State of Nevada
Board of Homeopathic Medical Examiners
1301 Cordone Avenue, Suite 126
Reno, NV 89502
Phone: (775) 324.3353
e-mail: support@nvbhme.org

Date of Application: _____

Date Application Fee Paid: _____

Date Fingerprint Card Fee Paid: _____

APPLICATION FOR LICENSURE AS A HOMEOPATHIC PHYSICIAN

Applicant: _____ _____
Last Name *First Name* *Middle Initial* *Date of Application*

PLEASE READ CAREFULLY: This Application and each of the requirements set forth below must be received by the State of Nevada Board of Homeopathic Medical Examiners at the above address at least sixty (60) days prior to the date set by the State of Nevada Board of Homeopathic Medical Examiners for the written and oral examination.

A. APPLICATION REQUIREMENTS FOR ALL APPLICANTS AND FOR PHYSICIANS TRAINED IN THE UNITED STATES, A UNITED STATES TERRITTORY, CANADA OR THE UNITED KINGDOM

1. To be eligible for licensure, the Applicant must answer completely the questions posed in this Application. Write "NA" if a question does not apply. If further space is required to answer a question, please attach the completed answer to this form.

2. Type or print with ink all information requested in this Application.

3. Read all questions carefully. False, misleading, inaccurate or incomplete answers are grounds for denial of certification or revocation of any certificate issued as a result of false information.

4. The Applicant is required to provide Affidavits from three (3) physicians licensed to practice allopathic, osteopathic or homeopathic medicine attesting to the good moral character of the Applicant and the Applicant's fitness to practice homeopathic medicine. In addition, the Applicant shall provide two (2) letters of recommendation from persons who have known the Applicant for three (3) years or longer. Please attach to the Application.

5. Provide two (2) photographs clearly evidencing the likeness of the Applicant, each taken within sixty (60) days of the date of the Application. The photographs must be approximately 3" x 3" and in color. The Applicant must sign and date both photos and attach where indicated.

6. The Applicant shall cause the registrar of the school from which it received its undergraduate degree to provide a certified copy of the Applicant's transcript from such school directly to the State of Nevada Board of Homeopathic Medical Examiners. The Applicant must fill out and sign the enclosed form for all schools that it attended to allow the schools where it received undergraduate academic education and training to provide certified transcripts in the event that the Applicant fails to obtain these certified transcripts. Such certified transcript shall be sent from such school directly to the State of Nevada Board of Homeopathic Medical Examiners. The Applicant shall be primarily responsible for obtaining all relevant certified transcripts.

7. The Applicant shall cause the registrar of an approved allopathic, osteopathic or homeopathic medical school

to provide a certified copy of the Applicant's transcript from such school directly to the State of Nevada Board of Homeopathic Medical Examiners. The Applicant must fill out and sign the enclosed form for all schools that it attended to allow the schools where it received its medical education and training to provide certified transcripts in the event that the Applicant fails to obtain these certified transcripts. The Applicant shall be primarily responsible for obtaining all relevant certified transcripts.

8. The Applicant shall cause the Medical Licensing Board in all jurisdictions in which it is licensed to practice medicine to confirm such licensure and to complete the Verification of License form in this Application and send such form directly to the State of Nevada Board of Homeopathic Medical Examiners. The Applicant must fill out and sign the enclosed form for every jurisdiction in which it holds a license to practice allopathic, osteopathic or homeopathic medicine to provide such certified verifications in the event that the Applicant fails to obtain these certified Verifications of License. The Applicant shall be primarily responsible for obtaining all relevant certified Verifications of License.

9. The Applicant must submit evidence of three (3) years of postgraduate training in allopathic or osteopathic medicine in a program approved by the State of Nevada Board of Homeopathic Medical Examiners.

10. (a) The Applicant, who is the graduate of a medical school located in the United States, a United States Territory, Canada or the United Kingdom, must submit evidence of a combined total of not less than 600 hours training in homeopathic medicine, as defined in NRS 630A.040, of which 300 hours is under the supervision of a licensed Homeopathic Physician in this state.

(b) The Applicant who is a graduate of a foreign medical school, must submit evidence of not less than six (6) months additional training in homeopathic medicine, as defined in NRS 630A.040, satisfactory to the State of Nevada Board of Homeopathic Medical Examiners. This homeopathic training is in addition to the three (3) years of postgraduate training in allopathic or osteopathic medicine that is required for licensing.

