Apprenticeship & Certification Board of Integrative & Pastoral Medicine
INTEGRATIVE PASTORAL MEDICAL ASSOCIATION MINISTRY OF HEALTH & REHABILITATION
Pastoral HEALTH PROFESSIONAL LICENSING ADMINISTRATION

Integrative Pastoral Medicine

NEW LICENSE APPLICATION

All applicants must complete every section of this application and submit the original application and all required supporting documents. If more space is needed to fully answer questions, attach additional sheets with typed responses. False or misleading statements will be cause for denial of licensure and Disciplinary action as allowed by law. If you have any questions, call ACBIPM Customer Service at **1-678-592-7289**, Monday through Friday, 10AM to 7PM EST.

SECTION 1. TYPE OF LICENSE

Check the box next to the type of license for which you are applying.

Prelicensing Education
Application & Registration Donation: 95.00 + (175.00 annually)=270.00

- ☐ IPM– Integrative Pastoral Medicine Doctor/Physicien (75hrs of CME)
- ☐ IPM– Integrative Pastoral Medicine Therapist (45 hrs of CME)
- ☐ IPM– Integrative Pastoral Therapist (35 hrs of CME
- ☐ IPM– Integrative Pastoral Consultant (25 hrs of CME)

(175.00 annual renewal plus up to 75 hrs Continuing Ed/CME)

Duplicate Licenses (limit 5) ______ X $35.00 = $_____.00
Total Enclosed $_____.00

Make money order only payable to ACBIPM
Or send credit card payments using Paypal to email: naturopathic@ edenic-kingdom.com

MAIL TO:
Edenic Light Integrative Family Life Care Ministry of Health
Pastoral Health Professional Licensing Administration
3695F Cascade Rd SW #117
Atlanta, GA 30331

HPLA		
CC amount $	**CC #**	**exp**
$ __ __ __ .00		

SECTION 2. APPLICANT NAME/DEMOGRAPHIC INFORMATION

Enter your name exactly as it should appear on the license. If your name has changed at any point since you first attended college or university, you must provide a copy of legal name change documents for EACH time that it has changed. Complete Section 4 of this application on page 2.

FIRST NAME | MI | LAST NAME | SUFFIX (Jr, Sr, etc.)

___ — ___ — ___
SOCIAL SECURITY NUMBER*
If applicant does not provide a social security number, a sworn affidavit is required.

M M — D D — Y Y Y Y
DATE OF BIRTH

PLACE OF BIRTH
Provide City and State for US birthplace or Country for foreign place of birth.

☐ Male ☐ Female
GENDER
Please check the correct box.

SECTION 3. SUPPORTING DOCUMENTS

Please indicate the supporting documents you have included with this package or requested to be sent to the Pastoral Medicine Registration. Keep a photocopy of all supporting documents for your records.

		YES	NO	HPLA ONLY
A.	Two recent and identical passport-type photos of the applicant's face (approx. 2"X2") with applicant's name printed on the back. The photos must be original photos and cannot be computer-generated copies or paper copies.	☐	☐	
B.	Signed Pastoral Medicine Statement.	☐	☐	☐
C.	Copies of legal documents supporting all name changes. All Transcripts, Licensures, Certifications notorarized.	☐	☐	☐

SECTION 4. PREVIOUS NAME CHANGE

If your name has changed at any point since you first attended college or university, you must provide a copy of a legal name change documents for EACH time that it has changed. Acceptable documents for individuals are marriage certificates, divorce decrees, or court orders.

Changed to current name by: ☐ Marriage ☐ Divorce ☐ Court Order ☐ Spouse Death Certificate

FIRST NAME | MI | LAST NAME | SUFFIX (Jr, Sr, etc.)

Changed to current name by: ☐ Marriage ☐ Divorce ☐ Court Order ☐ Spouse Death Certificate

FIRST NAME | MI | LAST NAME | SUFFIX (Jr, Sr, etc.)

Changed to current name by: ☐ Marriage ☐ Divorce ☐ Court Order ☐ Spouse Death Certificate

FIRST NAME | MI | LAST NAME | SUFFIX (Jr, Sr, etc.)

Changed to current name by: ☐ Marriage ☐ Divorce ☐ Court Order ☐ Spouse Death Certificate

FIRST NAME | MI | LAST NAME | SUFFIX (Jr, Sr, etc.)

SECTION 5A. HOME ADDRESS

Even if you have a PO Box, a street address should also be provided, if applicable.

☐ APARTMENT ☐ SUITE ☐ FLOOR ☐ PO BOX NUMBER

HOME STREET ADDRESS 1 (If applicable, use this line for additional building information. Otherwise, use this line to indicate STREET NUMBER and STREET NAME)

HOME STREET ADDRESS 2 (If additional space is needed, use this line to indicate STREET NUMBER and STREET NAME)

CITY | STATE | ZIP CODE + 4

HOME PHONE NUMBER | HOME FAX NUMBER | E-MAIL ADDRESS

SECTION 5B. BUSINESS ADDRESS

Please note: This information will be made available to the public.

