



BOARD OF ACUPUNCTURE AND ORIENTAL MEDICINE

New Mexico Regulation and Licensing Department

BOARDS AND COMMISSIONS DIVISION

Toney Anaya Building ▪ 2550 Cerrillos Road ▪ PO Box 25101 Santa Fe, New Mexico 87504
(505) 476-4622 ▪ Fax (505) 476-4545 ▪ www.RLD.state.nm.us/acupuncture

APPLICATION FOR CERTIFIED AURICULAR DETOXIFICATION SPECIALIST (CADS) SUPERVISOR

Before you complete this application, please read the following.

- The Certified Auricular Detoxification Specialist (CADS) Supervisor shall: Be a licensed Doctor of Oriental Medicine; and must be registered with the Board as an CADS Supervisor; and shall Supervise no more than thirty (30) Certified Auricular Detoxification Specialists (CADS); and must be accessible for consultation directly or by telephone to a CADS under his or her supervision; and must at intervals of not more than six weeks with the first visit occurring not more than two weeks after supervision has begun for the first year, then at least once per year thereafter at the supervisor's discretion with regular meetings by electronic methods (telephone, email, teleconferencing as examples) at intervals to be determined by the supervisor;
- and shall ensure that the CADS is following a Board approved treatment protocol; and is required to notify the Board in writing, within five (5) days working days, when a CADS enters into a supervisory relationship with the CADS Supervisor or the supervisory relationship is terminated.
- The Certified Auricular Detoxification Specialist (CADS) Supervisor shall be responsible for the delivery of competent, professional services and ensuring that patient consents are obtained.
- The Certified Auricular Detoxification Specialist (CADS) Supervisor shall terminate the supervisory relationship if he/she has the reasonable belief that the CADS has violated the Act or the Rules. In such case the CADS Supervisor shall notify the Board and the CADS's employer, in writing, within five (5) working days that the supervisory relationship is terminated and give in writing the reasons for the termination.

Please check each item off to indicate that you have included the following with this application for Certified Auricular Detoxification Specialist (CADS) Supervisory and to complete its requirements:

- ☐ Application fee of \$50.00
- ☐ One (1) passport type photograph of the applicant taken within the last six months.
- ☐ New Mexico Doctor of Oriental Medicine License **DOM #**_____.
- ☐ proof of successful completion of an official national acupuncture detoxification association (NADA) course, or another board-approved training program, or a CV demonstrating experience, or education in the field of harm reduction and alcoholism, substance abuse and chemical dependency at least equivalent to that provided in a NADA training, and three letters of reference attesting to the applicant's competence and experience in the field of auricular treatment for harm reduction, auricular treatment of alcoholism, substance abuse or chemical dependency;
- ☐ List of Certified Auricular Detoxification Specialists under supervision.
- ☐ Complete disciplinary questions on page 2 and 3 of this application.

PERSONAL INFORMATION

Please note that all applicant information provided is public record.

Pursuant to Chapter 14, Article 2, Sections 5 and 6.E., NMSA 1978, Inspection of Public Records Act

Last Name:	First Name:	M.I.:
Address:		
City/State/Zip:		
Social Security Number: - -	Date of Birth: / /	
Telephone: () -	Email:	
Place of Birth (City/County/State/Country):		

Name as you wish it to appear on your certificate:	
Alternate name(s) that you use or that may appear on documents: Reason(s) for alternate name(s):	
<h2 style="margin: 0;">Photograph of Applicant</h2> <div style="display: flex; justify-content: space-between; align-items: center; margin-top: 20px;"> <div style="width: 60%;"> <ul style="list-style-type: none"> Photograph must be an official U.S. passport photograph. Photo must have been taken within six months of this application. Sign your name in ink across bottom right corner if the photograph </div> <div style="width: 35%; text-align: center; vertical-align: middle;"> <p>Attach photo here.</p> </div> </div>	
Read the following carefully, check all boxes (<input type="checkbox"/>) and sign below in the presence of a notary.	
Disciplinary/Legal Issues	
<input type="checkbox"/> Yes <input type="checkbox"/> No	1. I have been found guilty of unprofessional conduct or incompetency.
<input type="checkbox"/> Yes <input type="checkbox"/> No	2. I was/am subject to disciplinary action in any jurisdiction for conduct related to the practice of acupuncture and oriental medicine, or related to another profession including other health care professions for which I was/am licensed, certified, registered or legally recognized to practice.
<input type="checkbox"/> Yes <input type="checkbox"/> No	3. I was/am party to litigation in any jurisdiction for claims or conduct arising out of my practice of acupuncture and oriental medicine, or related to another profession including other health care professions for which I was/am licensed, certified, registered or legally recognized to practice.
<input type="checkbox"/> Yes <input type="checkbox"/> No	4. I have been convicted of a felony in a jurisdiction, including any finding of guilt by a court or jury, or any plea of guilty, or any plea of <i>nolo contendere</i> or <i>no contest</i> or disposition of conditional discharge, and including any such proceeding in which a sentence was imposed, suspended or deferred.
<input type="checkbox"/> Yes <input type="checkbox"/> No	5. I have resigned from practice, withdrawn my license, or surrendered my license, certificate or registration, during the pendency of disciplinary proceedings, or investigation for potential disciplinary proceedings.
CASH IS NO LONGER ACCEPTED as a form of payment for all business transactions including but not limited to licenses, permits, fees, and penalties. Payment must be made in one of the following methods: <ul style="list-style-type: none"> Check Cashier's check Money order Credit Card (where authorized) 	
Please review and check each box below to acknowledge that you have read each statement.	
<input type="checkbox"/>	If I answered yes to one or more of the above statements, I have given a full explanation on a separate page and have included it with this <i>Application for Certified Auricular Detoxification Specialist Supervisor</i> .
<input type="checkbox"/>	I understand the Board may refuse to issue or may suspend, or revoke any license or auricular detoxification supervisor registration in accordance with the Uniform Licensing Act, 61-1-1 to 61-1-31 NMSA 1978, for reasons authorized in 61-14A-17 NMSA 1978 of the Act and clarified in 16.2.12 NMAC.
<input type="checkbox"/>	I have enclosed a non-refundable <i>Application for Certified Auricular Detoxification Specialist Supervisor</i> fee paid by certified check or money order for \$50.00 (in U.S. funds).