11. You may be denied a license if you have been convicted on any basis for a crime. The questions asked regarding criminal record must be answered and the answers must be verified. You are required to go to the Nevada Highway Patrol, Police or Sheriff's Department and inform them of the need for a criminal records check. You will be required to submit fingerprints and pay a standard fee for this service. You must instruct the Highway Patrol, Police or Sheriff's Department to send the original to the State of Nevada Board of Homeopathic Medical Examiners and provide you with a copy.

12. The Applicant must provide evidence that it is a citizen of the United States or that it is legally entitled to work and remain in the United States.

13. Provided there are no apparent problems with your Application, you will be required to appear before the State of Nevada Board of Homeopathic Medical Examiners, or a representative of the State of Nevada Board of Homeopathic Medical Examiners, and pass a written open book examination. You may use books, notes, computer, or similar materials during the examination. The written examination will be administered at various times during the year. The Applicant must receive a score of at least 76% on the written examination; or a passing score on the oral examination from a majority of the State of Nevada Board of Homeopathic Medical Examiners Members who are present and grading the oral examination which will be graded on a pass or fail basis.

14. Send a certified check or money order in the amount of $600.00 made payable to the State of Nevada Board of Homeopathic Medical Examiners, and a second check for $50.00 for the fingerprint card fee.

15. The Applicant must appear personally before the State of Nevada Board of Homeopathic Medical Examiners for the oral interviewand pass the required examination.

B. ADDITIONAL APPLICATION REQUIREMENTS FOR APPLICANTS WHO ARE GRADUATES OF A FOREIGN MEDICAL SCHOOL

In addition to fulfilling all of the requirements of Section A, above, an Applicant who is a graduate of a foreign medical school must also comply with the following additional requirements.

1. The Applicant must have received the Degree of Doctor of Medicine or Doctor of Osteopathic Medicine, or their equivalents, as determined by the State of Nevada Board of Homeopathic Medical Examiners, from a foreign medical school recognized by the Educational Commission for Foreign Medical Graduates.

2. The Applicant must have completed three (3) years of postgraduate training in allopathic or osteopathic medicine satisfactory to the State of Nevada Board of Homeopathic Medical Examiners and provided proof thereof.

3. The Applicant must have completed an additional six (6) months of training in homeopathic medicine, as defined in NRS 630A.040, in a program, or programs, satisfactory to the State of Nevada Board of Homeopathic Medical Examiners and provided proof thereof.

4. The Applicant must have received the standard certificate of the Educational Commission for Foreign Medical Graduates and provided proof thereof.

5. The Applicant must have passed all parts of the Federation Licensing Examination, or has received a written statement from the Educational Commission for Foreign Medical Graduates that the Applicant has passed the examination given by the Educational Commission for Foreign Medical Graduates and provided proof thereof.

6. In addition to the proofs required by Paragraphs 1 through 5, above, the State of Nevada Board of Homeopathic Medical Examiners may require such further evidence and require such further proof of the professional and moral qualifications of the Applicant as it deems proper at its discretion.

7. If the Applicant is a diplomate of a specialty board recognized by the State of Nevada Board of Homeopathic Medical Examiners, the requirements of Paragraphs 2 and 3, above, may be waived by the State of Nevada Board of Homeopathic Medical Examiners at its discretion.

