

**Kentucky Board of Medical Licensure**

310 Whittington Parkway, Suite 1B

Louisville, KY 40222

(502) 429-7150

[www.kbml.ky.gov](http://www.kbml.ky.gov)

TO: Applicants for Acupuncture Certification

FROM: Dawn Beahl, Acupuncture Coordinator

RE: Board Certification as an Acupuncturist

**The following requirements must be met in accordance with Kentucky statutes:**

- The applicant must have achieved a passing score on the acupuncture examination administered by the National Commission for Certification of Acupuncture and Oriental Medicine, **and** must have graduated from a course of training of at least one thousand eight hundred (1,800) hours, including three hundred (300) clinical hours, that is approved by the Accreditation Commission for Acupuncture and Oriental Medicine.

**Attached is an application for certification as an Acupuncturist in the Commonwealth of Kentucky. Please note that all documentation received by the Board must be translated if it is in any language other than English. The applicant will incur any and all costs for these translations. Instructions for completing the application are as follows:**

1. Completed application must be **signed and notarized**. This information is used for verification purposes. Please indicate your practice address on the application. If no practice address is listed, your mailing address will be published.
2. Recent **original** photograph of yourself (**passport size**) **signed and dated**.
3. FORM 1 – Release and Waiver of Rights, **signed and notarized**.
4. FORM 2 – National Commission for Certification of Acupuncture and Oriental Medicine-complete Exam Results Order Form and **mail directly to the NCCAOM** along with the \$35.00 fee.
5. FORM 3 – Verification of Education – send this form to your school for certification of your degree as an acupuncturist. If you graduated from a foreign acupuncture program, the program must send original translations of your course transcripts directly to the Board. This form must be sent directly to the Board in a sealed envelope.
6. FORM 4 – Verification of Acupuncture Training Hours – send this form to the institution in which you completed your training hours. This form must be sent directly to the Board in a sealed envelope.
7. FORM 5 – Verification of Certification – send this form to any state in which you currently hold or have ever held an Acupuncture certification/license. The verification must come directly from the state.
8. FORM 6 – Treatment Plan for Consultation, Emergency Transfer and Referral of Patients.
9. \$150.00 Initial Certification Fee – **Checks should be made payable to the Kentucky Board of Medical Licensure**.

**Please keep in mind that completion of the application is your responsibility. Only completed applications will be considered by the Acupuncture Advisory Committee. If the Committee determines that you have met the statutory requirements for certification, your application will be presented to the Kentucky Board of Medical Licensure for final approval. Incomplete applications will be returned to the applicant. Should you have any questions concerning your application, please contact Ms. Dawn Beahl, Acupuncture Coordinator at (502) 429-7150, extension 231.**

**Faxes Will Not Be Accepted**

**Kentucky Board of Medical Licensure**  
310 Whittington Parkway, Suite 1B  
Louisville, KY 40222  
(502) 429-7150

**Application For Acupuncture Certification In Kentucky**

*(Please Type or Print)*

**Note: Intentional false answers or misrepresentation in applying for or procuring a license, registration or reactivation in Kentucky are grounds for disciplinary action, including denial or revocation of license, and are reported to the National Practitioner Data Bank and/or appropriate national professional credentialing organization. You must answer "yes" to any question if the event(s) described in that question has actually occurred. You must answer, "yes" in such circumstances even if you have been advised by an attorney or other person that you may answer "no". You must also answer "yes" in such circumstance even if the record of the event has been sealed or expunged by Court order, or has been designated "confidential" by the body involved. After answering "yes" to the appropriate question(s), you may advise the Board of any additional relevant information pertaining to your answer (i.e., record has been sealed or expunged, record is designated "confidential," attorney has advised that you properly answer "no"). The Board will consider this additional information, along with your answer(s), in determining the appropriate action. If you have any question about whether or not you should answer "yes" to a question, you should err in favor of answering "yes" and provide an explanation, because any non-disclosure violation will likely result in denial of your application or disciplinary action against your certification.**

