



Commonwealth of the Northern Mariana Islands  
**HEALTH CARE PROFESSIONS LICENSING BOARD**

P.O. Box 502078, Bldg., 1242 Pohnpei Court  
Capitol Hill, Saipan, MP 96950  
Tel No: (670) 664-4809 Fax: (670) 664-4814  
Email: [cnmi@cnmibpl-hcplb.net](mailto:cnmi@cnmibpl-hcplb.net)  
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**General Information for Renewal of License**

**License Renewal**

All licenses issued by the Board expired every two years following its issuance or renewal and becomes invalid after that date. Notification for license renewal is mailed or emailed to licensees at least sixty (60) days before the expiration date. You are required by regulations to keep your current address on file with the Board. Failure to receive renewal notices does not relieve you of the responsibility of renewing your license.

There is a late fee of \$25.00 charged for every 1<sup>st</sup> of the month after the expiration date.

Licenses, which have expired for failure to renew on or before the date required may be reinstated within one year of the expiration date. Each licensee whose license has expired and lapsed for more than one year by failure to renew must file a new application, meet present day requirements for licensure, and receive board approval.

**Continuing Education (CE)**

All licensees must submit satisfactory evidence of completion of Continuing Education (CE) requirements, as required in each health care profession's regulations to be completed during the twenty-four (24) months prior to the expiration of their license as a prerequisite to the renewal of their biennial license.

It shall be the responsibility of the licensee to obtain documentation, satisfactory to the Board, from the organization or institution of his or her participation in the continuing education and of the number of credits earned.

If a licensee fails to meet the CE requirements for renewal of license because of illness, military service, or other extenuating circumstances, the Board, upon appropriate written explanation, may grant an extension of time to complete same, on an individual basis.

Licensure renewal shall be denied to any licensee who fails to provide satisfactory evidence of completion of CE requirements or who falsely certifies attendance at and/or completion of the CE.

**Completion of the Application Forms**

Help us to do a good job processing your application. Type or print legibly all application documents. Please read the instructions and give careful thought before answering the questions in the application. Remember, you are certifying that the information is truthful and correct. Make sure all documents are originals or a certified or notarized true copy of original documents. Provide all documents requested in the application; incomplete applications will delay processing. Application fees must accompany applications before initial review can begin.

Each question in the application must be answered. Attach separate sheets of paper, labeled with your name and signed by you, for any question for which you provided a "yes" response.

Failure to answer all questions completely and accurately, or the omission or falsification of information may be cause for denial of your application or disciplinary action if the board subsequently issues you a license.

The application cannot be altered, changed, modified or added to unless approved by the Board.

**Confidentiality**

The contents of licensing files are generally considered public records. If you believe that the additional information you are attaching to explain a "yes" answer should be considered confidential, state that in the attachment. A request for confidentiality may or may not be granted.

**Documents sent by Fax or Email**

Fax copies or documents sent via email are not accepted for documentation or verification in our licensing process. If copy of document is sent via fax or email, the original must be sent via U.S. Postal Service to the Board's office.

**Processing Time**

In general, average processing time for a permanent license is 1 - 2 weeks. Application processing time depends to a large extent on our workload and the volume of applications being processed or the routing of the renewal application.

**License Denial**

If for any reason your application for renewal of your license is denied you are entitled to a hearing pursuant to the Commonwealth Administrative Procedures Act, 1 CMC §9108-15.

**Abandonment of Application**

Your application shall be considered abandoned and shall be destroyed if you fail to provide evidence of continued efforts to complete the licensing process for one (1) year. If the application is deemed abandoned the applicant shall be required to reapply for licensure and comply with the licensing requirements in effect at the time of the reapplication.

**Schedule of Fees**

Renewal License Fee (physicians, dentists, pharmacists, optometrists, psychologists, professional counselors, and chiropractors)	\$200.00
All other health professions	\$100.00
Temporary License Fee	\$100.00
Delinquent Fee (1 <sup>st</sup> of the month)	\$25.00
Replacement of License	\$75.00
Replacement of Card	\$25.00
Verification of License	\$25.00
Letter of Good Standing	\$25.00



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Attach a recent 2x2 ID photo here taken within 6 months of the application.

**RENEWAL APPLICATION TO PRACTICE**

**HCPLB STAFF USE ONLY**

Date Received:

**APPLICATION INFORMATION – Please Type or Print**

<b>1.</b> Last:	First:	Middle:	<b>2.</b> Social Security No:
<b>3.</b> Birthdate: (Mo/Day/Yr.)	<b>4.</b> Email Address:		<b>5.</b> Citizenship: <input type="checkbox"/> U.S. <input type="checkbox"/> Other-Specify:
<b>6.</b> Mailing Address:		<b>7.</b> Residence Address:	
<b>8.</b> Phone No: (W): (H):		<b>9.</b> NPI # (if available):	

**10. LICENSES – (List of all jurisdiction where you are licensed.)**

Name of Jurisdiction	Date Issued	Expiration Date	License Number	Current Status

**11. Name/Address of Intended Employment within the CNMI:**


*If you answer "yes" for any of items 12-26 you must attach a detailed explanation on a separate sheet, which includes state or country where action is pending or took place, relevant dates, action taken and reasons for such action. (Include Findings of Fact, Conclusion of Law, Final Order and whether you have been reinstated. If reinstated, date and conditions of license.*