C. PERSONAL BACKGROUND: All Applicants must answer the following questions in detail.

IDENTIFYING INFORMATION

Name: _____ SS No.: _____
Last Name *First Name* *Middle Initial*

Maiden Name if Applicable: _____
Last Name *First Name* *Middle Initial*

Any other names used: _____

Residence Address: _____

Business Address: _____
Street *City* *State* *Zip*

Business Address: _____
Street *City* *State* *Zip*

Mailing Address: _____
Street *City* *State* *Zip*

Email Address: _____

Business Telephone: _____ Home Telephone: _____

U.S. Citizen: Yes _____ No _____ Naturalized: Yes _____ No _____

Naturalized Certificate Number:_____ Date of Birth: _____

Place of Birth: _____

Height: _____ Weight: _____ Hair Color: _____ Eye Color: _____ Sex: _____

U.S. Military Service: Yes _____ No _____ Branch of Service: _____

Dates of Service: From:_____ To: _____

Did you serve as a Medical Officer? Yes _____ No _____

Rank: _____Serial Number: _____ Type of Discharge: _____

Licensed to drive? Yes _____ No _____ Class: _____ State of Issue: _____

Drug Enforcement Administration No.: _____

Nevada State Board of Pharmacy No.: _____

Other State Board of Pharmacy No.: _____

NPI No.: _____ Medicare No: _____

Staple one photograph here.
Include a second photograph with the Application, unattached.
Place your signature and the date of the photo on both photos.

PROFESSIONAL BACKGROUND INFORMATION

1. Has any disciplinary action, including the voluntary surrender, revocation, limitation or restriction, been taken against any medical license held by you in the State of Nevada?

Yes _____ No _____

If yes, attach a certified copy of the final order, stipulation or consent agreement.

2. Has any disciplinary action, including the voluntary surrender, revocation, limitation or restriction, been taken against any license you hold from another licensing authority?

Yes _____ No _____

If yes, attach a certified copy of the final order, stipulation or consent agreement.

3. Has any malpractice or any other lawsuit or settlement, award, or judgment been made against you or your practice?

Yes _____ No _____

If yes, attach a certified copy of the court action or settlement.

4. Have you been convicted of, pled guilty, or pled nolo contendre to, a felony or to a misdemeanor involving a crime of moral turpitude?

Yes _____ No _____

If yes, attach a certified copy of the court records showing the court's decision and sentence.

5. Have you ever been convicted of, or pled guilty, or pled nolo contendre to a crime that is not one of moral turpitude? (Traffic violations involving a fine of $150.00 or less or any juvenile offense that was not prosecuted as an adult are not considered crimes for these purposes).

Yes _____ No _____

If yes, attach a certified copy of the court records showing the court's decision and sentence.

6. List all States, United States Territories and/or Foreign Countries where you currently hold a license to practice allopathic, osteopathic or homeopathic medicine and the corresponding license number and type of license.

State/Territory/Country: _____ License No.:_____ MD _____ DO _____ HMD _____

State/Territory/Country: _____ License No.:_____ MD _____ DO _____ HMD _____

State/Territory/Country: _____ License No.:_____ MD _____ DO _____ HMD _____

State/Territory/Country: _____ License No.:_____ MD _____ DO _____ HMD _____

State/Territory/Country: _____ License No.:_____ MD _____ DO _____ HMD _____

State/Territory/Country: _____ License No.:_____ MD _____ DO _____ HMD _____

7. Are these licenses held by examination, endorsement or reciprocity? State the method of licensing for each other license held by you.

_____

_____

_____

_____

8. How many years have you been actively practicing medicine? _____

9. List all locations and time periods for your active practice of medicine.

Location: _____ Time Period: _____

Location: _____ Time Period: _____

Location: _____ Time Period: _____

Location: _____ Time Period: _____

Location: _____ Time Period: _____

Location: _____ Time Period: _____

10. Do you currently have Malpractice Insurance?

Yes _____ No _____

If yes, attach a copy of your most recent Certificate of Liability Insurance.

11. Do you currently have staff and/or admitting privileges at any hospital or hospitals?

Yes _____ No _____

If yes, complete the following.

Name of Hospital: _____

Address of Hospital: _____

Date Privileges Granted: _____

Name of Hospital: _____

Address of Hospital: _____

Date Privileges Granted: _____

Name of Hospital: _____

Address of Hospital: _____

Date Privileges Granted: _____

12. Have your staff and/or admitting privileges ever been limited, suspended, surrendered or revoked by any hospital or hospitals?

Yes _____ No _____

If yes, attach a detailed explanation for any such limitation, suspension, surrender or revocation.

CHILD SUPPORT INFORMATION

Federal Welfare Reform, as implemented by the 1997 Session of the Legislature by SB 356 requires that professional and occupational licensing agencies add the following questions regarding child support to all Applications for new licenses and for renewals. Please mark the appropriate response. Failure to mark one of the three will result in denial of the Application.

