How to Apply for an Acupuncture License

Step 1
Click on Apply for a License and select Acupuncture.

Step 2
Enter the requested information in the online application and submit payment. Applicants will be assessed the application and criminal background check fee and a service charge for the processing of the payment online. Print a summary of the information you entered when prompted. A summary of the information will also be e-mailed to you.

Step 3
Review the enclosed checklist of items that are needed to complete the application and submit the requested items to the board.

Step 4
To check the status of your application after it has been submitted:

- Log into your online services account,
- Click on Licensing,
- Click on Details to view the status and items needed to complete the application.

Questions?
Questions about content that needs to be entered on the application, eligibility requirements or the application process, contact the Iowa Board of Medicine at 515-281-6641.

Checklist for Initial Acupuncture Licensure

Use this checklist to ensure that you are submitting the appropriate documents for acupuncture licensure.

Do not send this form back to the Iowa Board of Medicine.

Application and Fees

_____ Completed application & application fee of $345 sent to the Board

Authorization for Release of Information

_____ Affidavit and Authorization for Release of Information forms sent to the Board

Transcript of Acupuncture Education

_____ Request an official transcript of your acupuncture education to be sent directly to this board from your acupuncture school(s).

Copy of Diploma

_____ Submit a copy of your diploma. An official translation is needed for any diploma not in English.

Verification of U.S. or Canadian License(s)

_____ Send this form to the state licensing agency to verify your acupuncture license and/or other professional licenses.

NCCAOM Status Report & Examination Results

_____ Request a status report and transcript of your examination results from the NCCAOM to be sent directly to this board.

Clean Needle Course

_____ Submit proof completion of a clean needle technique course approved by NCCAOM

English Proficiency

_____ Fluency in English language demonstrated by having either having completed the NCCAOM exam in English or a passing score on the TSE or TOEFL.

Name Change

_____ Supporting documentation of any legal name change sent to the Board

Checklist for Reinstatement of an Acupuncture License

Use this checklist to ensure that you are submitting the appropriate documents to reinstate your acupuncture license.

Do not send this form back to the Iowa Board of Medicine.

Application and Fees

_____ Completed reinstatement application & fee of $445 sent to the Board

Authorization for Release of Information

_____ Affidavit and Authorization for Release of Information forms sent to the Board

Verification of U.S. or Canadian License(s)

_____ Send this form to the state licensing agency to verify your acupuncture license and/or other professional licenses.

NCCAOM Status Report

_____ Request a status report from the NCCAOM to be sent directly to this board.

Name Change

_____ Supporting documentation of any legal name change sent to the Board

Section 13— Affidavit of Applicant

Enter the state and county in which the affidavit is being notarized. Sign the affidavit in the presence of a notary. The notary must supply the jurisdiction at the beginning of the affidavit, sign, enter the date of the notarization, and the expiration date of his/her commission. Attach a recent photo of yourself that has been taken within the last 90 days.

State of: _____ **County of:** _____

I,_____

hereby swear or affirm, under penalty of perjury, that I am the person described and identified; that the attached photo is a true likeness of myself; that I am the person named in the diploma which accompanies this application; that I am the lawful holder of said diploma; that said diploma was procured in the regular course of instruction and examination without fraud or misrepresentation.

I certify that I have carefully read the questions on this application and have answered them completely and truthfully. I declare under penalty of perjury that my answers, and all other statements or information submitted by me in this application process, are true and correct. If it is determined at any time that I have provided misleading or false information on or in support of this application, I understand that my application may be denied or that I may be subject to disciplinary action and criminal prosecution if I am already licensed.

I understand that I am required to update answers or information submitted with this application if the response or the information changes during the time period the application is pending. I also understand that this application is a public record in accordance with Iowa Code chapter 22 and that application information is public information, subject to the exceptions contained in Iowa law. Finally, in submitting this application, I consent to any reasonable inquiry that may be necessary to verify the information I have provided on or in conjunction with this application.

I also declare, under penalty of perjury, that if I did not personally complete the foregoing application that I have fully read and confirmed each question and accompanying answer and take full responsibility for all answers contained in this application.

_____
Signature of Applicant

_____
Signature of Notary Public

_____
Sworn/Affirmed to before me on

_____
My commission expires:

_____
Notary Seal or Stamp:

ATTACH A RECENT PHOTO THAT HAS BEEN TAKEN WITHIN THE LAST 90 DAYS HERE

Office Use Only	
License Number:	_____
Issue Date:	_____
Expiration Date:	_____
Initials:	_____

Applicant Name:

Section 14— Authorization for Release of Information
All applicants must sign and date this section.

I, _____(print name), do hereby authorize a disclosure of records concerning myself to the Iowa Board of Medicine (IBM). This release includes records of a public, private or confidential nature.

