BOARD OF INTEGRATIVE MEDICINE

MEMBERSHIP APPLICATION

Name: _____
Address: _____
Postal code/Zip code: _____*Country:* _____
Phone number: _____ *Fax number:* _____ *Email:* _____

State designation category? :_____

Application for certification is a voluntary act entered into by practitioners who choose to incorporate integrative medicine principles into their practices. The certification enables practitioners to obtain a credential, which attests to their knowledge in the field and affords them the recognition of having met an identified peer-developed standard of achievement.

The certification process includes:

1. *Please enclose certified photocopies of all relevant Certificates, Diplomas, Transcripts, and Curriculum Vitae.*
2. Evidence of education at the doctoral or a minimum of diploma, for practitioners, education in the healthcare field such as; (Medical Doctor (MD), Doctor of Osteopathic Medicine (DO), Registered Dental Hygienist (RDH), Registered Physiotherapists (RP), Dentist (DDS), Registered Nurse (RN), Registered Nurse extended class (RN-E) Doctor of Chiropractic (DC) and other healthcare professionals are accepted.
3. Applicant must provide evidence by certified copies of diplomas or degree and residency training, and other post-graduate certified training.
4. Submission evidence of training in integrative medicine modalities.
5. Submission of one letter of reference from a professional colleague.
6. Payment of assessment fee ($100.00). Please note assessment fee is not registration fee which will be communicated to you upon acceptance for registration.

AGREEMENT

Please read the following statements, sign and date at the bottom and submit this form along with certified photocopies of your Certificates, Diplomas and/ or Curriculum Vitae

- *I have successfully completed the course of instruction as indicated on the enclosed documentation.*
- *I understand the registration as a doctor or practitioner of Integrative Medicine is not an academic degree, it is to validate my educational standing and suitability for certification on the BOIM registry and it must be renewed annually to validate my position on its registry.*
- *I understand and agree that to maintain registration with the BOIM I must participate in professional development courses(30)hours, maintain professional liability insurance and also participate in 10 hours of humanitarian medicine activities geared towards the poor (non financial gain) in the twelve months before renewal of my registration.*

- *I certify that the above information is correct to the best of my knowledge.*
- *I the undersigned respectfully request to be admitted into membership with BOIM registry.*
- I give BOIM permission to contact educational institutions and licensing organizations and other references/entities for purposes of verifying information in this application if deemed necessary.

_____ _____

Date of Application *Applicant's Signature*

OFFICE USE ONLY *(Do not write below this line)*

Recommended by: _____

*BOIM registrar or authorized officer Name :*_____*(print)*

Signature: _____ *Date*_____