



# Professional Membership Application

## Personal Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_  
 Former Last Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_  
 Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_  home  office  cell Email: \_\_\_\_\_

## Professional Information

Degree(s):  N.D. / N.M.D.  Certificate of Naturopathic Midwifery  
 Additional Degree(s):  M.S. Acupuncture  Other: \_\_\_\_\_  
 Naturopathic School: \_\_\_\_\_ Year of Graduation: \_\_\_\_\_

### Licensure Information

(Please list **all** professional licenses **currently** and **previously** held)

State	Type of License	Year Licensed	License Number	Status
				<input type="radio"/> Active <input type="radio"/> Expired <input type="radio"/> Revoked
				<input type="radio"/> Active <input type="radio"/> Expired <input type="radio"/> Revoked
				<input type="radio"/> Active <input type="radio"/> Expired <input type="radio"/> Revoked
				<input type="radio"/> Active <input type="radio"/> Expired <input type="radio"/> Revoked

*If you ever had a license to practice suspended or revoked, please explain on a separate piece of paper.*

Practice Name: \_\_\_\_\_  
 Practice Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Practice Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Please send VANP communications to:  Personal address  Practice address

***I attest that the above information is true and complete. I understand that omitted or false information is grounds for denial or termination of membership. I have read the by-laws of the VANP and, if accepted for membership, I agree to abide by them.***

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### FOR VANP USE ONLY

Date Received: \_\_\_\_\_  Signed application  Copy of License(s)  Application fee \_\_\_\_\_  
 License verification:  Active  Expired Date of Verification: \_\_\_\_\_  
 In good status  Disciplinary action/complaint  Revoked  
 Executive Committee Vote: \_\_\_\_\_  Approved  Denied Applicant Notified: \_\_\_\_\_

Please submit the following to VANP:

1. Completed application form
2. Copies of all state professional license(s).
3. Check for Professional Membership dues payable to the Vermont Association of Naturopathic Physicians:  
1<sup>st</sup>-year Professional Membership: \$100  
2<sup>nd</sup>-year Professional Membership: \$150  
3<sup>rd</sup>-year Professional Membership: \$200

*Please note: Membership is renewed on January 1 of each year and dues are expected on or before that date.*

Send all materials to: VANP  
PO Box 4351  
Burlington, VT 05406

Please call Joshua Green, ND, VANP Secretary, with questions: (802) 238-8603.