I acknowledge that the information released to the IBM may include material that is protected by federal and/or state laws applicable to substance abuse and mental health information. If applicable, I specifically authorize the release of confidential information to and from the IBM relating to substance abuse or dependence and/or mental health.

I further agree that the IBM may receive confidential information and records, including, but not limited to the following records:

- Medical Records
- Education Records
- Personnel or employment records, including records of any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Post-graduate training (internship, residency, & fellowship) records, including records of any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Any information the IBM deems reasonably necessary for the purposes set forth in this release.

Release of Liability. I do hereby irrevocably and unconditionally release, covenant not to sue, and forever discharge any person or entity, including but not limited to any medical school, residency or fellowship training program, hospital, health care provider, health care facility, licensing board, impaired practitioner program, agency, or organization, which releases information to the IBM pursuant to this release from any liability, claim, or cause of action arising out of the release of such information. I further irrevocably and unconditionally release, covenant not to sue, and forever discharge the IBM, the State of Iowa, and its employees and agents from any liability, claim, or cause of action arising out of the collection or release of information pursuant to this release.

A photocopy of this release form will be valid as an original thereof, even though the photocopy does not contain an original writing of my signature.

This authorization is valid until completion of the licensure process. I understand I have the right to revoke this authorization in writing, except to the extent that the IBM has already taken action in reliance upon this consent.

I have read and fully understand the contents of this "Authorization to Release Information."

_____ _____
Signature of Physician Date

PROHIBITION ON REDISCLOSURE

This form does not authorize redisclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for alcohol/drug abuse records or by state law for mental health records, federal requirements (42 C.F.R. Part 2) and state requirements (Iowa Code Ch. 228) prohibit further disclosure without the specific written consent of the patient except as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse or mental health information.

Applicant Name:

Iowa Board of Medicine
400 SW 8th Street, Suite C, Des Moines, IA 50309-4686
(515) 281-6641 www.medicalboard.iowa.gov

Professional Licensure Verification

Applicant: Submit this form to each jurisdiction where you were issued a license. Complete the top portion and page two of the form only and submit the form to the appropriate licensing agency.

State or Provincial Licensure Board: Complete and mail the form directly to the Iowa Board of Medicine. Any processing fees are the applicant's responsibility.

Applicant's Name (Print Legibly):_____

Applicant's Date of Birth (Month/Day/Year):_____

It is hereby certified that _____
(Name of Licensee)

Date of Birth:_____ Profession:_____ Issued License Number: _____

By _____ On _____
(State or Province) (Month/Year)

License Type: Permanent _____ Training/Educational _____ Temporary _____ Other _____

Has the licensee ever been investigated or had a complaint filed against him/her?
Yes _____ No _____ Unable to Disclose _____
If Yes, provide a copy of the documentation related to the investigation or complaint.

Has disciplinary action ever been initiated, invoked, or is disciplinary action pending?
Yes _____ No _____ Unable to Disclose _____
If Yes, provide a copy of the documentation related to the disciplinary action.

Has the licensee ever voluntarily relinquished their medical license?
Yes _____ No _____ Unable to Disclose _____
If Yes, provide a copy of the documentation related to this event.

Institutional Seal

If the institution does not have an official seal, the form must be notarized.

Completed by State or Provincial Licensure Board:

Print Name:_____

Signature:_____

Date (month/day/year):_____ Phone: _____

Fax: _____ E-mail: _____

Authorization for Release of Information-Verification of Licensure

The applicant must sign this form and submit it with the Verification of Licensure form. The licensing agency may retain this release of information for their own records.

I, _____ (print name), do hereby authorize a disclosure of records concerning myself to the Iowa Board of Medicine (IBM). This release includes records of a public, private or confidential nature.

I acknowledge that the information released to the IBM may include material that is protected by federal and/or state laws applicable to substance abuse and mental health information. If applicable, I specifically authorize the release of confidential information to and from the IBM relating to substance abuse or dependence and/or mental health.

I further agree that the IBM may receive confidential information and records, including, but no limited to the following records:

- Medical Records
- Education Records
- Personnel or employment records, including records of any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Post-graduate training (internship, residency, & fellowship) records, including records of any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Any information the IBM deems reasonably necessary for the purposes set forth in this Release.

Release of Liability. I do hereby irrevocably and unconditionally release, covenant not to sue, and forever discharge any person or entity, including but not limited to any medical school, residency or fellowship training program, hospital, health care provider, health care facility, licensing board, impaired practitioner program, agency or organization which releases information to the IBM pursuant to this release from any liability, claim, or cause of action arising out of the release of such information. I further irrevocably and unconditionally release, covenant not to sue, and forever discharge the IBM, the state of Iowa and its employees and agens from many liability, claim, or cause of action arising out of the collection or release of information pursuant to this release.

