FIRST NATION MEDICAL BOARD

Application for License of a Certified Tribal Practitioner

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:

License

Type of Physician: MD: DO: HMD: APRN: Other:
DEA Number:
State License(s) and Number(s):
Driver's License: State:

Education*

College:
Dates Attended: to
Date of Graduation: Degree(s) Earned:

Medical School:
Dates Attended: to
Date of Graduation: Degree(s) Earned:

Internship:
Dates Attended: to
Residency:
Dates Attended: to

Fellowship:
Dates Attended: to

Board Certification:____
Date:____

*Curriculum vitae is recommended to be submitted for more complete background and training information.

Questions

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:____
7. List the major indigenous medicine services you intend to offer under your supervision to patients:
   a. ______________________________ f. ______________________________
   b. ______________________________ g. ______________________________
   c. ______________________________ h. ______________________________
   d. ______________________________ i. ______________________________
   e. ______________________________ j. ______________________________

Identification

1. Upload a copy of your Driver's License or Government Identification.
2. Upload a photo that meets the following requirements:

   a. Headshot; and
   b. Against a White Background.

Statements

By checking this box I am agreeing to: ☐

- abide by all the terms and conditions listed herein;
- background search for National Criminal and Healthcare compliance databases;
- 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
($650)

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

EMAIIL THIS FORM TO: info@skymdpro.com