



STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TN 37243

TENNESSEE BOARD OF MEDICAL EXAMINERS
COMMITTEE FOR ACUPUNCTURE
(800) 778-4123, ext. 532-4384 or Local (615) 532-3202, ext. 532-4384
<http://tennessee.gov/health/>

APPLICATION INSTRUCTIONS FOR CERTIFICATION AS AN ACUPUNCTURE DETOXIFICATION
SPECIALIST (ADS)
APPLICATION CHECK SHEET

Provided below is a checklist for your personal use and convenience containing all the things you must do to receive consideration for issuance of a Tennessee certification to practice. **NOTE: All submissions must be executed and dated less than one (1) year before receipt or they will be rejected by the Committee.**

- | | <u>Done</u> |
|---|-------------|
| 1. Complete, sign, have notarized and mail the application pages 1 through 6. | _____ |
| 2. Attach to the application a clear, recognizable, recently taken passport size photograph of yourself. | _____ |
| 3. Have submitted directly from the training program to the Administrative Office documentation of successful completion of a board-approved training program in auricular detoxification acupuncture. To become board-approved, the training program must meet or exceed standards of training set by NADA. See Attachment 2 . | _____ |
| 4. If you are or have ever been licensed, certified, registered, or permitted by any state or country to practice as an ADS or other health professional, you must complete and mail Attachment 1 to each and every state. Copies of Attachment 1 may be duplicated to accommodate each request. | _____ |
| 5. Submit two (2) <u>original</u> letters of recommendation from medical professionals who can attest to your character as an ADS. These letters must be written within the preceding 12 months, identify the individuals as medical professionals, and must be originals on the signator's letterhead. | _____ |
| 6. Attach to the application a check or money order in the amount of \$110.00 made payable to the Committee for Acupuncture. | _____ |
| 7. Have submitted directly from an employing institution, facility, or entity to the Administrative Office satisfactory proof of the practice of auricular detoxification treatment in a hospital, clinic, or treatment facility which provides comprehensive alcohol and substance abuse or chemical dependency services including counseling. Accompanying this proof must also be a certification from the supervising certified acupuncturist or medical director of the institution, facility, or entity attesting to employment and acceptance of supervisory responsibility. | _____ |
| 8. Criminal background check. For instructions to obtain a criminal background check, go to http://tn.gov/health/article/CBC-instructions . | _____ |
| 9. Complete Declaration of Citizenship, Attachment 3 and submit. | _____ |

UNDERSTANDING THE APPLICATION PROCESS

If an address change occurs at any time, you must notify the Committee's administrative office, in writing, immediately.

1. All application fees are non-refundable.
2. All documents and fees required to be submitted by you or which must be requested from the appropriate institutions in this application process, must be mailed directly to:

Committee for Acupuncture
665 Mainstream Drive
Nashville, TN 37243

For Federal Express or Special Courier:
Committee for Acupuncture
665 Mainstream Drive
Nashville, TN 37243

3. Allow fourteen (14) working days for information mailed to our office to be received and placed in your file. Federal Express or special courier services will not appreciably reduce the processing time. Additionally, if Federal Express or special courier services are used you will be responsible for charges incurred. The Committee asks that you please give the administrative office every consideration in this matter.
4. If necessary documentation has not been received when your application has been received by the Committee's administrative office, an initial deficiency letter will be sent to you. The supporting documentation requested in the letter must be received in the Committee's administrative office sixty (60) days from the date of the initial deficiency letter. Files not completed within sixty (60) days will be closed.
5. Absent any complicating factors, the average application processing time is six weeks. Once the application is completed, your file will be promptly reviewed and an initial certification determination made. You will be promptly notified by letter of the initial determination and if your application is approved you will be able to view certification approval on the Internet at <http://tennessee.gov/health/>
6. It is recommended that you do not make arrangements to accept employment as an ADS in Tennessee until you are granted certification by the Committee for Acupuncture.

Thank you for your cooperation. We will make every effort to expedite your application in an efficient manner.