Please circle one: Mr./Mrs./Ms./Miss

1. Name: \_\_\_\_\_  
(first) (middle) (last)

2. Mailing Address \_\_\_\_\_  
(street) (city) (state) (zip)

3. \*Practice Address \_\_\_\_\_  
(street) (city) (state) (zip)

4. Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

5. Phone: (home) \_\_\_\_\_ (work) \_\_\_\_\_

6. Place of Birth \_\_\_\_\_ Date of Birth \_\_\_\_\_

7. Have you been known by any other name?  YES  NO

If yes, please list names \_\_\_\_\_

8. Are you a current Kentucky resident?  YES  NO

9. Are you a U.S. citizen?  YES  NO

10. Employment History: Beginning with the most recent, include all acupuncture employment from NCCAOM certification to date of this application. Attach additional sheets if necessary.

Dates: From-To \_\_\_\_\_ Position Held \_\_\_\_\_

Business Address \_\_\_\_\_

Type of Practice \_\_\_\_\_ Phone \_\_\_\_\_

List Duties Performed in Practice \_\_\_\_\_

\_\_\_\_\_

Name \_\_\_\_\_ Social Security Number \_\_\_\_\_

11. Have you completed an educational program approved by the Accreditation Commission for Acupuncture and Oriental Medicine? (ACAOM)  YES  NO

If yes, please list school/program and graduation date: \_\_\_\_\_

12. Are you currently certified by the following?

National Commission for Certification of Acupuncture and Oriental Medicine  YES  NO

If Yes, Certification # \_\_\_\_\_ Issue Date \_\_\_\_\_ Expiration Date \_\_\_\_\_

13. List all states in which you have applied for or been granted certification/license as an acupuncturist.

| State | Certification # | Issue Date | Expiration Date |
|-------|-----------------|------------|-----------------|
| _____ | _____           | _____      | _____           |
| _____ | _____           | _____      | _____           |
| _____ | _____           | _____      | _____           |
| _____ | _____           | _____      | _____           |

14. Have you had any certificate, license, registration or other privilege to practice as a health care professional, denied, revoked, suspended, probated, or restricted by a State or Federal authority, or have you ever surrendered such credential to avoid or in connection with disciplinary investigation/action by such jurisdiction?

YES  NO

15. Are any legal proceedings regarding certification/licensure presently pending against you by any State or Federal licensure authority or any drug licensure/enforcement authority?

YES  NO

16. Have you been convicted of a felony or misdemeanor by any State or Federal court? Are any criminal charges presently pending against you in any of those courts?

YES  NO

17. To your knowledge, are you the subject of an investigation for a criminal act?

YES  NO

18. Are you currently in default on any student loan repayment obligations payable to the financial aid programs administered by the Kentucky Higher Education Authority?

YES  NO

19. Have you ever been denied a license/certificate or denied the privilege of taking a licensure/certification examination by any State, Federal or International licensure jurisdiction?

YES  NO

20. Have you ever had any license, certificate, registration or other privilege as a health care professional denied, revoked, suspended, probated, restricted or limited, or subjected to any other disciplinary action, by a State medical/osteopathic licensing board, or Federal, or International authority?

YES  NO

21. Have you been or are you currently under investigation by any State or Federal licensure authority or any drug licensure/enforcement authority?

