American Naturopathic Council Application Addendum

Supplemental Professional Information

If you selected any of the items listed in Question 15 of your application, you should complete this addendum. Review the modalities listed below. Place a check mark ☑ next to each modality you are using or intend to use, then complete the requested information. If you intend to use a modality, but have not done so yet, answer questions based on how you intend to integrate that modality into your practice. For coverage to extend to any of these modalities, this addendum must be submitted to and approved by the American Naturopathic Council.

☐ *Cheletion Therapy*

Currently Licensed / Certified?: ☐ Yes ☐ No If ***Yes,*** Designation: ______________

Training Training as a part of your Naturopathic College curriculum? ☐ Yes ☐ No # Hours: ________ Completed: ________

Other? (Specify where): ______________ # Hours: ________ Completed: ________

Describe Training: ______________
(Nature of Curriculum) ______________

Usage Indicate the *number* of times per month that you use cheletion therapy: ________ Times per Month

Do you ever do I.V. Cheletion Therapy? ☐ Yes ☐ No If *Yes*, how often: ________ Times per Month

Indicate the *percentage* of your patients with whom cheletion therapy is used: ________ % of Patients

Describe the indications you observe / diagnostic analysis you conduct prior to recommending cheletion therapy: ______________

____

____

☐ *Colonoscopy*

Currently Licensed / Certified?: ☐ Yes ☐ No If ***Yes,*** Designation: ______________

Training Training as a part of your Naturopathic College curriculum? ☐ Yes ☐ No # Hours: ________ Completed: ________

Other? (Specify where): ______________ # Hours: ________ Completed: ________

Describe Training: ______________
(Nature of Curriculum) ______________

Usage Indicate the *number* of times per month that you perform colonoscopies: ________ Times per Month

Indicate the *percentage* of your patients for whom you perform colonoscopies: % of Patients

Describe the indications you observe / diagnostic analysis you conduct prior to recommending a colonoscopy: ______________

____

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____

☐ *Gynecology*

Currently Licensed / Certified?: ☐ Yes ☐ No If ***Yes,*** Designation: ______________

Training Training as a part of your Naturopathic College curriculum? ☐ Yes ☐ No # Hours: ________ Completed: ________

Other? (Specify where): ______________ # Hours: ________ Completed: ________

Describe Training: ______________
(Nature of Curriculum) ______________

Usage Indicate the *number* of times per month that you render gynecological services: ________ Times per Month

Indicate the *percentage* of patients for whom you perform gynecological procedures: ________ % of Patients

Describe the five most common gynecological services / procedures provided to patients at your office: ______________

____

____

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☐ ***Hypnosis*** Currently Licensed / Certified?: ☐Yes ☐ No If ***Yes,*** Designation: ____________

Training Training as a part of your Naturopathic College curriculum? ☐Yes ☐ No # Hours:________ Completed:________

Other? (Specify where): ____________________ # Hours:________ Completed:________

Describe Training: ____________________
(Nature of Curriculum) ____________________

Usage Indicate the *number* of times per month that you use hypnosis as a therapy: ________ Times per Month

Indicate the *percentage* of your patients with whom you use hypnosis as a therapy: ________ % of Patients

Describe the indications you observe / diagnostic analysis you conduct prior to recommending hypnosis therapy: ____________

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☐ ***Needle Biopsies*** Currently Licensed / Certified?: ☐Yes ☐ No If ***Yes,*** Designation: ____________

Training Training as a part of your Naturopathic College curriculum? ☐Yes ☐ No # Hours:________ Completed:________

Other? (Specify where): ____________________ # Hours:________ Completed:________

Describe Training: ____________________
(Nature of Curriculum) ____________________

Usage Indicate the *number* of times per month that you use needle biopsies in diagnosis: ________ Times per Month

Indicate the *percentage* of your patients with whom you utilize needle biopsies: ________ % of Patients

Describe the indications you observe / diagnostic analysis you conduct prior to performing a needle biopsy: ____________

____

____

____

☐ ***Neo Natal / Pre Natal Care*** Currently Licensed / Certified?: ☐Yes ☐ No If ***Yes,*** Designation: ____________

Training Training as a part of your Naturopathic College curriculum? ☐Yes ☐ No # Hours:________ Completed:________

Other? (Specify where): ____________________ # Hours:________ Completed:________

Describe Training: ____________________
(Nature of Curriculum) ____________________

Usage Indicate the *number* of patients at any time actively in your Neo Natal / Pre Natal care: ________ Times per Month

Indicate the *percentage* of patients for whom you provide Neo Natal / Pre Natal care: ________ % of Patients