_____ I am not subject to a court order for the support of my child.

_____ I am subject to court order for the support of one or more children and am in compliance with the order or am in compliance with a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order; or

_____ I am subject to a court order for the support of one or more children and am not in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

EDUCATIONAL BACKGROUND

Please provide the following information:

Graduated from High School: Yes _____ No _____

Location: _____ When: _____

Technical School: Name: _____

(Attach a copy of all Degrees, Diplomas or Certificates showing qualifications)

Course or Program: _____

Date of Completion: _____ Diploma: _____ Certificate: _____

College/University: _____

(Attach a copy of all Degrees, Diplomas or Certificates showing qualifications)

Address: _____ Phone No.: _____

Course or Program: _____

Date of Completion: _____ Diploma: _____ Certificate: _____

Medical School: _____

(Attach a copy of all Degrees, Diplomas or Certificates showing qualifications)

Address: _____ Phone No.: _____

Date of Completion: _____ Degree: _____

Homeopathic Training Program: _____
(Attach a copy of all Degrees, Diplomas or Certificates showing qualifications)

Address of School: _____ Phone No.: _____

Date of Completion: _____ Degree: _____

Naturopathic Training Program: _____
(Attach a copy of all Degrees, Diplomas or Certificates showing qualifications)

Address of School: _____ Phone No: _____

Date of Completion: _____ Degree: _____

Preceptorship Training Location: _____
(Attach a copy of Certificate from the Preceptor showing the number of credits and subject matter)

Preceptor: _____

Address of School: _____ Phone No: _____

Date of Completion: _____ Degree: _____

POSTGRADUATE TRAINING AND EXPERIENCE INFORMATION

1. Internship: From: _____ To: _____

Name of Hospital for Internship: _____
(Attach a copy of all Certificates showing qualifications)

Address of Hospital for Internship: _____

Contact for Hospital: _____ Telephone No:. _____

2. Internship: From: _____ To: _____

Name of Hospital for Internship: _____
(Attach a copy of all Certificates showing qualifications)

Address of Hospital for Internship: _____

Contact for Hospital: _____ Telephone No:. _____

3. Residency: From: _____ To: _____

Type of Residency: _____

Name of Hospital for Residency: _____
(Attach a copy of all Certificates showing qualifications)

Address of Hospital for Residency: _____

Contact for Hospital: _____ Telephone No:. _____

4. Residency: From: _____ To: _____

Type of Residency: _____

Name of Hospital for Residency: _____

(Attach a copy of all Certificates showing qualifications)

Address of Hospital for Residency: _____

Contact for Hospital: _____ Telephone No:. _____

5. Residency: From: _____ To: _____

Type of Residency: _____

6. Fellowship: From: _____ To: _____

Type of Fellowship: _____

Name of Hospital for Fellowship: _____

(Attach a copy of all Certificates showing qualifications)

Address of Hospital for Fellowship: _____

Contact for Hospital: _____ Telephone No:. _____

7. Fellowship: From: _____ To: _____

Type of Fellowship: _____

Name of Hospital for Fellowship: _____

(Attach a copy of all Certificates showing qualifications)

Address of Hospital for Fellowship: _____

Contact for Hospital: _____ Telephone No:. _____

8. Fellowship: From: _____ To: _____

Type of Fellowship: _____

Name of Hospital for Fellowship: _____

(Attach a copy of all Certificates showing qualifications)

Address of Hospital for Fellowship: _____

Contact for Hospital: _____ Telephone No:. _____

9. Other Post GraduateTraining: From: _____ To: _____

Type of Other Training: _____

Name of Institution for Other Training: _____

(Attach a copy of all Certificates showing qualifications)

Address of Institution for Other Training: _____

Contact for Institution: _____ Telephone No:. _____

10. Other Post GraduateTraining: From: _____ To: _____

Type of Other Training: _____

Name of Institution for Other Training: _____

(Attach a copy of all Certificates showing qualifications)

Address of Institution for Other Training: _____

Contact for Institution: _____ Telephone No:. _____

11. Other Post Graduate Training: From: _____ To: _____

Type of Other Training: _____

Name of Institution for Other Training: _____

(Attach a copy of all Certificates showing qualifications)

Address of Institution for Other Training: _____

Contact for Institution: _____ Telephone No:. _____

12. Name of Specialty Board: _____

Address of Specialty Board: _____

Type of Specialty Certification: _____

(Attach a copy of all Certificates showing qualifications)

