STATE OF NEVADA

BOARD OF ORIENTAL MEDICINE

3191 E. Warm Springs Rd.

Las Vegas, NV 89120

Phone: 702-675-5326/Fax: 702-989-8584

Email: [omboardexecutivedirector@gmail.com](mailto:omboardexecutivedirector@gmail.com)

10/16/2018

Dear Doctors,

This is a friendly reminder regarding the renewal of your OMD licenses as your current licenses expire on 2/1/2019. Attached is a copy of the Licensure Renewal for Calendar Year 2019 Fact Sheet (“Renewal Form”) or you can go to the FORMS tab at our website at orientalmedicine.nv.gov/ where you can find the same Renewal Form.

Please remit the completed Renewal Form, the license fee of $700 payable to the Nevada State Board of Oriental Medicine, and your CEU certificate(s) by 12/31/2018 to ensure timely processing. We will accept these documents until the postmarked date of 1/31/2019 without a late fee. However, please understand that if you send in your packet after 12/31/2018, you may get your new license card after 2/1/2019.

You can send your Renewal Form, check, and CEU certificate(s) to our address at:

Nevada State Board of Oriental Medicine

3191 E. Warm Springs Rd.

Las Vegas, NV 89120

Also, the Board would welcome your request to be placed on our email list to receive our Agendas for upcoming meetings. Kindly let us know if you would like to be on the list by emailing us at omboardexecutivedirector@gmail.com.

Thank you.

Yours truly,

Maggie Tracey, OMD, President, and Merle Lok, Executive Director

**LICENSURE RENEWAL FOR CALENDAR YEAR 2019 FACT SHEET**

*Please remit your license fee, the completed fact sheet and CEU Certificate(s) by 12/31/18. Failure to comply may result in additional late fees.*

Licensee Name:

(Please print the name as it appears on your license)

License Number: Date of original issue: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Name of your business:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Business address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: State: Zip:\_\_\_\_\_\_\_\_\_\_\_\_

Phone: Office (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: Office ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: Home: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LICENSURE SCREENING QUESTIONNAIRE

*If you answer “yes” to any of the screening questions, please give the details on a separate sheet of paper.*

1. In the past year, I have completed 10 hours of continuing education and attached the certificate of completion (Must be previously approved by the Board) Yes\_\_\_\_ No\_\_\_\_
2. In the past two years, I have been convicted of a felony. Yes\_\_\_\_ No\_\_\_\_
3. In the past two years, I have been convicted of a morals charge. Yes\_\_\_\_ No\_\_\_\_
4. In the past two years, I have been treated for the use of narcotics. Yes\_\_\_\_ No\_\_\_\_
5. In the past two years, I have been treated for the use of alcohol. Yes\_\_\_\_ No\_\_\_\_
6. In the past two years, my license by any governmental agency has had some type of

action taken against it. Yes\_\_\_\_ No\_\_\_\_

1. In the past two years, I have been treated for a physical or mental condition which may

impact upon my ability to practice the Oriental Medicine. Yes\_\_\_\_ No\_\_\_\_

CHILD SUPPORT INFORMATION

*Please initial next to the statement which best describes your situation.*

\_\_\_\_\_\_I am NOT subject to a court order for the support of one or more children.

\_\_\_\_\_\_ I am subject to a 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.

\_\_\_\_\_\_ I am subject to a court order for the support of one or more children and am NOT in compliance with the order or am NOT 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.

MILITARY SERVICE

*Please initial next to the statement which best describes your situation.*

\_\_\_\_\_\_\_\_\_\_\_ I am a veteran or a service member of the United States military.

\_\_\_\_\_\_\_\_\_\_\_ I am NOT a veteran or a service member of the United States military.

guidelines of the Centers for Disease Control and Prevention Please initial next to the statement which best describes your situation. *Please initial next to the statement which best describes your situation.*

NRS 634A.144 states:

**Board prohibited from issuing or renewing license unless applicant attests to certain information related to safe and appropriate injection practices.**The Board shall not issue or renew a license to practice Oriental medicine unless the applicant for issuance or renewal of the license attests to knowledge of and compliance with the guidelines of the Centers for Disease Control and Prevention concerning the prevention of transmission of infectious agents through safe and appropriate injection practices.

\_\_\_\_\_\_\_\_\_\_\_ I attest that I have knowledge of and am in compliance with the guidelines of the Centers for Disease Control and Prevention concerning the prevention of transmission of infectious agents through safe and appropriate injection practices. (NRS 634A.144)

\_\_\_\_\_\_\_\_\_\_\_ I DO NOT attest that I have knowledge of and am in compliance with the guidelines of the Centers for Disease Control and Prevention concerning the prevention of transmission of infectious agents through safe and appropriate injection practices.

MALPRACTICE INSURANCE INFORMATION

Do you have malpractice insurance? YES\_\_\_\_\_\_ NO\_\_\_\_\_\_\_

If YES, please complete the questions below:

Name of Your Malpractice Insurance Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address of Your Malpractice Insurance Provider:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number of Your Malpractice Insurance Provider:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Expiration:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CARDIOPULMONARY RESUSCITATION (“CPR”) CERTIFICATION INFORMATION

Are you currently certified in CPR? YES\_\_\_\_\_ NO\_\_\_\_\_\_

I attest that the information provided above is factual and accurate.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

ADA Compliant
