ACCREDITATION CANDIDATE APPLICATION-CLINICS
AMERICAN ASSOCIATION OF INTEGRATIVE MEDICINE

Complete this form on your computer, print, sign, and submit the form and **all** required exhibits, including the application fee to AAIM. If you have submission questions, please contact AAIM toll-free at (877) 718-3053.

Type of application: ☐ **Initial** ☐ **Reaccreditation**

Fee: Check Number (Exhibit 1)

I. MAIN CLINIC INFORMATION

All of the questions in this application pertain to the site immediately listed below unless otherwise indicated. For AAIM accreditation purposes, this site is designated as the main clinic. *All correspondence will be sent to the main clinic.*

1. Clinic Name:

2. License or Accreditations:

3. Physical Address:

4. Telephone & Fax Numbers:

5. E-mail & Website:

6. Contact Person's name, title, and e-mail address:

7. Clinic Specialty:

8. How long organization has been in existence:

9. Name(s) of all Licensed Practitioner(s) (attach Curriculum Vitae):

10. Submit a statement describing the clinic's integrative care philosophy with a description of how it is implemented. Describe how the various modalities are integrated with one another.

11. Show evidence that each licensed practitioner has directly and personally experienced the modality of his/her clinic partners.

II. LEGAL NATURE OF THE CLINIC

1. Indicate the legal tax status of your clinic by checking the appropriate box:

   ☐ For-profit entity

   ☐ Non-profit entity (If a non-profit entity, you must provide, as **Exhibit 2**, written notice from the IRS acknowledging such status).

2. Identify the type of legal entity of the clinic by checking all that apply:

   ☐ Wholly owned subsidiary
   ☐ Partnership
   ☐ Sole Proprietorship
   ☐ Limited Liability Company (LLC)
   ☐ Limited Partnership (LP)
   ☐ Professional Trade Association
   ☐ Other, please specify:

3. Federal Employee Identification Number (EIN):

4. Fiscal Year End Date: / (month/day)

5. Is there a legal name or corporate name other than the name indicated in Section 1, "Main Clinic Information?" ☐ Yes ☐ No

   If yes, provide the legal name or corporate name and the state under whose laws the entity is organized.

   Name:
   State:

6. Has the clinic ever been investigated for any reason? ☐ Yes ☐ No

   If yes, why, and what was the outcome?

7. Has any other clinic associated with the clinic's founder, principle, or staff member, ever been investigated, shut down, or placed on probation? ☐ Yes ☐ No

   If yes, please explain.

8. Has any practitioner or staff person been: (a) convicted or pled no contest or guilty to a crime (b) judicially determined to have committed fraud (c) debarred by an accrediting agency and/or state/federal agency? ☐ Yes ☐ No

   If yes, provide, as **Exhibit 3**, a detailed narrative explanation of: (a) the crime involving the acquisition, use, or expenditure of public funds; (b) committed fraud involving fiduciary

responsibility; or (c) debarment by an accrediting agency and/or state/federal agency.

9. Is any employee that works in the clinic currently on probation? ☐ Yes ☐ No

   If yes, please explain.

10. Provide a copy of your malpractice insurance policy as **Exhibit 4**.

11. Provide a copy of your professional liability insurance policy as **Exhibit 5**.

III. OFFSITE ADMINISTRATIVE HEADQUARTERS/OFFICES

1. Does the clinic have a corporate or administrative office other than the main clinic?

   ☐ Yes ☐ No

   If yes, please complete the following:
   Name of Office:
   Corporate Name:
   Street Address:
   City/State/Zip:
   Telephone Number:
   FAX Number:
   E-mail Address:
   Contact person's name:
   Contact person's title:
   Contact person's e-mail:

IV. ADDITIONAL SITES

1. Does the clinic operate sites in addition to the main location? ☐ Yes ☐ No

   If no, please proceed to Section V, "Ownership Information." If yes, complete the following:
   A. Number of Sites

2. Additionally, please complete and provide, as **Exhibit 6**, the "Additional Location Addendum."

V. OWNERSHIP INFORMATION

1. The clinic has been under continuous operation under the ownership described herein since what date? / (month/year)

2. Provide a brief professional background of the clinic's founder(s).

VI. LICENSE/APPROVAL INFORMATION

1. Is the clinic required to obtain state authorization (e.g., licensure, certification, approval) to operate? ☐ Yes ☐ No

2. Has the clinic been subject to any limitation, suspension, or termination by a state or federal government agency? ☐ Yes ☐ No

If yes, provide, as **Exhibit 7**, a narrative explanation and relevant documentation regarding this action.

VII. ACCREDITATION HISTORY

1. Has the clinic previously held, applied for, been denied, or been withdrawn from accredited status with an accrediting agency? ☐ Yes ☐ No

   If yes, provide, as **Exhibit 8**: (a) a detailed written narrative indicating the name under which the clinic made application, the name of the agency, and a chronology of significant events relative to that status; and (b) a copy of the denial/withdrawal/resignation letter as applicable.

2. Does the clinic presently hold accreditation with another accrediting agency?

   ☐ Yes ☐ No

   If yes, what is the name of the accrediting agency, issue date, and expiration date?

VIII. FINANCIAL INFORMATION

1. Provide, as **Exhibit 9**, a list and description of the sources of funds used for the operation of your clinic and associated liabilities.

2. Provide, as **Exhibit 10**, a description of the financial controls in place to ensure the independence of the clinic.

IX. ADDITIONAL INFORMATION

1. Provide, as **Exhibit 11**, examples of promotional materials utilized by the clinic.

2. Provide, as **Exhibit 12**, a copy of the clinic's privacy policy.

X. ATTESTATION

Verification Statement

I certify that the information I have provided to the American Association of Integrative Medicine (AAIM) is true, correct, and complete. I may be asked to provide additional documentation at a later time. I understand that AAIM reserves the right to verify any and all information that I provide. If information is misrepresented or if a request to provide additional documentation is refused, I understand and agree that my application will be rejected. I agree that I will notify AAIM in writing of any civil, criminal, action, or complaint that is made against me or anyone involved in the program. I agree to hold harmless and indemnify AAIM and its officers, directors, employees, and agents for any misrepresentation of credentials and for all claims, loss, judgment, or expense. AAIM does not endorse, guarantee, or warrant the work or opinions of any individuals. Accreditation does not imply licensing or registration by the organization of an individual's qualifications, abilities, or expertise. The objective of the activities that AAIM sponsors is to raise the standards of the profession.

The undersigned, authorized representative of this clinic hereby attests to the following statements:

I have read our application for accreditation and affirm that it and all attached materials are accurate and complete.

During the application process and upon and following accreditation, the clinic will abide by and support the following:

- The AAIM Eligibility Requirements;
- The AAIM Standards for Accreditation;
- The AAIM policies, procedures and practices
- The goals and integrity of the accreditation process

During the application process and upon and following accreditation, the clinic will timely notify AAIM of any changes in contact information.

The clinic consents to the exchange of information between AAIM and the clinic's lawyers and accountants and between AAIM and all other accrediting agencies and state and federal administrative agencies to the extent that such exchange of information is necessary or convenient to the consideration of the clinic's application for AAIM accreditation.

Name: ______________________________

Title: ______________________________

Signature of Attesting Party: ____

(**Note**: Non-profit organizations must provide the name and signature of the chairman of the board and/or the managing director of the applicant institution.)