YES  NO

Name \_\_\_\_\_ Social Security Number \_\_\_\_\_

22. Have you ever voluntarily or involuntarily surrendered an acupuncture certificate or license, or controlled substance registration certificate issued to you?  
 YES  NO
23. Have you ever been disciplined by any licensed hospital (including postgraduate training) or the medical staff of any licensed hospital, including removal, suspension, probation, limitation of hospital privileges or any other disciplinary action if the action was based upon what the hospital or medical staff found to be unprofessional conduct, professional incompetence, malpractice or a violation of a provision(s) of a Medical Practice Act?  
 YES  NO
24. Have you surrendered such credential, or placed it into an inactive status, to avoid disciplinary action or in connection with or in anticipation of a disciplinary investigation/action by the licensing authority of such jurisdiction?  
 YES  NO
25. Have you ever resigned your privileges or failed to renew privileges at a licensed hospital or from the medical staff of the hospital, while under investigation or while you were subject to disciplinary proceedings by the hospital?  
 YES  NO

*If you answered "YES" to any of the above questions (#14 – 25), please attach a written explanation*

**AFFIDAVIT OF APPLICANT: I hereby state that the information contained in this application is true, accurate, and complete to the best of my knowledge and belief. I understand that under Kentucky law the submission of any false, fraudulent or forged statement, document or other matter in connection with this application is grounds for criminal prosecution and the denial of certification. I authorize the Board, or its agents, to obtain from other sources any information necessary for determining my qualifications for certification. I also authorize them to furnish any information they may now, or in the future, have concerning my qualifications and fitness to practice as an acupuncturist to any person, institution, association, school, hospital or government entity. I understand any false information on my application may subject my certification to disciplinary action pursuant to the Kentucky Certified Acupuncture Statutes**

\_\_\_\_\_  
**Signature of Applicant**

\_\_\_\_\_  
**Date**

Subscribed and sworn before me by the above named applicant this

\_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_

This application consists of 3 pages.

\_\_\_\_\_  
**Signature of Notary**

My commission expires: \_\_\_\_\_

**Seal of Notary**

\*This Application is in compliance with the American Disabilities Act

Name \_\_\_\_\_ Social Security Number \_\_\_\_\_

*The answers to these questions are exempt from public disclosure under KRS 61.878(1)(a) and (I) and KRS 311.619 and shall be subject to inspection only upon order of a court of competent jurisdiction, except that no court shall authorize the inspection by any party of any materials pertaining to civil litigation beyond that which is provided by the Kentucky Rules of Civil Procedure governing pretrial discovery. The answers to these questions may be considered by the Board (KBML) and may be disclosed in any contested case proceeding, including a Show Cause proceeding, or appeal of a certification decision based upon them.*

*“Illegal drug use” means the use of an illegally obtained controlled substance or dangerous drug; the term “illegal drug use” also means the use of a legally obtained controlled substance or dangerous drug which is not taken in accordance with the direction of the licensed health care professional who prescribed the controlled substance or dangerous drug.*

1. Do you currently, or have you had within the past 5 years, any physical, mental, or emotional condition, which impaired, or might reasonably impair your ability to practice your health care profession safely and competently?  
 Yes  No
2. Within the past 5 years, have you been admitted to any hospital or other in-patient care facility for any physical, mental or emotional condition, which impaired, or might reasonably be considered to impair, your ability to practice your health care profession safely and competently?  
 Yes  No
3. Do you currently have, or have you had within the past 5 years, a dependency on or abuse of the use of alcohol or drugs, which impaired, or might reasonably impair, your ability to practice your health care profession safely and competently?  
 Yes  No
4. Within the past 5 years, have you engaged in the excessive use of alcohol or illegal drugs, or received any in-patient or outpatient or individual therapy/treatment or been hospitalized for alcoholism, or illegal use, or been arrested for a DUI (Driving Under The Influence)?  
 Yes  No
5. Within the past 5 years, have you been the subject of any chemical substance screening test which resulted in an indication of the presence in your body of any controlled substance, any dangerous drug, or alcohol level above .10% BAC? (This does not include those drugs taken by you as a result of a legitimate health care diagnosis, and prescribed for you in good faith by another licensed health care professional.)  
 Yes  No