Date of Certification: _____ Expiration Date: _____

13. Name of Specialty Board: _____

Address of Specialty Board: _____

Type of Specialty Certification: _____

(Attach a copy of all Certificates showing qualifications)

Date of Certification: _____ Expiration Date: _____

14. Name of Specialty Board: _____

Address of Specialty Board: _____

Type of Specialty Certification: _____

(Attach a copy of all Certificates showing qualifications)

Date of Certification: _____ Expiration Date: _____

By signing this Application, the Applicant hereby expressly gives its consent to the State of Nevada Board of Homeopathic Medical Examiners to run a detailed background check on the Applicant. The Applicant further consents to the use, by the State of Nevada Board of Homeopathic Medical Examiners, of a third party to run any such background checks as the State of Nevada Board of Homeopathic Medical Examiners deems necessary.

By signing this Application, the Applicant acknowledges that (1) it is the Applicant's sole responsibility to provide certified copies of all documents evidencing the Applicant's education and/or credentials and (2) pursuant to the provisions of NRS 630A, the Applicant shall be responsible for reimbursing the State of Nevada Board of Homeopathic Medical Examiners for any and all costs incurred by the State of Nevada Board of Homeopathic Medical Examiners in the course of the State of Nevada Board of Homeopathic Medical Examiners' verification of the materials submitted by the Applicant in support of this Application or the verification of the credentials submitted by the Applicant along with this Application. Such reimbursement must be made prior to the issuance of any certificate or license by the State of Nevada Board of Homeopathic Medical Examiners.

STATE OF NEVADA)

) ss.

COUNTY OF _____)

AFFIDAVIT

(To be signed by the Applicant and notarized)

I, _____, being duly sworn, upon oath and under penalty of perjury do depose and state: That I am the Applicant named in the foregoing document and the person named in the Diplomas accompanying this Application. That the Applicant is the lawful holder of said Diplomas and that the same were procured in the regular course of instruction and examination without fraud or misrepresentation. That the Applicant is the person who subscribed to the above Application and that the facts stated therein, as well as any facts stated on separate sheets attached hereto are true. That I have answered all questions truly and accurately to the best of my ability. That I understand if any information contained herein is false or altered in any way, pursuant to NRS 630A.350, it is grounds for denial or revocation of the License applied for in this Application.

_____ _____

Signature of Applicant *Printed Name of Applicant*

SUBSCRIBED AND SWORN TO before me this ____day of _____, 20 _____.

_____ _____

Notary Public *My Commission Expires*

REQUEST FOR UNDERGRADUATE SCHOOL TRANSCRIPT

Dear Sir:

I have applied for Licensure as a Homeopathic Physician in the State of Nevada. The State of Nevada Board of Homeopathic Medical Examiners requires this form to be completed by the Undergraduate School which I attended and from which I obtained a degree. Please take this request as my authorization for the release of all information related to my attendance at your school. Please complete this form and release all information in your files, favorable or otherwise, to the State of Nevada Board of Homeopathic Medical Examiners, 1301 Cordone Avenue, Suite 126, Reno, NV 89502.

Your early response is appreciated.

_____ _____

Signature *Printed Name*

Dates Attended: _____

Address: _____

City: _____ State: _____ Zip: _____

DO NOT DETACH. THIS SECTION TO BE COMPLETED BY AN OFFICIAL OF THE UNDERGRADUATE SCHOOL AND RETURNED DIRECTLY TO THE STATE OF NEVADA BOARD OF HOMEOPATHIC MEDICAL EXAMINERS AS STATED ABOVE.

School Name:_____

Address: _____

Applicant's Name: _____

Dates of Attendance: _____ to _____ Date of Graduation:_____

Degree: _____ Grade Average: _____

Comments, if any: _____

_____

I hereby certify the above information: _____

Signed

_____ _____

Date Signed *Official Capacity*

REQUEST FOR MEDICAL OR PROFESSIONAL SCHOOL TRANSCRIPT

Dear Sir:

I have applied for Licensure as a Homeopathic Physician in the State of Nevada. The State of Nevada Board of Homeopathic Medical Examiners requires this form to be completed by the Medical or Professional School which I attended and from which I obtained a degree. Please take this request as my authorization for the release of all information related to my attendance at your school. Please complete this form and release all information in your files, favorable or otherwise, to the State of Nevada Board of Homeopathic Medical Examiners, 1301 Cordone Avenue, Suite 126, Reno, NV 89502.