<b>12.</b> Since the date of your last application for a license in the Commonwealth or within the past two years, have you ever been charged with, or been found to have committed dishonorable, unprofessional conduct, negligence, incompetence, misconduct, or repeated negligent acts against you for your profession by any licensing board, other agency, or healthcare facility?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>13.</b> Since the date of your last application for a license in the Commonwealth or within the past two years, has a claim or an action ever been filed against you for your profession which resulted in a settlement, judgment, or arbitration award of \$25,000 or more?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>14.</b> Since the date of your last application for a license in the Commonwealth or within the past two years, has any licensing board, other agency, or disciplinary authority refused to issue you a license, renew your license, suspended, revoked, accepted surrender of your license, placed on probation or conditioned your license, held by you now or previously, or ever fined or otherwise disciplined you?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

15. Since the date of your last application for a license in the Commonwealth or within the past two years, is there any ongoing or pending investigation against you?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
16. Since the date of your last application for a license in the Commonwealth or within the past two years, is there any disciplinary action pending against you?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
17. Since the date of your last application for a license in the Commonwealth or within the past two years, has any healthcare facility or training program restricted or terminated your professional training, employment, or privileges or have you ever voluntarily or involuntarily resigned or withdrawn from such association to avoid imposition of such measures?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
18. Since the date of your last application for a license in the Commonwealth or within the past two years, has your ability to practice your profession in a competent and safe manner ever been impaired or limited by any condition, behavior, impairment, or limitation of a physical, mental, or emotional nature?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
19. Since the date of your last application for a license in the Commonwealth or within the past two years, have you used or are you currently using any chemical substances(s), legal or illegal, that in any way impaired or limited, or is currently impairing or limiting, your ability to practice your profession in a safe and competent manner?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
20. Since the date of your last application for a license in the Commonwealth or within the past two years, have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
21. Since the date of your last application for a license in the Commonwealth or within the past two years, have you been treated for or had a recurrence or a diagnosed addictive disorder?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
22. Since the date of your last application for a license in the Commonwealth or within the past two years, have you ever been diagnosed with a neurological or other physical condition that would impair your ability to practice your profession safely?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
23. Since the date of your last application for a license in the Commonwealth or within the past two years, do you have any other condition in which in any way impairs or limits your ability to practice your profession safely?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
24. Since the date of your last application for a license in the Commonwealth or within the past two years, have you ever been found guilty, pleaded guilty, no contest, or nolo contendere to a crime involving moral turpitude or crime related to your profession, or felony in any court?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
25. Since the date of your last application for a license in the Commonwealth or within the past two years, is there any criminal action pending against you in any court?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
26. Since the date of your last application for a license in the Commonwealth or within the past two years, are you required to register as a Sex Offender?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

**27. DECLARATION:**

I hereby certify that I am the person herein named subscribing to this application. I have read the complete application, and I know the full content hereof. I declare that all of the information contained herein and evidence or other credentials submitted herewith are true and correct. I understand that any falsification or misrepresentation of any item or response in this application, or any attachment hereto or falsification or misrepresentation of credentials to support this application, is sufficient grounds for denying, revoking, or otherwise disciplining a license to practice a health profession in the Commonwealth of the Northern Mariana Islands. I further certify that I have read and will abide by P.L. 15-105 and the HCPLB Regulations regulation my health profession.

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

\_\_\_\_\_  
Date

*Please complete the application form and attach the renewal fee (money order or cashier's check make payable to "CNMI Treasurer"). Do not send Cash.*

**AUTHORIZATION FOR RELEASE OF INFORMATION**

I, \_\_\_\_\_ (print name), do hereby authorize a disclosure of records concerning myself to the Health Care Professions Licensing Board (HCPLB). This release includes records of a public, private or confidential nature.

I acknowledge that the information released to the HCPLB may include material that is protected by federal and/or state laws applicable to substance abuse and mental health information. If applicable, I specifically authorize the release of confidential information to and from the HCPLB relating to substance abuse or dependence and/or mental health.

I further agree that the HCPLB may receive confidential information and records, including, but not limited to the following records:

- Medical Records
- Education Records
- Personnel or employment records, including records of any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Post-graduate training (internship, residency, and fellowship) records, including records or any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Any information the HCPLB deems reasonably necessary for the purposes set forth in this release.

**Release of Liability:**

I do hereby irrevocably and unconditionally release, covenant not to sue, and forever discharge any person or entity, including but not limited to any medical school, residency or fellowship training program, hospital, health care provider, health care facility, licensing board, impaired practitioner program, agency, or organization, which releases information to the HCPLB pursuant to this release from any liability, claim, or cause of action arising out of the release of such information. I further irrevocably and unconditionally release, covenant not to sue, and forever discharge the HCPLB, the Commonwealth of the Northern Mariana Islands, and its employees and agents from any liability, claim, or cause of action arising out of the collection or release of information pursuant to this release.

A photocopy of this release form will be valid as an original thereof, even though the photocopy does not contain an original writing of my signature.

I have read and fully understand the contents of this "Authorization to Release Information".

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

\_\_\_\_\_  
Date