COMPANY NAME

☐ APARTMENT ☐ SUITE ☐ FLOOR ☐ PO BOX NUMBER

BUSINESS STREET ADDRESS 1 (If applicable, use this line for additional building information. Otherwise use this line to indicate STREET NUMBER and STREET NAME)

BUSINESS STREET ADDRESS 2 (If additional space is needed, use this line to indicate STREET NUMBER and STREET NAME)

CITY | STATE | ZIP CODE + 4

BUSINESS PHONE NUMBER | BUSINESS FAX NUMBER | E-MAIL ADDRESS

SECTION 5C. PREFERRED MAILING ADDRESS

Indicate your preferred mailing address by placing an "X" in the appropriate box. This will be the address to which all future registration documents will be mailed. The address that will appear on your registration will be your business address.

☐ HOME ☐ BUSINESS

Apprenticeship & Certification of Integrative & Pastoral Medicine

MINISTRY OF HEALTH – PASTORAL HEALTH PROFESSIONAL LICENSING ADMINISTRATION

NEW REGISTRATION APPLICATION

SECTION 6A. PROFESSIONAL SCHOOLS ATTENDED

List all colleges and universities attended prior to and including medical/professional schools. List schools attended in reverse chronological order, with the most recent at the top.

School Name, City, State, Country	Number of Hours Completed	Date of Graduation	Type of Degree/Certificate

SECTION 6B. MEDICAL/PROFESSIONAL TRAINING AND MEDICAL/PROFESSIONAL PRACTICE

List all experience since medical/professional school graduation below. Include letters from employing facilities and organizations for internships, residencies, fellowships or employment. For "Description", use the letter from the key below. List experience in reverse chronological order, beginning with the most recent.

Organization/Institution	Start Date	End Date	Description (Use Key Below)*

*** TRAINING AND PRACTICE DESCRIPTIONS**

A. Fellowship
B. Internship
C. Residency
D. Apprenticeship
E. Employment
F. Private Practice
G. Other (Attach a typed explanation on a separate sheet of paper to this form.)

SECTION 6C. MEDICAL/PROFESSIONAL LICENSES IN OTHER STATES/JURISDICTIONS

Are you now or have you ever been licensed in any other state/ecclesiasticfal jurisdiction? ☐ YES ☐ NO (including Board Certifications)

(If "Yes", be sure to complete section 6C of this form.) You must request verification of licensure for all of these licenses, past and/or present.

Jurisdiction	Date License Was First Obtained	License Number

Apprenticeship & Certification Board of Integrative & Pastoral Medicine

MINISTRY OF HEALTH – PASTORAL HEALTH PROFESSIONAL LICENSING ADMINISTRATION

NEW REGISTRATION APPLICATION

SECTION 7. SCREENING QUESTIONS – Applicants MUST answer all of the following questions.

All applicants must complete ALL questions. ***If you answer "Yes" to any of the questions B through J below, please provide a complete explanation on a separate sheet of paper and attach with this application form.***

	Question		HPLA ONLY
A.	**Clean Hands Before Receiving a License or Permit** Please read the information below carefully before responding to this yes or no question, as **any false information provided requires that the Ministry of Health proceed immediately to revoke your License or Commission** for which you are now applying. A. Have you ever been convicted or arrested for a crime or misdemeanor (other than minor traffic violations) not previously reported to the Board? following: Yes ☐ No ☐		YES ☐ NO ☐
B.	Are you now or have you ever been licensed with any other state/ecclesiastical jurisdiction? *(If "Yes," be sure to complete section 6C of this form.)*	YES ☐ NO ☐	☐
		YES ☐ NO ☐	☐
C.	Have you ever been party to a malpractice action or had a malpractice action brought against you?	YES ☐ NO ☐	☐
D.	Have you ever voluntarily surrendered a license after formal charges have been filed against you or while under investigation?	YES ☐ NO ☐	☐
E.	Have you ever been terminated from or resigned from a clinical or professional training program?	YES ☐ NO ☐	☐
F.	Do you have a physical or medical condition that currently impairs your ability to practice your profession?	YES ☐ NO ☐	☐
G.	Has the use of drugs and/or alcohol resulted in an impairment of your ability to practice your profession?	YES ☐ NO ☐	☐
H.	(1) Have you withdrawn an application (with any other state/ecclesiastical jurisdiction) to practice your profession? (2) Has any authority or peer review board taken adverse action against your license or privileges? (3) Are you currently under investigation or were you investigated by any authority or peer review board for any violation of state, federal, or local law? (4) Has any authority or peer review board informed you of any pending charges(s) or investigation not previously reported to this Board?	YES ☐ NO ☐	☐
I.	Have you ever been terminated or asked to resign from employment since obtaining your (professional) license?	YES ☐ NO ☐	☐

Please be sure to complete the affidavit of application below.

All applications that are unsigned by the applicant will be returned unprocessed.

SECTION 8. LICENSEE AFFIDAVIT

I hereby attest that the information given in this application, including all writings and exhibits attached hereto, is true and complete to the best of my knowledge. I understand that the making of a false statement on this application, including all writings and exhibits attached hereto, is punishable by Denial of Licensure/Commission or permenant revocation thereof.

REGISTRATION SIGNATURE	NAME (Please Print)	DATE	HPLA ONLY
____________________	____________________	____________	☐