NMRLD
NEW MEXICO
REGULATION &
LICENSING DEPARTMENT

2023 DOM RENEWAL APPLICATION

License No: _____

Name: _____

Home Address: _____

City/State/Zip Code: _____

Business Address: _____

City/State/Zip Code: _____

Business telephone: _____

Email address: _____

☐ **RENEWAL FEE: $225, if application received before July 31, 2023.**
☐ **LATE RENEWAL FEE: $200 if application received after August 1, 2023, + $225 = $425**
☐ **EXPIRED FEE: $350, assessed after Oct. 1, 2023, + $425 = $775**

We do NOT accept Cash or Credit cards in the board office. Payments can be made via check, cashier's check or money order; payable to: Board of Acupuncture and Oriental Medicine, PO Box 25101, Santa Fe, NM 87504.

☐ **REGULAR LICENSE RENEWAL:** To renew your license to practice Acupuncture and Oriental Medicine please complete this form and return it to the board office with a check or money order for $225.00, on or before July 31, 2023.

A license not renewed by July 31, 2023, is considered late and will be assessed a **Late Fee** of $200.00 in addition to the $225.00 renewal fee, provided the application form and check or money order for $425.00 are submitted to the board office on or before September 30, 2023 (before the expiration of the 60-day grace period.)

A license that is not renewed on or before September 30, 2023 is deemed **Expired** and the licensee shall not practice oriental medicine until the expired license is renewed.

Renewal of an **Expired license** requires submission of a completed renewal form to the board office within one year of the last regular renewal date (on or before July 31, 2023). The renewal fee for an expired license is $775.00 ($225 annual renewal, plus $200 late license renewal, plus $350.00 expired license renewal.)

Note: A licensee who does not renew within one year of license expiration will be required to reapply as a new applicant.

☐ **EXPEDITED LICENSE RENEWAL**: A licensee holding an expedited license may apply for license renewal in the manner provided by the board's rules. However, if the licensee has not passed the NCCAOM in another jurisdiction, the licensee shall be required to take and pass the NCCAOM prior to renewing the license. Additionally, if the licensee has not passed any additional examinations as required by 16.2.4.10 NMAC, including the New Mexico clinical skills examination, the licensee shall be required to take and pass such examinations prior to renewing the license. Contact the Board office for additional information or refer to 16.2.6.11 NMAC.

☐ **INACTIVE STATUS**: A licensee can place a license on **Inactive Status** by submitting this form and the Inactive Status fee of $100.00 to the board office. A licensee with an inactive license cannot practice, teach or represent themselves as DOM's in New Mexico during the Inactive Status period. An attempt to teach or practice with an inactive license will subject the licensee to disciplinary action. Contact the Board office for additional information or refer to 16.2.15 NMAC.

Please provide any additional information relevant to the questions, and attach supporting documentation if necessary, especially if you have discipline in any jurisdiction.		
1. You, the licensee, hereby certify that you are the individual named on this renewal application form and that you have provided the information requested on this form.	Yes	No
2. Since your last renewal, has any disciplinary action been taken against your New Mexico acupuncture & oriental medicine license and whether licensed in another state or not, by another licensing board?	Yes	No
3. Since your last renewal, has any licensing board denied your application for a license to practice acupuncture & oriental medicine?	Yes	No
4. Since your last renewal, have you knowingly failed to renew a license during an investigation or a disciplinary action?	Yes	No
5. Are you current with your CPR Certification? CPR Organization name: _____ Certification Expiration Date: _____	Yes	No
6. I certify that I have met all continuing education requirements for this renewal period, and will provide certificates to the Board if audited or upon request.	Yes	No

By signing this application, I hereby swear or affirm under the penalty of perjury, that I have answered all the questions truthfully and to the best of my knowledge. I also understand that if I provide the board with false information, make a false statement on this renewal form or on any supporting document**,** I may be subject to disciplinary action, including denial, suspension or revocation of my license.