**ATTACH A
CURRENT FULL-
FACE
PHOTOGRAPH**



**FOR OFFICIAL USE
ONLY**

2483-001 \$100.00
2483-006 \$ 10.00
\$110.00

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**APPLICATION FOR
CERTIFIED ACUPUNCTURE DETOXIFICATION SPECIALIST (ADS)**

PERSONAL INFORMATION

PLEASE PRINT IN INK

Name: _____
Last First Middle Maiden

Have you ever been known by any other names: Yes _____ No _____

If yes, list names: _____

Social Security Number: _____ - _____ - _____ Date of Birth: _____

Mailing Address _____

_____ Zip _____

Phone: Home: (_____) _____ Office: (_____) _____

Place of Birth: _____ Sex: (optional, for statistical purposes only)

Female _____

U.S. Citizen: Yes ___ No ___

Male _____

Email address: _____

Do you wish to receive notification, including renewal notification, from the Department of Health via email? Y N

EDUCATIONAL AND EMPLOYMENT INFORMATION

Please provide the following information for all educational institutions you have attended beyond high school. Use the back of this page if you need additional space.

From:	_____	To:	_____	Educational Institution/Location	Degree Earned
	Mo/Yr		Mo/Yr		
From:	_____	To:	_____	Educational Institution/Location	Degree Earned
	Mo/Yr		Mo/Yr		
From:	_____	To:	_____	Educational Institution/Location	Degree Earned
	Mo/Yr		Mo/Yr		
From:	_____	To:	_____	Educational Institution/Location	Degree Earned
	Mo/Yr		Mo/Yr		

Please complete your entire employment history starting with the most current position first. Use the back of this page if you need additional space.

<u>DATES</u>		<u>LOCATION</u>	<u>POSITION AND DUTIES</u>
From:	_____	To:	_____
	Mo/Yr		Mo/Yr
		(Name of Location)	_____
		(City) (State)	_____
From:	_____	To:	_____
	Mo/Yr		Mo/Yr
		(Name of Location)	_____
		(City) (State)	_____
From:	_____	To:	_____
	Mo/Yr		Mo/Yr
		(Name of Location)	_____
		(City) (State)	_____
From:	_____	To:	_____
	Mo/Yr		Mo/Yr
		(Name of Location)	_____
		(City) (State)	_____

LICENSURE INFORMATION

List below all states, countries or provinces in which you have ever been or currently are licensed, permitted or certified. Submit a copy of **Attachment 1** to all such states, countries, or provinces regarding such licensure, certification or permit. Use the back of this page if you need additional space.

STATE	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List below **ALL** states, countries or provinces in which you hold or have ever held a license, certification or permit as a health professional other than ADS. Submit a copy of **Attachment 1** to all such states, countries or provinces regarding such licensure, certification or permit. Use the back of this page if you need additional space.

STATE	PROFESSION	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

COMPETENCY INFORMATION

PLEASE ANSWER THE FOLLOWING QUESTIONS. If any answers to the questions in this part are in the affirmative, attach an explanation on a separate sheet. In support of your explanation, the final documents or orders from the issuing states, courts, or agencies must be submitted along with this application.

For the purposes of these questions, the following phrases or words have the following meanings:

- 1. "Ability to practice your profession" is to be construed to include all of the following:
a. The cognitive capacity to exercise reasoned professional judgments and to learn and keep abreast of developments in your profession; and
b. The ability to communicate those judgments and information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
c. The physical capability to perform tasks and procedures required of your profession, with or without the use of aids or devices, such as corrective lenses or hearing aids.
2. "Medical condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to; orthopedic, visual, speech and/or hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV, tuberculosis, drug addiction and alcoholism.
3. "Chemical substances" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.
4. "Currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs or alcohol may have an ongoing impact on one's functioning as a licensee, or within the past two (2) years.
5. "Illegal use of controlled substances" means the use of controlled substances obtained illegally (e.g. heroin, or cocaine) as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

QUESTIONS

YES NO

- 1. Do you currently have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety?
a. If yes, are they reduced or ameliorated because you receive ongoing treatment (with or without medication) or participate in a monitoring program?
b. If you have any limitations or impairments caused by an existing medical condition, are they reduced or ameliorated because of the field of practice, the setting or the manner in which you have chosen to practice?

[IF you receive such ongoing treatment or participate in such a monitoring program, the Committee will make an individual assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed or whether you are not eligible for licensure.]