Do you require all Neo Natal/Pre Natal patients to be under the concurrent care of a Neo Natal / Pre Natal physician? ☐Yes ☐ No

Describe the diagnostic analysis you conduct prior to accepting a patient for Naturopath Neo Natal / Pre Natal care: ____________

____

____

____

☐ ***Obstetrics/ Deliveries*** Currently Licensed / Certified?: ☐Yes ☐ No If ***Yes,*** Designation: ____________

Training Training as a part of your Naturopathic College curriculum? ☐Yes ☐ No # Hours:________ Completed:________

Other? (Specify where): ____________________ # Hours:________ Completed:________

Describe Training: ____________________
(Nature of Curriculum) ____________________

____

Usage Indicate the *number* of times per month that you are involved with a delivery of a child: ________ Times per Month

Indicate the *percentage* of your patients who are pregnant: ____________ % of Patients

Do you ever induce and / or stop labor ? ☐ Yes ☐ No If *Yes*, how often: ____________ Times per Month

Do you ever render care while a woman is in labor? ☐ Yes ☐ No If *Yes*, how often: ____________ Times per Month

Do you ever deliver babies? ☐ Yes ☐ No If *Yes*, how often: ____________ Times per Month

Do you require all obstetrical patients to be under the concurrent care of an obstetrical medical doctor? ☐ Yes ☐ No

Describe the diagnostic analysis you conduct prior to accepting a patient as suitable for naturopath birthing services: ____________

☐ *Office Surgery*

Currently Licensed / Certified?: ☐ Yes ☐ No If ***Yes,*** Designation: ____________

Training Training as a part of your Naturopathic College curriculum? ☐ Yes ☐ No # Hours: ____________ Completed: ____________

Other? (Specify where): ____________ # Hours: ____________ Completed: ____________

Describe Training: ____________
(Nature of Curriculum)

Usage Indicate the *number* of times per month that you perform office surgery: ____________ Times per Month

Indicate the *percentage* of your patients for whom you perform office surgery: ____________ % of Patients

Describe the five most common surgical procedures conducted at your office: ____________

☐ *Prescription Drugs*

Currently Licensed / Certified?: ☐ Yes ☐ No If ***Yes,*** Designation: ____________

Training Training as a part of your Naturopathic College curriculum? ☐ Yes ☐ No # Hours: ____________ Completed: ____________

Other? (Specify where): ____________ # Hours: ____________ Completed: ____________

Describe Training: ____________
(Nature of Curriculum)

Usage Indicate the *number* of times per month that you use prescription drugs: ____________ Times per Month

Indicate the *percentage* of your patients for whom you prescribe prescription drugs: ____________ % of Patients

For each drug you prescribe, describe 1) the indications you observe / diagnostic analysis you conduct prior to prescribing that drug, and 2) the outcome you expect from prescribing that drug:

Drug	**Indications / Diagnosis**	**Expected Outcome**

☐ ***Prolo/Sclero Therapy*** Currently Licensed / Certified?: ☐ Yes ☐ No If ***Yes,*** Designation: ____________

Training Training as a part of your Naturopathic College curriculum? ☐ Yes ☐ No # Hours: ________ Completed: ________

Other? (Specify where): ____________ # Hours: ________ Completed: ________

Describe Training: ____________
(Nature of Curriculum)

Usage Indicate the *number* of times per month that you use prolo / sclero therapy: ________ Times per Month

Indicate the *percentage* of your patients with whom prolo / sclero therapy is used: ________ % of Patients

Describe the indications you observe / diagnostic analysis you conduct prior to recommending prolo / sclero therapy : ____________

☐ ***Other/Experimental Therapy*** Currently Licensed/Certified?: ☐ Yes ☐ No If ***Yes,*** Designation: ____________

Training Training as a part of your Naturopathic College curriculum? ☐ Yes ☐ No # Hours: ________ Completed: ________

Other? (Specify where): ____________ # Hours: ________ Completed: ________

Describe Training: ____________
(Nature of Curriculum)

Usage Indicate the *number* of times per month that you use some experimental therapy: ________ Times per Month

Indicate the *percentage* of your patients with whom you use some experimental therapy: ________ % of Patients

Describe the diagnostic analysis you conduct prior to recommending experimental therapy to a patient: ____________

Describe the three most common experimental procedures you used in your practice during the last twelve months:

NO FALSE STATEMENTS: I hereby declare that the above statements are true and that I have not suppressed or misstated any facts and I agree that this declaration shall be a basis of the contract and form a part of my professional liability policy. I understand that untrue statements could void my insurance policy:

Print Name ____________ Signature ____________ Date ____________