Please date and sign:

Date:_____

Sign: _____

NMRLD
NEW MEXICO
REGULATION &
LICENSING DEPARTMENT

MANDATORY SURVEY

New Mexico License Number: _____

CURRENT WORK STATUS (Select all that apply)

- ☐ Practice in New Mexico
- ☐ Practice Medicine in another state: ☐ TX ☐ CO ☐ AZ ☐ Other
- ☐ Permanently or Temporarily Inactive in New Mexico
- ☐ Retired, but maintain an active license
- ☐ Retired and do not maintain an active license
- ☐ Current Resident of Fellowship Training

CURRENT ACTIVITIES

How many weeks per year do you practice in NM? _____

How many hours per week do you practice in NM? _____

For you practice in New Mexico, approximately what percent of your time was spent on the following activities (percentage of all selected activities should total 100%)

	Direct Patient Care
	Teaching/Precepting
	Research
	Healthcare Administration

	Other, please specify:_____

For Direct Patient Care, approximately what percent of your time was spent in the following types of facilities (percentage should total 100%)

	Hospital/Inpatient
	Outpatient/Clinic
	Mobile Services
	Other, please specify:_____

NMRLD
NEW MEXICO
REGULATION &
LICENSING DEPARTMENT

LOCATION OF EDUCATION AND TRAINING

	New Mexico	Other U.S. state or Canada	Foreign country	Not Applicable
Location of the high school from which you graduated:	☐	☐	☐	☐
Location of the undergraduate college or university from which you graduated:	☐	☐	☐	☐
Location of the licensure training from which you graduated:	☐	☐	☐	☐
Location of primary specialty training:	☐	☐	☐	☐
Location of secondary specialty training:	☐	☐	☐	☐

PRACTICE SPECIALTY (IES) IN WHICH YOU SPEND MOST OF YOUR PROFESSIONAL TIME

Primary Specialty: _____

% Patient care time for primary specialty: _____

Secondary Specialty: _____

% Patient care time for secondary specialty:_____

TRAINING AND CERTIFICATION

	Yes	No
Completed accredited residency programs for primary specialty?	☐	☐
Board certified/Certificate of Added/Special Qualifications for primary specialty?	☐	☐
Completed accredited residency programs for secondary specialty?	☐	☐
Board certified/Certificate of Added/Special Qualifications for secondary specialty?	☐	☐

HOSPITAL ADMITTING PRIVILEGES

Number of hospitals in New Mexico at which you have admitting privileges

☐None ☐One ☐Two ☐Three or more

REIMBURSEMENT: PAYMENT SOURCES

Primary source of payment for patient care (**select top 3**):

NMRLD
NEW MEXICO
REGULATION &
LICENSING DEPARTMENT

- ☐ Medicare
- ☐ Medicaid
- ☐ Tricare/VA/HIS
- ☐ Private Insurance
- ☐ Self-pay
- ☐ Bad Debt/Charity
- ☐ Other
- ☐ Do Not Know or Not Applicable
- ☐ Other: _____

% of patients with Medicare as their primary payer:_____
% of patients with Medicaid as their primary payer:_____
% of patients with Tricare/VA/HIS as their primary payer:_____
% of patients with Private Insurance as their primary payer:_____
% of patients with Self-pay as their primary payer:_____
% of patients with Bad Debt/Charity as their primary payer:_____
% of patients with Other as their primary payer: _____

Provide an approximate monetary value for the **uncompensated** patient care you provided during the last year for **emergency** services: ☐

Provide an approximate monetary value for the **uncompensated** patient care you provided during the last year for **non-emergency** services: ☐

PATIENT CARE PRACTICE LOCATIONS

For PRIMARY location of patient care:

PRIMARY patient care street address:	
PRIMARY patient care city/town:	
PRIMARY patient care state:	
PRIMARY patient care 5-digit zip code:	
Weekly PRIMARY patient care hours:	
Weekly PRIMARY number of patients:	

For SECONDARY location of patient care:

SECONDARY patient care street address:	
SECONDARY patient care city/town:	
SECONDARY patient care state:	
SECONDARY patient care 5-digit zip code:	
Weekly SECONDARY patient care hours:	
Weekly SECONDARY number of patients:	

NMRLD
NEW MEXICO
REGULATION &
LICENSING DEPARTMENT

PRACTICE SETTINGS

What best describes your PRIMARY location practice?