COMPETENCY INFORMATION continued

		YES	NO
2.	Do you currently use chemical substances?	_____	_____
	If yes, do they in any way impair or limit your ability to practice your profession with reasonable skill and safety?	_____	_____
	Please list: _____ _____		
3.	Are you currently engaged in the illegal use of controlled substances?	_____	_____
	If yes, are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you in order to assure that you are not engaged in the illegal use of controlled substances?	_____	_____
4.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?	_____	_____
5.	If you have ever held or applied for a license or certificate to practice as an ADS in any state, country or province, has it been or was it ever denied, reprimanded, suspended, restricted, revoked, or otherwise disciplined, curtailed or voluntarily surrendered under threat of investigation or disciplinary action?	_____	_____
6.	If you have ever had staff privileges at any hospital or health care facility have they ever been revoked, suspended, curtailed, restricted, limited or otherwise disciplined or voluntarily surrendered under threat of restriction or disciplinary action?	_____	_____
7.	Have you ever been convicted of a felony or a misdemeanor other than a minor traffic violation?	_____	_____
8.	Have you ever been rejected or censured by a professional society?	_____	_____
9.	In relation to the performance of your professional services in any profession:		
	a. Have you ever had a final judgment rendered <u>against</u> you; or	_____	_____
	b. Have you ever had settlement of any legal action rendered <u>against</u> you; or	_____	_____
	c. Are there any legal actions pending <u>against</u> you or to which you are a party?	_____	_____
10.	If you have ever held a license or certificate in any health care profession, has it ever been reprimanded, suspended, restricted, revoked, or otherwise disciplined, curtailed or voluntarily surrendered under threat of investigation or disciplinary action?	_____	_____



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CLEARANCE FROM OTHER STATE LICENSURE BOARDS

APPLICANT: Please provide the information requested in the top box and then mail one form to the licensure board in EACH state where you **hold or have ever held** a license to practice any profession. (Copies of this form can be used). **NOTE:** Some states require a fee for providing clearance information. To expedite your application, you may wish to contact the applicable state(s).

To Be Completed By Applicant (Please Print In Ink)

I, the undersigned applicant, was granted a (**circle one**) license or certificate to practice _____ (Profession)
 numbered _____ on _____ in the State of _____ (Date)

The Committee for Acupuncture of Tennessee requests that I submit evidence of the current status of that license or certificate in your state.
 You are hereby authorized to release any information in your files, favorable or otherwise, directly to the Tennessee Committee for Acupuncture.

Date _____ Applicant's Signature _____
 Applicant's typed or printed name _____

To Be Completed By Administrative Office of State Licensure Board

Name In Full As it Appears On License/Certificate or Permit:
 _____ (First) (M.I.) (Last)

License/Certificate/Permit Number: _____ Profession: _____
 Date Issued: _____ Expiration Date: _____

Basis of Issuance: _____ Endorsement/Reciprocity with _____ (State)
 (Check One) _____ Written Examination _____

Is the license currently active and registered? Yes _____ No _____
 Is there any derogatory information on file? Yes _____ No _____ If yes, please attach supporting documentation.

 Authorized Signature Title Date

Please mail directly to: Committee for Acupuncture
 665 Mainstream Drive
 Nashville, TN 37243

ATTACHMENT 2



**STATE OF TENNESSEE
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TRAINING PROGRAM DOCUMENTATION REQUEST

APPLICANT: supply the information requested in this box and then mail this entire form to your training program.

Full Name: _____ (Last) (First) (Middle/Maiden)
Address: _____ _____ _____
Number of Certificate of Completion: _____
Year of Completion: _____

TO WHOM IT MAY CONCERN:

I am applying for a license to practice as an Acupuncture Detoxification Specialists in the State of Tennessee. Please forward an original verification letter proving my successful completion of a board approved training program that meets or exceeds standards of training set by NADA. Letters should be sent to:

**Tennessee Board of Medical Examiners
Committee for Acupuncture
665 Mainstream Drive
Nashville, TN 37243**

Thank you for cooperation and prompt response.

Applicant's Signature

Date

ATTACHMENT 3



STATE OF TENNESSEE
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DECLARATION OF CITIZENSHIP
MUST ACCOMPANY ALL APPLICATIONS FOR INITIAL LICENSURE OR REINSTATEMENT OF LICENSURE

The "SAVE Act" requires Tennessee Department of Health (including all Boards, Commissions, and contractors), along with every local health department in the State, to verify that every adult applicant for a professional license is either a U.S. citizen, a "qualified alien," or a nonimmigrant who meets the requirements set out at 8 U.S.C. 1621.

