



american naturopathic application addendum



Supplemental Professional Information

If you selected any of the items listed in Question 14 of your application, you should complete this addendum. Review the modalities listed below. Place a check mark next to each item applicable to your practice and complete the requested information. For coverage to extend to any of these modalities, this addendum must be submitted to and approved by the American Naturopathic Council.

Cheleton Therapy Currently Licensed / Certified?: Yes No If Yes, Designation: _____

Training Training as a part of your Naturopath College curriculum? Yes No # Hours: _____ Completed: _____
Other? (Specify where): _____ # Hours: _____ Completed: _____
Describe Training: _____
(Nature of Curriculum)

Usage Indicate the number of times per month that you use cheleton therapy: _____ Times per Month
Do you ever do I.V. Cheleton Therapy? Yes No If Yes, how often: _____ Times per Month
Indicate the percentage of your patients with whom cheleton therapy is used: _____ % of Patients
Describe the indications you observe / diagnostic analysis you conduct prior to recommending cheleton therapy: _____

Colonoscopy Currently Licensed / Certified?: Yes No If Yes, Designation: _____

Training Training as a part of your Naturopath College curriculum? Yes No # Hours: _____ Completed: _____
Other? (Specify where): _____ # Hours: _____ Completed: _____
Describe Training: _____
(Nature of Curriculum)

Usage Indicate the number of times per month that you perform colonoscopies: _____ Times per Month
Indicate the percentage of your patients for whom you perform colonoscopies: _____ % of Patients
Describe the indications you observe / diagnostic analysis you conduct prior to recommending a colonoscopy: _____

Gynecology Currently Licensed / Certified?: Yes No If Yes, Designation: _____

Training Training as a part of your Naturopath College curriculum? Yes No # Hours: _____ Completed: _____
Other? (Specify where): _____ # Hours: _____ Completed: _____
Describe Training: _____
(Nature of Curriculum)

Usage Indicate the number of times per month that you render gynecological services: _____ Times per Month
Indicate the percentage of your patients for whom you perform colonoscopies: _____ % of Patients
Describe the five most common gynecological services / procedures provided to patients at your office: _____

Hypnosis Currently Licensed / Certified?: Yes No If **Yes**, Designation: _____

Training Training as a part of your Naturopath College curriculum? Yes No # Hours: _____ Completed: _____
 Other? (Specify where): _____ # Hours: _____ Completed: _____
 Describe Training: _____
 (Nature of Curriculum) _____

Usage Indicate the *number* of times per month that you use hypnosis as a therapy: _____ Times per Month
 Indicate the *percentage* of your patients with whom you use hypnosis as a therapy: _____ % of Patients
 Describe the indications you observe / diagnostic analysis you conduct prior to recommending hypnosis therapy: _____

Needle Biopsies Currently Licensed / Certified?: Yes No If **Yes**, Designation: _____

Training Training as a part of your Naturopath College curriculum? Yes No # Hours: _____ Completed: _____
 Other? (Specify where): _____ # Hours: _____ Completed: _____
 Describe Training: _____
 (Nature of Curriculum) _____

Usage Indicate the *number* of times per month that you use needle biopsies in diagnosis: _____ Times per Month
 Indicate the *percentage* of your patients with whom you utilize needle biopsies: _____ % of Patients
 Describe the indications you observe / diagnostic analysis you conduct prior to performing a needle biopsy: _____

Neo Natal / Pre Natal Care Currently Licensed / Certified?: Yes No If **Yes**, Designation: _____

Training Training as a part of your Naturopath College curriculum? Yes No # Hours: _____ Completed: _____
 Other? (Specify where): _____ # Hours: _____ Completed: _____
 Describe Training: _____
 (Nature of Curriculum) _____

Usage Indicate the *number* of patients at any time actively in your Neo Natal / Pre Natal care: _____ Times per Month
 Indicate the *percentage* of patients for whom you provide Neo Natal / Pre Natal care: _____ % of Patients
 Do you require all Neo Natal/Pre Natal patients to be under the concurrent care of a Neo Natal / Pre Natal physician? Yes No
 Describe the diagnostic analysis you conduct prior to accepting a patient for Naturopathic Neo Natal / Pre Natal care: _____

Obstetrics/ Deliveries Currently Licensed / Certified?: Yes No If **Yes**, Designation: _____

Training Training as a part of your Naturopath College curriculum? Yes No # Hours: _____ Completed: _____
 Other? (Specify where): _____ # Hours: _____ Completed: _____
 Describe Training: _____
 (Nature of Curriculum) _____

Usage Indicate the *number* of times per month that you are involved with a delivery of a child: _____ Times per Month

Prolo/Sclero Therapy Currently Licensed / Certified?: Yes No If *Yes*, Designation: _____

Training Training as a part of your Naturopath College curriculum? Yes No # Hours: _____ Completed: _____

Other? (Specify where): _____ # Hours: _____ Completed: _____

Describe Training:
(Nature of Curriculum) _____

Usage Indicate the *number* of times per month that you use prolo / sclero therapy: _____ Times per Month

Indicate the *percentage* of your patients with whom prolo / sclero therapy is used: _____ % of Patients

Describe the indications you observe / diagnostic analysis you conduct prior to recommending prolo / sclero therapy : _____

Other/Experimental Therapy Currently Licensed/Certified?: Yes No If *Yes*, Designation: _____

Training Training as a part of your Naturopath College curriculum? Yes No # Hours: _____ Completed: _____

Other? (Specify where): _____ # Hours: _____ Completed: _____

Describe Training:
(Nature of Curriculum) _____

Usage Indicate the *number* of times per month that you use some experimental therapy: _____ Times per Month

Indicate the *percentage* of your patients with whom you use some experimental therapy: _____ % of Patients

Describe the diagnostic analysis you conduct prior to recommending experimental therapy to a patient: _____

Describe the three most common experimental procedures you used in your practice during the last twelve months:

NO FALSE STATEMENTS: I hereby declare that the above statements are true and that I have not suppressed or misstated any facts and I agree that this declaration shall be a basis of the contract and form a part of my professional liability policy. I understand that untrue statements could void my insurance policy:

Print Name

Signature

Date