**\*\*\*Affidavit of Applicant\*\*\***

**I hereby state that the information contained in this application is true, accurate, and complete to the best of my knowledge and belief. I understand that under Kentucky law the submission of any false, fraudulent or forged statement, document or other matter in connection with this application is grounds for criminal prosecution and the denial of certification. I authorize the Board (KBML) or its agents to obtain from other sources any information necessary for determining my qualifications for certification. I also authorize them to furnish any information they may now or in the future have concerning my qualifications and fitness to practice as an acupuncturist to any person, institution, association, school, hospital or government entity.**

\_\_\_\_\_  
(Signature of Applicant)

\_\_\_\_\_  
(Print Name)

Subscribed and sworn to before me by the above named applicant this \_\_\_\_\_ day of \_\_\_\_\_  
(month, year)

\_\_\_\_\_  
(Signature of Notary)

**Seal of Notary**

My commission expires: \_\_\_\_\_

• • • **Deadlines For Council Meeting Dates** • • •

In order for your application to be presented to the State Advisory Committee on Acupuncturists, your application must be completed in its entirety and must be on file in the Board office no later than the deadline dates listed below. Once the Committee reviews your application, it will be presented to the Kentucky Board of Medical Licensure for final approval.

| <b><u>Deadline Date</u></b> | <b><u>Meeting Date</u></b> | <b><u>Board Meeting Date</u></b> |
|-----------------------------|----------------------------|----------------------------------|
| November 18, 2009           | December 16, 2009          | December 17, 2009                |
| February 17, 2010           | March 17, 2010             | March 18, 2010                   |
| May 26, 2010                | June 23, 2010              | June 24, 2010                    |
| August 25, 2010             | September 22, 2010         | September 23, 2010               |
| November 17, 2010           | December 15, 2010          | December 16, 2010                |

### Release and Waiver of Rights Form

I, \_\_\_\_\_, hereby authorize the following individuals and entities to release all information (documented, oral or other) about me in their possession to the Kentucky Board of Medical Licensure (KBML) or its agents:

1. All hospitals or other health care facilities at which I have ever held staff privileges, whether full or limited, temporary or permanent; and all hospitals or other health care facilities at which I have ever received training.
2. All acupuncture organizations/societies, specialty boards and other related organizations with which I have been associated.
3. All other state or Canadian licensure boards, federal health agencies, and federal and state drug control agencies.
4. All licensed physicians, nurses, acupuncturists or other health care professionals of any state or Canadian province.
5. All schools of educational facilities at which I have ever received training as an acupuncturist.
6. All attorneys who have participated in civil or criminal actions in which I am named party.

I hereby release the above-named individuals and entities from all liability for the release of information to the Board (KBML) or its agents.

I further authorize the Board (KBML) or any of its duly authorized agents, to make any investigations that they deem necessary to secure information concerning me, which is relevant to the requirements of certification. I further authorize them to release such information they may now or in the future have, concerning me to (i) any federal, state, county or local governmental entity, (ii) any hospital or other health care facility, or (iii) any other person upon a showing that the release of the information is vital to the health, safety and welfare of the general public.

I hereby make this release and waiver of rights for the purpose of allowing the Board (KBML) to carry out its duties pursuant to my request for certification to practice as an acupuncturist in the Commonwealth of Kentucky; and further, for the purpose of allowing the Board (KBML) to carry out its duties in regard to my continued certification.

This release and waiver of rights has no expiration date and shall remain effective during my certification in the Commonwealth of Kentucky.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Applicant

Sworn to and subscribed before me by the above named applicant on this \_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_.

**Seal**

\_\_\_\_\_  
Notary Public

My Commission expires: \_\_\_\_\_



**Exam Results Order Form**

**National Certification Commission for Acupuncture and Oriental Medicine**

Please submit this form to have NCCAOM forward your exam results and/or certification forwarded to State Licensing Board.

