



RI Association of
Naturopathic Physicians

Associate Membership Application

Associate Member is one of the following:

- 1) A licensed healthcare practitioner other than a naturopathic physician wishing to support the purposes, mission, vision, and goals of the RIANP
- 2) A naturopathic physician who has graduated from programs of naturopathic medicine recognized by the AANP and the Council on Naturopathic Medical Education but who does not hold a valid license from a state or jurisdiction whose license is acceptable to the AANP

Associate Member dues are \$75

Please complete the following:

Name: _____

Office Address: _____

Office phone: _____ Fax number: _____

Home Address: _____

Home phone: _____ Cell: _____

E-mail: _____

Naturopathic college (or Medical Institution) attended: _____

Address: _____

Degree(s): _____

Year of graduation: _____

If you carry/have previously carried a medical license, complete the following:

State(s) in which you are/were licensed: _____

License number(s): _____

Year(s) licensed: _____

Has your license to practice naturopathic medicine ever been revoked? Y N

If yes, what was the reason? _____

Additional professional information:

Other professional, academic or specialty training: _____

Other professional affiliations: _____



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If accepted for membership by the RIANP, I agree to abide by its policies and bylaws, follow its code of ethics, and uphold the high standards of naturopathic medical practice.

Signature: _____ Date: _____

Print name: _____

Please enclose:

- Check or money order made payable to RIANP for \$75
- Payment via PayPal donation link of RIANP website www.RIANP.org
- The appropriate items below depending on your profession:

If you are an N.D., you must enclose with your application the following:

- Copies of:
 - ND diploma & results of NPLEX or ND diploma
 - Proof of registration at a CNME recognized school of naturopathic medicine
 - State License(s) to practice naturopathic medicine (if applicable)

If you are a non-ND health practitioner, you must enclose with your application:

- Copies of:
 - Medical-related diploma
 - Results of your board exams
 - State license to practice your field of medicine (if applicable)
 - Curriculum vitae

Annual dues are as follows:

Associate Member: _____ \$75.00

Send completed application form, supporting documentation, and your check or money order to:

RIANP
c/o Sheila M. Frodermann, ND
Providence Wholistic Healthcare
144 Waterman Street #3
Providence, RI 02906