



APPLICANT NAME \_\_\_\_\_

Are there any pending complaints against you in any other jurisdictions?  YES  NO

Have you ever had any disciplinary action taken against you by another jurisdiction?  YES  NO

Have you ever committed or been convicted of a felony or entered a plea of *nolo contendere* to a felony?  YES  NO

➤ If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

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**I state under penalty of perjury in the second degree, as defined in §18-8-503, C.R.S., that the information contained in this application, to the best of my knowledge, is true and correct.**

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

\*Social Security Number Disclosure: Section 24-34-107(1) of the Colorado Revised Statutes requires that every application by an individual for a license issued pursuant to the authority set forth in title 12, C.R.S., by the Department of Regulatory Agencies, shall require the applicant's social security number. Disclosure of your social security number is mandatory for purposes of establishing, modifying, or enforcing child support under § 14-14-113 and § 26-13-126, C.R.S.; locating an individual who is under an obligation to pay child support as required by § 26-13-107(3)(a)(I)(A), C.R.S.; and reporting disciplinary actions to the Health Integrity and Protection Data Bank as required by 45 CFR §§ 61.1 *et seq.* Failure to provide your social security number for these mandatory purposes will result in the denial of your licensure application. Disclosure of your social security number is voluntary for disclosure to other state regulatory agencies, testing and examination vendors, law enforcement agencies, and other private federations and associations involved in professional regulation for identification purposes only. Your social security number will not be released for any other purpose unless provided for by law.

## MANDATORY DISCLOSURE CHECKLIST

All items on this checklist must be included on the mandatory disclosure form provided to your patients.

- \_\_\_\_\_ Your name, business address, and business phone number.
- \_\_\_\_\_ Your fee schedule.
- \_\_\_\_\_ A listing of your education, experience, degrees, memberships in professional organizations, certificates or credentials related to acupuncture awarded by such organizations, length of time required to obtain said degrees or credentials, and work experience.
- \_\_\_\_\_ A list of any license, certificate, or registration in acupuncture or any other health care profession which was issued to you by any local, state, or national health care agency, including whether any such license, certificate, or registration was suspended or revoked.
- \_\_\_\_\_ A statement that you are complying with all rules and regulations promulgated by the Colorado Department of Public Health and Environment, including those related to the proper cleaning and sterilization of needles used in the practice of acupuncture and the sanitation of acupuncture offices.
- \_\_\_\_\_ A statement indicating that the practice of acupuncture is regulated by the Colorado Department of Regulatory Agencies including the address and phone number of the Director of the Division of Registrations in the Department of Regulatory Agencies. The Director's address and telephone number is:  
  

Director of Registrations  
Acupuncturists Licensure  
1560 Broadway, Suite 1350  
Denver, CO 80202  
(303) 894-7800
- \_\_\_\_\_ A statement that the patient is entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy, if known.
- \_\_\_\_\_ A statement that the patient may seek a second opinion from another health care professional or may terminate therapy at any time.
- \_\_\_\_\_ A statement that in a professional relationship, sexual intimacy is never appropriate and should be immediately reported to the Director of the Division of Registrations in the Department of Regulatory Agencies.
- \_\_\_\_\_ A statement indicating your training and experience in the recommendation and application of adjunctive therapies and herbs as defined by traditional oriental medical concepts.
- \_\_\_\_\_ A space on the form for the patient's signature, and date of signature.