**Personal Information**

|   |        |                          |  |
|---|--------|--------------------------|--|
| Name:   |        | Candidate ID (Optional): |  |
| Address:  |        |                          |  |
| City:   | State: | Zip:                     |  |
| Country:  |        | Postal Code:             |  |
| Phone:  |        | Fax:                     |  |
| Email:  |        | Birth Date:              |  |
| <b>Please send this report to (STATE/AGENCY):</b> |        |                          |  |
| Address:  |        |                          |  |
| City:   | State: | Zip:                     |  |

**Exam Results/Status Report Fees**

|                          |  |       |
|--------------------------|--|-------|
| <input type="checkbox"/> | Certified Diplomat or Current Applicant for Certification* ..... | \$35  |
| <input type="checkbox"/> | Inactive Diplomat .....  | \$75  |
| <input type="checkbox"/> | Lapsed Diplomat .....  | \$100 |
| <input type="checkbox"/> | Non Diplomat** .....   | \$150 |

\* An applicant for certification is an individual who has applied for certification and taken an exam but has yet not been certified.  
 \* Individual who have taken an NCCAOM examination administered through a state licensing board for the purposes of licensure but have never applied for NCCAOM certification:

**In order to process your request, you must choose one:**

|                          |  |
|--------------------------|--|
| <input type="checkbox"/> | I would like my report sent, even if I am not yet certified.                               |
| <input type="checkbox"/> | I would like my report sent after I become certified or I am already a certified Diplomat. |

- If you request an addition report you will be required to pay \$35 fee.
- It is your responsibility to contact your state for information on current licensure requirements, including the requirements of your CNT Certificate.
- Please allow 7-10 business days for your request to be processed.

**Payment Information (Check One)**

|   |                                     |                               |
|---|-------------------------------------|-------------------------------|
| <input type="checkbox"/> Check or Money Order     | <input type="checkbox"/> MasterCard | <input type="checkbox"/> VISA |
| <i>*Make check/money order payable to NCCAOM.</i> |                                     |                               |
|   |                                     | Expiration Date:              |
| Name on Card:                                     |                                     |                               |
|   |                                     |                               |

|   |  |
|---|--|
| <p><b>Submit This Form with Payment to:</b></p> | <p><b>NCCAOM</b><br/> <b>76 South Laura Street, Suite 1290</b><br/> <b>Jacksonville, FL 32202</b></p> <p>If paying with Credit Card, you may fax this form to:<br/>                 904-598-5001</p> |
|---|--|

**Verification of Education**

In applying for certification as an acupuncturist in the Commonwealth of Kentucky, the Kentucky Board of Medical Licensure requires this form to be completed by the training institution/school where I obtained a degree, diploma or certification while training to be an acupuncturist. My signature below is your authority to release any and all information in your files, favorable or otherwise regarding myself, directly to:

**Kentucky Board of Medical Licensure**  
**310 Whittington Parkway, Suite 1B**  
**Louisville, KY 40222**

\_\_\_\_\_  
**Name**

\_\_\_\_\_  
**Address**

\_\_\_\_\_  
**Signature**

***Do Not Detach***

-----  
Certification of Education: (to be completed by the training institution/school where the acupuncture degree was conferred)

This is to certify that \_\_\_\_\_

Attended the \_\_\_\_\_

Located at \_\_\_\_\_

And was granted the degree of \_\_\_\_\_ on \_\_\_\_\_

\_\_\_\_\_  
**Signature**

**Seal of Institution**

\_\_\_\_\_  
**Title**

\_\_\_\_\_  
**Date**

### Verification of Acupuncture Training Hours

In applying for certification as an acupuncturist in the Commonwealth of Kentucky, the Kentucky Board of Medical Licensure requires this form to be completed by the institution where I obtained at least one thousand eight hundred (1,800) hours, including three hundred (300) clinical hours, that is approved by the Accreditation Commission for Acupuncture and Oriental Medicine. My signature below is your authority to release any and all information in your files, favorable or otherwise regarding myself, directly to:

**Kentucky Board of Medical Licensure**  
**310 Whittington Parkway, Suite 1B**  
**Louisville, KY 40222**

\_\_\_\_\_  
Name

\_\_\_\_\_

\_\_\_\_\_  
Address

\_\_\_\_\_  
Signature

*Do Not Detach*

.....