Your early response is appreciated.

_____ _____

Signature *Printed Name*

Dates Attended: _____

Address: _____

City: _____ State: _____ Zip: _____

DO NOT DETACH. THIS SECTION TO BE COMPLETED BY AN OFFICIAL OF THE MEDICAL OR PROFESSIONAL SCHOOL AND RETURNED DIRECTLY TO THE STATE OF NEVADA BOARD OF HOMEOPATHIC MEDICAL EXAMINERS AS STATED ABOVE.

School Name: _____

Address: _____

Applicant's Name: _____

Dates of Attendance: _____ to _____ Date of Graduation: _____

Degree: _____ Grade Average: _____

Comments, if any: _____

_____

I hereby certify the above information: _____

Signed

_____ _____

Date Signed *Official Capacity*

REQUEST FOR VERIFICATION OF MEDICAL LICENSE

(This is not an endorsement certification.)

Page 1

Dear Sir:

I have applied for Licensure as a Homeopathic Physician in the State of Nevada. The State of Nevada Board of Homeopathic Medical Examiners requires this form to be completed by the Medical Licensing Boards in all jurisdictions in which I hold a License to Practice Medicine. Please take this request as my authorization for the release of all information related to my Medical License in you jurisdiction. Please complete this form and release all information in your files, favorable or otherwise, to the State of Nevada Board of Homeopathic Medical Examiners, 1301 Cordone Avenue, Suite 126, Reno, NV 89502.

Your early response is appreciated.

_____ _____

Signature *Printed Name*

Dates Attended: _____

Address: _____

City: _____ State: _____ Zip: _____

DO NOT DETACH. THIS SECTION TO BE COMPLETED BY AN OFFICIAL OF THE MEDICAL LICENSING BOARD AND RETURNED DIRECTLY TO THE STATE OF NEVADA BOARD OF HOMEOPATHIC MEDICAL EXAMINERS AS STATED ABOVE.

Country / State:_____

Address: _____

Licensee's Name: _____ License No.: _____

Issue Date: _____ Degree: _____

By Endorsement/Reciprocity with: _____

By your Board's written examination given on: _____

Is this License current? _____ If not, why? _____

_____

REQUEST FOR VERIFICATION OF MEDICAL LICENSE

(This is not an endorsement certification.)

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Has this License ever been suspended, surrendered, limited or revoked? _____ If yes, why? _____

_____

_____(Attach additional pages if needed.)

Has disciplinary action ever been instituted against the Licensee? If yes, why? _____

_____

_____ (Attach additional pages if needed.)

Has the Licensee ever been on probation? _____ If yes, why? _____

_____

_____ (Attach additional pages if needed.)

Has the Licensee ever been requested to appear before your Board? _____ If yes, why? _____

_____

_____ (Attach additional pages if needed.)

Comments, if any: _____

_____

_____ (Attach additional pages if needed.)

I hereby certify the above information: _____

Signed

_____ _____

Date Signed *Official Capacity*

OFFICIAL BOARD SEAL

A. 600 HOURS POSTGRADUATE TRAINING IN HOMEOPATHIC MEDICINE

FOR PHYSICIANS TRAINED IN THE UNITED STATES, A UNITED STATES TERRITTORY, CANADA OR THE UNITED KINGDOM

An Applicant must have adequate training in homeopathic medicine as defined in NRS 630A.040. You must submit evidence of a combined total of 600 hours of postgraduate training in homeopathic medicine of which 300 hours must be completed in the State of Nevada under the supervision of a licensed Homeopathic Physician.

Listed below are courses which have been approved by the State of Nevada Board of Homeopathic Medical Examiners for the 300 hour portion of this requirement. You may also obtain your required 600 hours of training by serving an apprenticeship with a licensed Homeopathic Physician located in the State of Nevada and approved by the State of Nevada Board of Homeopathic Medical Examiners.