- ☐ Independent Practice
- ☐ Group Practice-Employee/Staff
- ☐ Organizationally affiliated (i.e. University, or Health Plan staff)
- ☐ Hospital-Inpatient
- ☐ Hospital-Outpatient dept./satellite clinic
- ☐ Hospital-Emergency room
- ☐ Federal Qualified Health Clinic (FQHC)
- ☐ Nursing home/Home Health agency
- ☐ Private health center/clinic
- ☐ Public/Non-profit community health center (non-FQHC)
- ☐ Other licensed community clinic
- ☐ Military/VA health facility
- ☐ Indian Health Service clinic
- ☐ Locum tenens
- ☐ Multi-Specialty Practice-Employee/staff
- ☐ Nurse Managed Clinic
- ☐ Other (please specify): _____

What best describes your PRIMARY location practice size?

- ☐ Solo Independent Practitioner
- ☐ Solo Independent Practitioner + Intermediate
- ☐ Two Independent Practitioners
- ☐ Three or Four Independent Practitioners
- ☐ Five to Nine Independent Practitioners
- ☐ Ten or More Independent Practitioners

What best describes your SECONDARY location practice?

- ☐ Independent Practice
- ☐ Group Practice-Employee/Staff
- ☐ Organizationally affiliated (i.e. University, or Health Plan staff)
- ☐ Hospital-Inpatient
- ☐ Hospital-Outpatient dept./satellite clinic
- ☐ Hospital-Emergency room
- ☐ Federal Qualified Health Clinic (FQHC)
- ☐ Nursing home/Home Health agency
- ☐ Private health center/clinic
- ☐ Public/Non-profit community health center (non-FQHC)
- ☐ Other licensed community clinic

NMRLD
NEW MEXICO
REGULATION &
LICENSING DEPARTMENT

- ☐ Military/VA health facility
- ☐ Indian Health Service clinic
- ☐ Locum tenens
- ☐ Multi-Specialty Practice-Employee/staff
- ☐ Nurse Managed Clinic
- ☐ Other (please specify): _____

What best describes your SECONDARY location practice size?

- ☐ Solo Independent Practitioner
- ☐ Solo Independent Practitioner + Intermediate
- ☐ Two Independent Practitioners
- ☐ Three or Four Independent Practitioners
- ☐ Five to Nine Independent Practitioners
- ☐ Ten or More Independent Practitioners

CURRENT PRACTICE CAPACITY

What describes your current patient care practice capacity?

- ☐ My practice is full: I cannot accept any new/additional patients
- ☐ My practice is nearly full: I can accept a few new/additional patients
- ☐ My practice is far from full: I can accept new/additional patients
- ☐ Not Applicable

MEANINGFUL USE OF HEALTH INFORMATION TECHNOLOGY (HIT) AND ELECTRONIC HEALTH RECORD (EHR) IN YOUR PRACTICE

Does your practice CURRENTLY have the following HIT/EMR capacity? (select all that apply)	
☐	Computerized Provider Order Entry (CPOE)
☐	E-Labs (Order, Retrieve and Store results)
☐	Create Registries (e.g. registry of patient with diabetes)
☐	Quality Reporting
☐	Record Demographics (e.g. patient race/ethnicity, insurance status)
☐	Patient access to electronic copy of health records
☐	E-Prescribing
☐	Patient timely access to labs, x-ray and other results
☐	Record Vital Signs (e.g. height, weight, blood pressure)
Does your practice PLAN TO HAVE IN THE NEXT YEAR? (select all that apply)	
☐	Computerized Provider Order Entry (CPOE)
☐	E-Labs (Order, Retrieve and Store results)