Certification of Training Hours: (to be completed by the institution where the applicant completed his/her training hours)

This is to certify that \_\_\_\_\_  
Name

has completed at least one thousand eight hundred (1,800) hours, including three hundred (300) clinical hours, that is approved by the Accreditation Commission for Acupuncture and Oriental Medicine.

\_\_\_\_\_  
Institution where completed hours

\_\_\_\_\_  
Address of Institution

\_\_\_\_\_  
Total number of hours completed

\_\_\_\_\_  
Total number of clinical hours completed

\_\_\_\_\_  
Supervisor

\_\_\_\_\_  
Title

\_\_\_\_\_  
Signature

### Verification of Certification Acupuncture

**Please complete this section of the form and mail to each state board in which you are now or have been certified. If needed, you may duplicate this form.**

As part of the application for certification as an acupuncturist, the Kentucky Board of Medical Licensure requires this form to be completed by each state in which I hold or have ever held certification. I hereby authorize the release of any information in your files, favorable or otherwise to be sent directly to the Kentucky Board of Medical Licensure, 310 Whittington Parkway, Suite 1B, Louisville, KY 40222.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Certificate Number

-----

State of \_\_\_\_\_ Certificate/Registration # \_\_\_\_\_ Issue Date \_\_\_\_\_

Full Name of Certificate Holder: \_\_\_\_\_

Graduate of: \_\_\_\_\_

By: Endorsement/Reciprocity with \_\_\_\_\_

By: Your State Board's Written Examination \_\_\_\_\_

Is Certificate Current? \_\_\_\_\_ If NO, Why? \_\_\_\_\_

Has certificate been subject to disciplinary action by your agency? \_\_\_\_\_

If YES, please attach copies of any formal orders of your agency and minutes of agency decisions.

Comments, if any \_\_\_\_\_

Board Seal

Signed: \_\_\_\_\_

Title: \_\_\_\_\_

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

## Treatment Plan for Consultation, Emergency Transfer and Referral

**Pursuant to Kentucky Statutes, please see the below requirements regarding providing a written treatment plan. The treatment plan shall be attached to this form and returned directly to the Board with your application. Please make sure that your name is included on the treatment plan.**

### Plans for Consultation, Emergency Transfer and Referral

1. Every certified acupuncturist shall develop a written plan for consultation, emergency transfer, and referral to appropriate health care facilities or to other health care practitioners operating within the scope of their authorized practices, which meets the requirements contained in administrative regulations promulgated by the Board. **The written plan shall be filed with the board and maintained at the acupuncturist's practice location and updated as appropriate to meet current regulatory requirements. The requirements of the written plan have been set in regulation, KAR 9:460, and are attached for your review.**
2. If, in the course of conducting an interview regarding the patient's medical history, the patient discloses that he or she suffers from one (1) of the potentially serious disorders or conditions listed below, the acupuncturist shall verify that the patient is currently under the care of a physician and consult with the treating physician before providing acupuncture treatment. If the patient refuses to provide a medical history or disclose information regarding any of the conditions listed below, acupuncture treatment shall not be provided.
  - Hypertension and cardiac conditions
  - Acute, severe abdominal pain
  - Undiagnosed neurological changes
  - Unexplained weight loss or gain in excess of fifteen percent (15%) of the patient's body weight in less than a three (3) month period.
  - Suspected fracture or dislocation
  - Suspected systemic infections
  - Serious hemorrhagic disorder
  - Acute respiratory distress without a previous history
  - Pregnancy
  - Diabetes
  - Cancer

**201 KAR 9:460. Written plan.**

RELATES TO: KRS 311.673(1), 311.680

STATUTORY AUTHORITY: KRS 311.673(1)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 311.673(1) authorizes the board to promulgate administrative regulations necessary to the certification and regulation of acupuncturists. This administrative regulation establishes a written plan required by KRS 311.680.

