			
If yes, enclose a detailed description of what happened (including dates) and a copy of the court judgment.			
2. Has any jurisdiction taken disciplinary action against any professional license you hold or have held, or denied your application for licensure? (circle one) NO YES			
If yes, enclose a detailed explanation and copies of all documents.			
By my signature, I hereby certify that the information provided on this application is true and accurate to the best of my knowledge and belief. By submitting this application, I affirm that the Office of Professional and Occupational Regulation will rely upon this information for issuance of my license and that this information is truthful and factual. I also understand that sanctions may be imposed including denial, fines, suspension or revocation of my license if this information is found to be false.			
SIGNATURE		DATE	

**Board of Complementary Health Care Providers
Custom-Made Chinese Herbal Formulation Certification
Required Fee: \$146.00**
(includes application, license and criminal records check fee)

CERTIFIED CUSTOM-MADE CHINESE HERBAL FORMULATION (ACA1421)

YOU MUST HOLD A VALID MAINE ACUPUNCTURE LICENSE TO BE ELIGIBLE FOR THIS CERTIFICATION.

ACUPUNCTURE LICENSE NUMBER: _____

	<i>Office Use Only:</i>
ACA	1446 - \$75.00
	1421 - \$50.00
	2619 - \$21.00

<i>Office Use Only:</i>	
Check #	_____
Amount:	_____
Cash #	_____
Lic. #	_____
Issue Date	_____
Exp. Date	_____

PAYMENT OPTIONS:

Make checks payable to "Maine State Treasurer" - If you wish to pay by Mastercard or Visa, fill out the following:

NAME OF CARDHOLDER (please print)	<i>FIRST</i>	<i>MIDDLE INITIAL</i>	<i>LAST</i>
I authorize the Department of Professional and Financial Regulation, Office of Professional and Occupational Regulation to charge my <input type="checkbox"/> VISA <input type="checkbox"/> MASTERCARD the following amount: \$_____			
Card number:	<i>XXXX-XXXX-XXXX-XXXX</i>	Expiration Date	<i>mm / yyyy</i>
SIGNATURE		DATE	

SECTION 1: EDUCATION

Please check all that apply:		
<input type="checkbox"/> Baccalaureate Degree	<input type="checkbox"/> NCCAOM Certification Acupuncture	
<input type="checkbox"/> Nursing Degree	<input type="checkbox"/> NCCAOM Certification Chinese Herbs	
<input type="checkbox"/> Doctorate Degree	<input type="checkbox"/> Other describe: _____	
Name of Educational Provider	Date of Graduation	
Contact Address:	Street or P.O. Box	
City	State	Zip Code
Official transcript demonstrating your education must be submitted with your application.		

SECTION 2: LIST BELOW EVERY JURISDICTION IN WHICH YOU HOLD OR HAVE EVER HELD A PROFESSIONAL LICENSE.

1. State, Territory, Country	License Number/ Type	Date Issued	Expiration Date
2. State, Territory, Country	License Number/ Type	Date Issued	Expiration Date
3. State, Territory, Country	License Number/ Type	Date Issued	Expiration Date
For each of the above, you must submit with this application an official Verification of Licensure from the licensing jurisdiction. IMPORTANT: Applications submitted without a Verification of Licensure from the licensing jurisdiction(s) for each of the above will not be accepted and your application returned as incomplete.			

INITIALS OF APPLICANT

SECTION 3: EXAMINATION:

Have you ever taken an NCCAOM examination?

If yes, list the jurisdiction(s) where you took the examination, type of examination, date of examination and score:

Jurisdiction	Examination Type	Date	Score

- Yes
- No

SECTION 4: CHECK APPROPRIATE RESPONSE TO THE QUESTIONS BELOW. ANY YES RESPONSE MUST BE FULLY EXPLAINED BY WRITTEN STATEMENT ON A SEPARATE SHEET OF PAPER, SIGNED AND DATED, AND SUBMITTED WITH YOUR APPLICATION.