NMRLD
NEW MEXICO
REGULATION &
LICENSING DEPARTMENT

☐	Create Registries (e.g. registry of patient with diabetes)
☐	Quality Reporting
☐	Record Demographics (e.g. patient race/ethnicity, insurance status)
☐	Patient access to electronic copy of health records
☐	E-Prescribing
☐	Patient timely access to labs, x-ray and other results
☐	Record Vital Signs (e.g. height, weight, blood pressure)

REFERRAL DIFFICULTIES

Identify the specialties that you or your patients have the greatest difficulty scheduling/obtaining/arranging a timely appointment **when making referrals** (MARK UP TO 3 SPECIALTIES)

☐ Advanced practice certified chiropractor
☐ Social Worker
☐ Social Worker - Clinical Specialty
☐ Social Worker - Medical Specialty
☐ Social Worker - School Specialty
☐ Social Worker - Researcher
☐ Social Work - Community Organizer
☐ Social Work Administrator
☐ Dental Public Health
☐ Endodontic
☐ Oral and maxillofacial surgery
☐ Orthodontics and dento-facial orthopedics
☐ Oral pathology
☐ Pediatric dentistry
☐ Periodontology
☐ Acupuncturists
☐ Cardiology/Vascular Specialists
☐ Chiropractors
☐ Dermatology
☐ Diabetic Educators
☐ Gynecology (only)
☐ Endocrinology and Metabolism
☐ Primary Care - Internal Medicine, Family
☐ Practice, Pediatrics, Geriatrics
☐ Infectious Disease
☐ Mental Health Adult, Child and Adolescent
☐ Nephrology
☐ Neurology
☐ Nutritionists
☐ Occupational /Rehabilation-Physiary
☐ Medicine
☐ Oncology/Hematology
☐ Orthoptists/Prosthetics
☐ Pain Management
☐ Physical Therapy
☐ Rheumatology
☐ Other - _____

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NEW MEXICO
REGULATION &
LICENSING DEPARTMENT

RECRUITMENT EXPERIENCES

How would you describe your experience in recruiting:	Easy	Somewhat Difficult	Very Difficult	Not Known or Now Applicable
Physicians	☐	☐	☐	☐
Nurses	☐	☐	☐	☐
Nurse Practitioners	☐	☐	☐	☐
Physician Assistants	☐	☐	☐	☐
Other Health Professionals	☐	☐	☐	☐

DEMOGRAPHIC INFORMATION

Gender: ☐Male ☐Female

Hispanic, Latino or Spanish Origin: ☐Yes ☐No

Race (Select all that apply):

☐White or Caucasian
☐Black or African American
☐Native American or Alaska Native
☐Asian or Pacific Islander
☐Other: _____

NEAR FUTURE PRACTICE PLANS

In the next 12 months I plan to (select all that apply):

☐Retire from patient care
☐Significantly reduce patient care hours
☐Move my practice to another geographic location in New Mexico
☐Move my practice out of New Mexico

NMRLD
NEW MEXICO
REGULATION &
LICENSING DEPARTMENT

☐ None of the above

If you are retiring, moving or reducing patient care hours in the next 12 months, what are the factors that led to that decision? (Select all that apply)

☐ Age
☐ Geographic preference
☐ Health
☐ Practice Environment
☐ Lack of Job Satisfaction
☐ Gross Receipts Tax
☐ Increasing Administrative/Regulatory Burden
☐ Reimbursement Issues
☐ Other: _____
☐ N/A

PROFESSIONAL LIABILITY INSURANCE INCREASE THRESHOLDS

At what percent increase in your annual liability insurance above your current level would you consider:

Retiring from patient care?	%
Significantly reduce patient care hours?	%
Moving practice out of state?	%

MEDICARE PAYMENT DECREASE THRESHOLDS

At what percent decrease to your Medicare payment level would you consider:

Retiring from patient care?	%
Closing practice to NEW Medicare patients	%
Closing practice to ALL Medicare patients	%
Significantly reduce patient care hours?	%
Moving practice out of state?	%

When billing for services:

☐ Submit billing through own license
☐ Submit billing through someone else's license
☐ Submit billing through Group/Hospital ID
☐ Do not know
☐ Other (please specify): _____