A photocopy of this release form will be valid as an original thereof, even though the photocopy does not contain an original writing of my signature.

This authorization is valid until completion of the licensure process. I understand I have the right to revoke this authorization in writing, except to the extent that the IBM has already taken action in reliance upon this consent.

I have read and fully understand the contents of this “Authorization to Release Information.”

Signature of Applicant _____ Date _____

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400 SW 8th Street, Suite C, Des Moines, IA 50309-4686
(515) 281-6641 www.medicalboard.iowa.gov

Professional Liability Suit Information

Applicant: Complete this form each suit you have been named a party. Summaries of this information from insurance carriers is not acceptable. Submit the requested documentation for each suit. You do not need to submit this form if you have not been named in a professional liability suit.

Name of patient/plaintiff:

Date of event:

Date of suit:

Does the suit involve any of the following?
Yes No

Death of the patient
Wrong sided surgery
Loss of limb or major organ

What is/was your role in the suit or claim:

Primary defendant
Co-defendant
Other

Status of Suit & Documents to Submit:

Pending—Submit copy of complaint and a letter from your attorney indicating the status of the case.

Dismissed—Submit copy of the dismissal order.

Settled— Submit copy of complaint, final disposition, and settlement/release.
Amount Settled on Your Behalf _____

Other

Describe the allegations:

Describe your involvement in the care of the patient:

Applicant Name (Print Name): _____

Applicant Signature: _____ **Date:** _____

Iowa Board of Medicine
400 SW 8th Street, Suite C, Des Moines, IA 50309-4686
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Verification of Medical Condition

Applicant: You are required to provide a statement explaining any medical condition you have experienced that has had an ongoing or adverse impact on your ability to function and practice. Physicians who had a condition that interrupted their education or training should also complete this form.

The physician who diagnosed and provides, or provided, treatment for the condition should complete the form.

Treating Physician: Complete and mail the form directly to the Iowa Board of Medicine. This form is also on our website as a pdf document which can be completed using the computer and printing the document. The applicant's signature on page three of this form authorizes the release of information, favorable or otherwise, directly to the Board.

Applicant's Name (Print Legibly):_____

Applicant's Date of Birth (Month/Day/Year):_____

Nature of Medical Condition (include specific diagnosis):

Summary of Treatment:

Treatment Period: From **To**

Recommended Treatment:

Is/Was the applicant in compliance with his/her treatment? **Yes** **No**
If no, please explain.

Is the applicant taking any prescribed medications for this condition? **Yes** **No**
If yes, please list the medication(s).

Provide a summary of other prescription medications this applicant is taking.

Has this medical condition in any way affected the applicant's ability to practice medicine with reasonable skill and safety? **Yes** **No**
If yes, please explain.

Do any limitations need to be in place with regard to the applicant's practice of medicine?
Yes **No**
If yes, please explain.

If treatment were to cease for any reason, could the applicant's condition in any way affect his/her ability to practice medicine with reasonable skill and safety? **Yes** **No**
If yes, please explain.

Is ongoing monitoring warranted? **Yes** **No**
If yes, please explain.

Treating Physician Information:

Name (print legibly): _____

Signature: _____ **Date:** _____

Address: _____

Phone: _____ **Fax:** _____

Authorization for Release of Information-Verification of Medical Condition

The applicant must sign this form and submit it with the Verification of Medical Condition form. The treating physician may retain this release of information for his/her own records.

I, _____ (print name), do hereby authorize a disclosure of records concerning myself to the Iowa Board of Medicine (IBM). This release includes records of a public, private or confidential nature.

I acknowledge that the information released to the IBM may include material that is protected by federal and/or state laws applicable to substance abuse and mental health information. If applicable, I specifically authorize the release of confidential information to and from the IBM relating to substance abuse or dependence and/or mental health.

I further agree that the IBM may receive confidential information and records, including, but no limited to the following records:

- Medical Records
- Education Records
- Personnel or employment records, including records of any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Post-graduate training (internship, residency, & fellowship) records, including records of any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Any information the IBM deems reasonably necessary for the purposes set forth in this Release.

Release of Liability. I do hereby irrevocably and unconditionally release, covenant not to sue, and forever discharge any person or entity, including but not limited to any medical school, residency or fellowship training program, hospital, health care provider, health care facility, licensing board, impaired practitioner program, agency or organization which releases information to the IBM pursuant to this release from any liability, claim, or cause of action arising out of the release of such information. I further irrevocably and unconditionally release, covenant not to sue, and forever discharge the IBM, the state of Iowa and its employees and agens from many liability, claim, or cause of action arising out of the collection or release of information pursuant to this release.

A photocopy of this release form will be valid as an original thereof, even though the photocopy does not contain an original writing of my signature.

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I have read and fully understand the contents of this “Authorization to Release Information.”

Signature of Applicant Date

_____ _____

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