<input type="checkbox"/>	<p>I understand that the Auricular Detoxification Specialist Supervisor shall:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Be a licensed Doctor of Oriental Medicine; and <input type="checkbox"/> Registered with the Board as a CADS Supervisor; and <input type="checkbox"/> Supervise no more than thirty (30) Certified Auricular Detoxification Specialists; and <input type="checkbox"/> Be accessible for consultation directly or by telephone to a CADS under his or her supervision; and <input type="checkbox"/> Directly visit each CADS under his or her supervision at the Treatment Program site at intervals of not more than six (6) weeks; and <input type="checkbox"/> Be responsible for having each CADS under his or her supervision require each patient to complete a written, signed consent form outlining the responsibilities of the CADS, the nature of the treatment, expected outcomes, and the scope and limits of practice; and <input type="checkbox"/> Ensure that the CADS is following a Board approved treatment protocol; and <input type="checkbox"/> Notify the Board in writing, within five (5) days working days, when a CADS enters into a supervisory relationship with the CADS Supervisor or the supervisory relationship is terminated.
<input type="checkbox"/>	<p>I understand that CADS are authorized to perform only the following, for the purpose of treating and preventing alcoholism, substance abuse or chemical dependency and only within a board approved substance abuse treatment program that demonstrates experience in disease prevention, harm reduction, or the treatment or prevention of alcoholism, substance abuse or chemical dependency:</p> <ul style="list-style-type: none"> <input type="checkbox"/> auricular acupuncture detoxification using the five auricular point national acupuncture detoxification association (NADA) procedure and/or other board approved procedure; and <input type="checkbox"/> the application to the ear of simple board approved devices that do not penetrate the skin using the five auricular point national acupuncture detoxification association (NADA) procedure and that the board approved devices that do not penetrate the skin are: seeds, grains, stones, metal balls, magnets and any small sterilized, spherical objects that are non reactive with the skin.
<input type="checkbox"/>	<p>I understand that a CADS shall be responsible for the delivery of competent, professional services and ensuring that patient consents are obtained.</p>
<input type="checkbox"/>	<p>I understand as the CADS Supervisor, I shall terminate the supervisory relationship if I have the reasonable belief that the CADS has violated the Act or the Rules. In such case, I shall notify the Board and the CADS employer, in writing, within five (5) working days that the supervisory relationship is terminated and give in writing the reasons for the termination.</p>
<input type="checkbox"/>	<p>I understand that I am responsible for reading, understanding and complying with the state of New Mexico laws and rules regarding this application as well as the practice of auricular detoxification and supervision.</p>
<input type="checkbox"/>	<p>I understand as the Certified Auricular Detoxification Specialist Supervisor, I shall not be a member of the CADS family or a member of the CADS household or have a conflict of interest with the CADS as defined in 16.2.16.21 NMAC. Exceptions may be made by the Board on an individual basis due to limited availability of Certified Auricular Detoxification Specialists or supervisors.</p>
<p>Licensure requirements, application procedures, application deadlines, fee schedules and applications forms are subject to change. The rules and forms in effect at the time application is made shall apply to all applications for licensure. The applicant shall obtain current rules and forms from the Board office. Applicants must satisfy all current licensure requirements or the application will be rejected. Applications submitted on outdated forms will be rejected.</p> <p><i>If you are a veteran, you may be entitled to use your G. I. Bill benefits to pay the cost of approved licensing and certification tests. Please contact 1-888-442-4551 for more information.</i></p> <p>I hereby certify that this <i>Application for Certified Auricular Detoxification Specialist (CADS) Supervisor</i> is a true and complete affidavit containing no willful misrepresentations. I also understand that if I provide the Board of Acupuncture and Oriental Medicine with false information on this <i>Application for Certified Auricular Detoxification Specialist Supervisor</i> or on any supporting document to this <i>Application for Certified Auricular Detoxification Specialist Supervisor</i>, or make a false statement to the Board of Acupuncture and Oriental Medicine on this <i>Application for Certified Auricular Detoxification Specialist Supervisor</i> or otherwise, I may be subject to disciplinary action, including denial, suspension or revocation of licensure.</p>	
<div style="display: flex; justify-content: space-between;"> Applicant name (Please Print) Applicant Signature </div>	

STATE OF () COUNTY OF ()

The foregoing instrument was acknowledged before me this ____ day of _____, 20____,

Notary Public

My Commission Expires: _____

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