Section 1. Pursuant to requirements of KRS 311.680, the written plan developed by each certified acupuncturist shall include the following information:

(1) Consultation.

(a) The acupuncturist shall identify the protocol to be used to determine whether a potential patient suffers from one of the potentially serious disorders or conditions listed in KRS 311.680(3), and to determine the identity of the physician treating the patient for the disorder or condition.

(b) The acupuncturist shall identify the telephone, facsimile, letter, or electronic mail as the means of communication to be used to:

1. Notify the treating physician that the patient is seeking treatment by acupuncture and has disclosed that he or she is being treated for a potentially serious disorder or condition; and

2. Obtain verification that the patient is under the care of the physician.

(c) The acupuncturist shall identify the method that will be used to document the consultation and verification made pursuant to Section 1(1)(b)2 of this administrative regulation. If notification and verification are accomplished by telephone, the documentation shall include, at a minimum, the name of the staff member in the physician's office providing the verification.

(d) The acupuncturist shall specify how many attempts he or she will make to obtain verification from the treating physician that the patient is under the care of before initiating treatment by acupuncture. A minimum of two (2) attempts is required before treatment is initiated, but the acupuncturist may choose a higher number of attempts.

(e) While verifying whether the patient is under the physician's care for a potentially serious disorder or condition, if the physician identifies possible contraindications for the use of acupuncture in the particular patient or recommends against the use of acupuncture, the acupuncturist may use her or his professional judgment to determine if it is reasonable to provide acupuncture treatment to that particular patient, considering all available facts.

(f) A potential patient shall be considered to be "under the care of a physician" if receiving regular or recurring treatment from the physician or from a physician assistant being supervised by the physician or from an advanced registered nurse practitioner who is practicing in association with the physician.

(2) Emergency transfer.

(a) The certified acupuncturist shall identify the nearest emergency room facility by name, address and telephone number.

(b) The certified acupuncturist shall identify the protocol for emergency transfer of patients which shall include, at a minimum, the requirement that the acupuncturist will utilize the "911" emergency notification system to arrange for emergency transfer of the patient.

(3) Referral to appropriate health-care facilities or practitioners.

(a) The acupuncturist shall identify, by name, address and telephone number, at least two (2) physicians who have agreed to consult with and accept referrals from the acupuncturist.

(b) If applicable, the acupuncturist shall also identify health-care facilities, that have agreed to accept referrals from the acupuncturist. (33 Ky.R. 4269; Am. 34 Ky.R. 231; eff. 8-16-07.)

## Sample A-Consult and Treatment Plan

### I. Consultation:

Enclosed please find a part of the initial intake forms to be filled out and signed by patients prior to the first treatment. Should any of these conditions on the form be checked, verifications will be made that the patient is under the care and treatment of a physician.

The name, address, phone number and fax number of the treating physician will be obtained. I will make two attempts to contact the treating physician by telephone. If the physician cannot be reached by phone the day of the initial visit, a letter will be sent to the treating physician stating that the patient has requested treatment for acupuncture. The letter will also ask the physician to contact the acupuncturist with any questions or concerns. A copy will be retained in the patient's chart.

If the patient refuses to provide a medical history or disclose information regarding any of the conditions listed on the form enclosed with this letter, the patient will not be treated with acupuncture.

### II. Emergency Transfer:

The emergency room facility nearest my office is:

Name of hospital  
Address  
City, State Zip  
Phone number

Should the need arise for emergency medical transfer; all staff have been trained to dial 911.

If the need arises, CPR will be administered until support arrives.

