FIRST NATION MEDICAL BOARD

Application for License of a Certified Tribal Healer

Personal

Date:_____ Date of Birth:_____
First Name:_____
Middle Name:_____
Last Name:_____
Social Security Number:_____
Gender: Male ☐ Female ☐
Home Address:_____
Home Phone:_____ Cell Phone:_____
Personal Email:_____

Business

Business Name:_____
Office Address:_____
Office Phone:_____ Office Fax:_____
Business Website:_____ Business Email:_____
Business TIN:_____

Questions

(Since your licensure as a Certified Tribal Healer)

1. Have you ever been convicted of, or pled nolo contender to, a felony or to a misdemeanor involving a crime of moral turpitude?
   YES:_____ NO:_____
   If yes, please explain:_____
2. Have you been, or are your currently, the subject of any disciplinary action, against your license(s)?
   YES:_____ NO:_____
   If yes, please explain:_____
3. Has your license been the subject of voluntary surrender, revocation, limitation or restriction?
   YES:_____ NO:_____
   If yes, please explain:_____
4. Has any malpractice or any other lawsuit or settlement, award, or judgement been made against you or your practice?
   YES:_____ NO:_____
   If yes, please explain:_____
5. Do you have any medical condition (e.g., physical, emotional, or psychiatric impairment) that adversely affects your ability to practice medicine?
   YES:_____ NO:_____
   If yes, please explain:_____
6. Are you currently in treatment for a mental illness, drug addiction, or alcohol abuse?
   YES:_____ NO:_____
   If yes, please explain:_____

Statements

By checking this box I am agreeing to: ☐

- provide a current credit card on file for annual renewal;
- acknowledging that license recertification is required every 3 years; and
- pay a tribal donation fee of five percent (5%) on gross receipts for all goods and services.

All information I have provided by me herein is true and complete to the best of my knowledge: ☐

Payment
($350)

Credit Card ☐ Debit Card ☐ Check ☐

Credit Card Type: VISA ☐ MASTERCARD ☐ DISCOVER ☐ AMEX ☐
Credit Card Number:_____
Expiration:_____ Security Code:_____

Debit Card Number:_____
Expiration:_____ Security Code:_____

I understand and agree that payment must accompany my FNMB submission form, my application will not be reviewed until it is complete, payment is no guarantee it will be approved, there is an administration fee to review my application, and in the event my application is not approved 50% (fifty percent) of my application fee will be refunded. Cancellation of payment must be done with written notice 30 days prior to annual renewal.

_____
Signature

MAIL THIS FORM TO:
First Nation Medical Board
2121 E. Flamingo Road, Suite 112
Las Vegas, Nevada 89119

EMAIIL THIS FORM TO:
info@firstnationmedicalboard.com

FAX THIS FORM TO:
(702) 902-2862