Had hospital or similar health care institution privileges ever been denied or which had previously been granted to you suspended, restricted or withdrawn involuntarily; or have you ever voluntarily surrendered privileges or resigned from staff membership while under peer review?

- Yes
- No

Have you ever received a sanction from Medicare or from a state Medicaid program?

1. Medicare OR Medicaid Program (State) _____
2. Submit a copy of the official action by the entity.
3. Provide a detailed explanation in your own words on a separate sheet of paper.

- Yes
- No

INITIALS OF APPLICANT

SECTION 5: Custom-Made Chinese Herbal Certification

This section to be completed only if you are applying for Custom-Made Chinese Herbal Certification. Please check the box to describe the method by which you are applying for certification to practice Custom-Made Chinese Herbal Formulations.

Method #1 **NCCAOM Certification with Chinese Herbology**

An official copy of the NCCAOM Certification must accompany this application.

Method #2 **Education**

Check one: Master’s Degree or Master’s-level professional program in Oriental Medicine

Institution: _____

Address: _____

Street

City

State

Zip

Degree Granted: _____ Date Awarded: _____

At the time of completion was this institution:

Accredited by ACAOM OR In candidacy for accreditation by ACAOM

Method #3 **Herb Certificate Training Program**

Have you completed an herb certificate training program that consisted of a minimum of 450 hours of combined didactic instruction in herbs and herbal clinical training?

YES NO

At the time of completion was this certificate training program:

Accredited by ACAOM or In candidacy for accreditation by ACAOM

Name of Certificate Training Program: _____

Program Sponsor: _____

Address: _____

Street

City

State

Zip

Date Certificate Awarded: _____

INITIALS OF APPLICANT

SECTION 6: NOTICES

Public Information

This application is a public record for purposes of Maine's Freedom of Access Law, 1 MRS §401, et seq. Public records must be made available to any person upon request. Information that you supply as part of this application (except your Social Security number) is public information. Other licensing records to which this information may later be transferred are also considered public records. Where permitted by law, your name, license number, contact address and other information listed on this application may be posted on the State's website.

10 Day Notification Requirement

This applicant/licensee must report in writing to the Board the following information no later than 10 days after the change or event, as the case may be:

- a. Change of name or address of the licensee;
- b. A criminal conviction of the licensee or anyone listed on this application as having an ownership interest in the licensee;
- c. A revocation, suspension, or other disciplinary action taken in this or any other jurisdiction against any occupational or professional license held by the applicant/licensee or anyone listed on this application as having an ownership interest in the licensee; or
- d. Any material change in the conditions or qualifications set forth in the original application for licensure submitted to the Board.

Notice Regarding Social Security Number Disclosure

The following statement is made pursuant to the Privacy Act of 1974 section 7 (B). Disclosure of your social security number is mandatory. Solicitation of your social security number is solely for tax administration purposes pursuant to 36 MRS section 175 as authorized by the Tax Reform Act of 1976 (42 USC section-405 (C) (2) (1)). Your social security number will be disclosed to the State Tax Assessor or an authorized agent for use in determining filing obligations and tax liability pursuant to Title 36 of the Maine Revised Statutes. No further use will be made of your social security number and it shall be treated as confidential tax information pursuant to 36 MRS §191.

INITIALS OF APPLICANT

SECTION 7: APPLICANT'S CERTIFICATION AND SIGNATURE

Read the statement below and sign where indicated as your certification of the information provided on this application.

By my signature, I hereby certify that the information provided on this application is true and accurate to the best of my knowledge and belief. By submitting this application I understand that the Maine Board of Complementary Health Care Providers will rely upon this information for issuance of my license and that this information is truthful and factual. I further understand that sanctions may be imposed, including denial, suspension or revocation of my license, if this information is found to be false.

Printed Name of Applicant	Title
Signature of Applicant	Date

Applications that are incomplete, altered, defaced, or compromised will not be accepted and will be returned. This includes, but not limited to, unanswered questions, lack of appropriate signature, information is illegible, missing supporting documents, and/or missing or wrong fee.