

**VERIFICATION OF EXAMINATION ON MINOR SURGERY - NATUROPATHIC PHYSICIAN**

Board of Naturopathic Medicine  
 P.O. Box 3469  
 Honolulu, HI 96801

Access this form via website at: [hawaii.gov/dcca/pvl](http://hawaii.gov/dcca/pvl)

**DO NOT submit this form if you took the NPLEX Clinical Elective Minor Surgery examination**

<b>APPLICANT</b>	<i>APPLICANT: Complete top of this page and forward to the licensing jurisdiction in which your examination on minor surgery was administered.</i>		
	Name (LAST, First, Middle)		
	Address (Include Apt. No., City, State, and Zip Code)	Social Security No.	Date of Birth
		Phone No.	
	Other Names Used	LICENSE/CERTIFICATE NUMBER	Date Issued
I hereby authorize the naturopathy licensing agency in the jurisdiction of _____ to furnish to the State of Hawaii Department of Commerce and Consumer Affairs, the information below.			
_____ Signature		_____ Date	

<b>LICENSING AGENCY ONLY</b>	This is to certify that the above-named individual was licensed in the licensing jurisdiction of _____ to practice as a naturopathic physician.		
	License No.: _____	Date of License: _____	Date of Expiration: _____
	License status:	<input type="checkbox"/> Current <input type="checkbox"/> Lapsed since: _____ <input type="checkbox"/> Inactive since: _____	
	Name of the examination on minor surgery: _____		
	Date passed: _____		
	Date allowed to perform minor surgery/minor office procedures: _____		
	Was this examination administered prior to the establishment of the NPLEX (July 1987)? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Was the successful passage of the examination on minor surgery required to allow this licensee to perform minor surgery/minor office procedures? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Has this license ever been encumbered in any way (revoked, suspended, surrendered, limited, placed on probation, or otherwise disciplined)? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No		
	<b>If the response is "YES", please send a copy of your Board's: 1) Administrative Action; and 2) Final order</b>		
COMMENTS:			
SEAL		Signature: _____	
		Print Name: _____	
		Title: _____	
		Licensing jurisdiction: _____	
		Date: _____	
TO THE BOARD: Return this form <b>directly</b> to the Hawaii Board of Naturopathic Medicine, DCCA, PVL, Licensing Branch, P.O. Box 3469, Honolulu, HI 96801.			

This material can be made available for individuals with special needs. Please call the Licensing Branch Manager at (808) 586-3000 to submit your request.