### III. Referrals:

Information on physicians who have agreed to accept referrals from me:

Dr. Name  
Address  
City, State Zip  
Phone number

Dr. Name  
Address  
City, State Zip  
Phone number

## Physician Care Form

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

I have been diagnosed with the following condition(s): Check all that apply

- Hypertension (high blood pressure)
- Cardiac Condition
- Acute, severe abdominal pain
- Undiagnosed neurological changes
- Unexplained weight loss or gain of more than 15% of body weight in last 3 months
- Suspected bone fracture or dislocation
- Suspected systemic infection
- Serious hemorrhagic (bleeding) disorder
- Acute respiratory distress without a previous history
- Pregnancy
- Cancer
- Other: \_\_\_\_\_

I am currently under the care of a physician for: Check all that apply

- Hypertension (high blood pressure)
- Cardiac Condition
- Acute, severe abdominal pain
- Undiagnosed neurological changes
- Unexplained weight loss or gain of more than 15% of body weight in last 3 months
- Suspected bone fracture or dislocation
- Suspected systemic infection
- Serious hemorrhagic (bleeding) disorder
- Acute respiratory distress without a previous history
- Pregnancy
- Cancer
- Other: \_\_\_\_\_

I am aware that I should not replace treatment from a physician with acupuncture, or any other holistic modality, for the above conditions.

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

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_

Cell: \_\_\_\_\_

## Sample B-Consult and Treatment Plan

### **Emergency Transfer Procedure**

1. The certified acupuncturist shall identify the nearest emergency room *facility by name, address and phone number*.
2. The certified acupuncturist shall identify the protocol for emergency transfer of patients which shall include, at a minimum, the requirements that the acupuncturist will utilize the “911” emergency notification system to arrange for emergency transfer of the patient.

### **Emergency Transfer Plan**

In case of an emergency, the acupuncturist shall immediately call 911.

If appropriate, the patient will be directed to the nearest hospital emergency room listed below:

Name of hospital  
Address  
City, State Zip  
Phone Number

Referral to an appropriate Health Care Facility or Practitioner:

1. The certified acupuncturist shall identify, *by name, address and phone number, at least two physicians who have agreed to consult with and accept referrals from the acupuncturist*.
2. Where applicable, the acupuncturist will also identify health care facilities, which have agreed to accept referrals from the acupuncturist.

The following physicians have agreed to consult with and accept referrals.

1. Name of physician  
Address  
City, State, Zip  
Phone number
2. Name of physician  
Address  
City, State, Zip  
Phone number

## Physician Care Form

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

I have been diagnosed with the following condition(s): Check all that apply

- Hypertension (high blood pressure)
- Cardiac Condition
- Acute, severe abdominal pain
- Undiagnosed neurological changes
- Unexplained weight loss or gain of more than 15% of body weight in last 3 months
- Suspected bone fracture or dislocation
- Suspected systemic infection
- Serious hemorrhagic (bleeding) disorder
- Acute respiratory distress without a previous history
- Pregnancy
- Cancer
- Other: \_\_\_\_\_

I am currently under the care of a physician for: Check all that apply

- Hypertension (high blood pressure)
- Cardiac Condition
- Acute, severe abdominal pain
- Undiagnosed neurological changes
- Unexplained weight loss or gain of more than 15% of body weight in last 3 months
- Suspected bone fracture or dislocation
- Suspected systemic infection
- Serious hemorrhagic (bleeding) disorder
- Acute respiratory distress without a previous history
- Pregnancy
- Cancer
- Other: \_\_\_\_\_

I am aware that I should not replace treatment from a physician with acupuncture, or any other holistic modality, for the above conditions.

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

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_

Cell: \_\_\_\_\_

## **Acupuncture**

### **Request For Temporary Certificate**

Once your application has been completed, if you need to begin working, you may request a temporary certificate. A check for \$75.00 must be submitted from you (this is part of the \$150.00 required for full certificate). The review process for temporary approval takes approximately one to two weeks.

**If Interested In A Temporary Certificate, Please Complete The Following:**

Name: \_\_\_\_\_

Anticipated Starting Date: \_\_\_\_\_

**Temporary Certificates Are Only Valid For Up To Six Months**

**And Cannot Be Extended Or Renewed**