B. SIX (6) MONTHS POSTGRADUATE TRAINING IN HOMEOPATHIC MEDICINE

FOR PHYSICIANS WHO ARE GRADUATES OF A FOREIGN MEDICAL SCHOOL

An Applicant, who is a graduate of a foreign medical school, must have adequate training in homeopathic medicine as defined in NRS 630A.040. You must submit evidence of a combined total of six (6) months of postgraduate training in homeopathic medicine satisfactory to the State of Nevada Board of Homeopathic Medical Examiners.

Listed below are courses which have been approved by the State of Nevada Board of Homeopathic Medical Examiners which may be used to fulfill some of this requirement at the discretion of the State of Nevada Board of Homeopathic Medical Examiners. You may also obtain your required six months (6) of training by serving an apprenticeship with a licensed Homeopathic Physician located in the State of Nevada and approved by the State of Nevada Board of Homeopathic Medical Examiners.

APPROVED COURSES

1. **Hahnemann College of Homeopathy (414) 849-1925**
   Albany CA
   900 hours of training consisting of one 4-day weekend per month for four years.
   *CHE approved

2. **National Center for Homeopathy (703) 548-7790**
   Alexandria, VA
   Professional Course - week one: 38 hours week two: 35 hours
   Case analysis - 21 hours
   Homeopathic Philosophy - 21 hours
   *CHE approved

3. **International Foundation for Homeopathy (206) 324-8230**
   Seattle, WA
   120 hours of training through five 4-day weekend courses.

4. **The Pacific Academy of Homeopathic Medicine (415) 549-3475**
   Berkeley, CA
   500 hours of training extending over 2 1/2 - 3 years

5. **Curentur University (310) 448-1700**
   Los Angeles, CA
   Ph.D. Course which meets one weekend a month for three years - 930 hours
   H.D. Course meets one weekend a month - 810 hours

6. **British Institute of Homeopathy (609) 927-5660**
   Home study course - 300 hours
   britishinstitutehom@yahoo.com

7. **The New England School of Homeopathy (800) 637-4440**
   Boston, New York, Fort Lauderdale
   Level I: Introductory level - 36 hours
   Level II: Case analysis and management - 108 hours

8. **The Northwestern Academy of Homeopathy (612) 593-9458**
   Plymouth, MN
   Class meets four days each month over three years - 1,152 hours

9. **The Atlantic Academy of Classical Homeopathy (718) 518-4593**
   New York, NY
   Class meets one weekend per month for three years - 500 hours

10. **International College of Homeopathy (310)640-3600**
    El Segundo, CA
    Class meets one weekend per month for 16 months - 200 hours

11. **Institute of Classical Homeopathy (707) 963-7796**
    Marin, CA
    Class meets one day a week with a summer break for four years

12. **Vancouver Homeopathy Academy (604) 254-6635**
    Vancouver, B.C.
    1st yr. class meets 11 weekends=132 hours/ 2nd-3rd yr. class meets 3-day weekend - 198 hours/yr

13. **Homeopathic College of Canada- Humber College (416) 481-8816 /Toll free 1 (888) DR.HOMEO (374-6636)**
    Toronto, Ontario Canada
    Doctorate Course - 3 yr. course-3045 hrs. of basis sciences, homeopathy and clinical externship

14. **The School of Homeopathy--U.S. Affiliate: NY Center for Homeopathy (212) 570-2576**
    Correspondence Courses- Study material will be sent from the U.K. by the Course Manager. Five study units- over 100 hours of study time required.

15. **Primary Care Homeopathy Training Program (800) 954-7005**
    San Francisco, CA
    Three sessions: Home study and practice based outcomes research-200 hours.

16. **Telosis School of Homeopathy (518) 392-7295**
Chatham, New York
60 hrs.a yr. for 2 yrs.- 1 Sat. per mo.for 8 months. Students with 300 hrs. training

17. **Canadian Academy of Homeopathy (416) 503-4003**
Toronto/ Montreal Quebec Canada
Three year program-36 sessions 18- Four day sessions
(Video and audio correspondence/ home study available)
*CHE approved

18. **International Bio-Medical Research Institute (775) 827-1444**
Reno, NV
Intermediate Course =200 hrs.= 6 weeks/Advanced Course-250 hrs.=8 weeks

19. **Resonance School of Homeopathy (775) 827-0222**
3621 Big Bend Lane
Reno, NV89509