I am a(n) _____
Healthcare Profession (Please Print) License number if applicable

Please Print Legibly

1. Name: _____
Last First Middle Maiden_
2. Mailing Address: _____
3. Phone Number: Home: (____)____-____ Office: (____)____-____ Fax: (____)____-____
4. I am a United States Citizen: ____Yes ____No
5. I am a foreign national not physically present in the United States ____Yes ____No. If you answered yes, to this question please sign this form in the presence of a notary and return it with your application. No further documentation is required.
6. Applicants Claiming United States Citizenship **MUST** provide one of the following:
 - a) Tennessee Driver's License, or photo ID issued by Department of Safety.
 - b) A valid driver license or ID issued by another state, provided its issuance requirements meet Department of Safety criteria.
 - c) An official birth certificate issued by a U.S. state, territory, or other jurisdiction. Puerto Rican birth certificates issued before July 1, 2010 do not count.
 - d) A federally issued birth certificate.
 - e) A valid, unexpired U.S. passport.
 - f) A report of birth abroad of a U.S. citizen.
 - g) A certificate of citizenship.
 - h) A certificate of naturalization.
 - i) A U.S. citizen ID card.
 - j) Any successor document to #'s a-i above.
 - k) SSN that the entity or local health department may verify with the Social Security Administration in accordance with federal law.
7. If you checked "No" in question 4 please indicate from the list below which category applies to you: (circle one)
 - a) Permanent Residents

- b) A nonimmigrant applicant for a professional or commercial license whose visa for entry into the United States is related to such employment, or a nonimmigrant under the Immigration and Nationality Act (8 U.S.C. 1101 *et seq.*).
- c) Asylees who meet the qualifications set out in 8 U.S.C. 1158
- d) Refugees who meet the qualifications set out in 8 U.S.C. 1157
- e) Persons who have been "paroled into the United States," under 8 U.S.C. 1182(d)(5) or whose deportation has been withheld under 8 U.S.C. 1253.
- f) Cuban or Haitian entrants as defined by section 501(e) of the Refugee Education Assistance Act of 1980
- g) Persons granted conditional entry into the U.S. under 8 U.S.C. 1153(a)(7) before April 1, 1980, because of persecution or fear of persecution on account of race, religion, or political opinion or because of being uprooted by catastrophic national calamity.
- h) An alien who has been "battered" or subjected to "extreme cruelty" by a parent or spouse as defined by 8 U.S.C. 1641(c), and also meets the qualifications set out 8 U.S.C. 1641(c)(1)(B). Under the circumstances set out in 8 U.S.C. 1641(c)(2) and (3), victims' children, or the parents of children who are victims, may also apply for benefits as qualified aliens.

Applicants claiming **qualified alien status** (question 7 above), please submit two of the following forms of "documentation of identity and immigration status" as determined by U.S. Homeland Security to be acceptable for verification through the SAVE program. Common types of documents used to verify immigration status are listed below. (Note: If you can provide only one document, your status will be verified through the U.S. Department of Homeland Security's SAVE program):

I-327 (Reentry Permit)

I-551 (Permanent Resident Card or "Green Card")

I-571 (Refugee Travel Document)

I-766 (Employment Authorization Card)

Machine Readable Immigrant Visa (with Temporary I-551 language)

Temporary I-551 stamp (on passport or I-94)

I-94 (Arrival/Departure record)

Unexpired foreign passport

WT/WB Admission Stamp in unexpired foreign passport

I-20 (Certificate of Eligibility for Nonimmigrant F(1) student status- "student visa")

DS2019 (Certificate of Eligibility for Exchange Visitor (J-1) Status)

I affirm under the penalty of perjury that the above is true and correct.

Signed this ____ day of _____, 20__.

Signature

Sworn to before me this ____ day of _____, 20__.

NOTARY PUBLIC

AFFIX SEAL HERE

My Commission Expires: _____

If an applicant is discovered to be an unqualified alien, or otherwise ineligible for benefits under the Act, all recurring benefits provided to that applicant must be immediately terminated. Anyone who purposefully makes a false, fictitious, or fraudulent claim of U.S. citizenship or qualified alien status will be liable under the Tennessee Medicaid False Claims Act, or Tennessee's False Claims Act. Any person who conspires to defraud the state or any local health department by securing a false claim allowed or paid to another person in violation of the Act may be liable under Tennessee's False Claims Act. Upon discovery of an applicant's false, fictitious, or fraudulent claim of U.S. citizenship, state governmental entities and local health departments must also file a criminal complaint with the United States Attorney.