# Application for Chiropractic Medical Faculty Certificate

**Board *of* Chiropractic Medicine**
**P.O. Box 6330**
**Tallahassee, FL 32314-6330**
**Website: floridaschiropracticmedicine.gov**
**Email: info@floridaschiropracticemedicine.gov**
**Phone: (850)245-4355**
**Fax: (850) 922-8876**

DH-MQA 1146, Revised 6/2020, Rule 64B2-12.022, F.A.C.

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**Do Not Write in this Space**
**For Revenue Receipting Only**

**Chiropractic Medical Faculty Certificate** (1010) **$205.00**

**Total fee of $205.00 includes the following:**

| | |
|---|---|
| Application Fee | $100.00 |
| Licensure Fee | $100.00 |
| Unlicensed Activity Fee | $5.00 |

Fees must be paid in the form of a cashier's check or money order, made payable to the Department of Health. An applicant who is denied licensure or withdraws their application is entitled to a $105.00 (Licensure Fee and Unlicensed Activity Fee) refund. Requests to withdraw or for a refund must be made in writing. Certain fees are refundable for up to three years from the date of receipt.

## 1. PERSONAL INFORMATION

**Name:** _____ **Date of Birth:** _____
Last/Surname First Middle MM/DD/YYYY

**Mailing Address:** (The address where mail and your license should be sent)

_____ _____ _____
Street/P.O. Box Apt. No. City

_____ _____ _____ _____
State ZIP Country Home/Cell Telephone (Input without dashes)

**Physical Location:** (Required if mailing address is a P.O. Box- This address will be posted on the Department of Health's website)

_____ _____ _____
Street (Place of Employment) Apt. No. City

_____ _____ _____ _____
State ZIP Country Work/Cell Telephone (Input without dashes)

**EQUAL OPPORTUNITY DATA:**

We are required to ask that you furnish the following information as part of your voluntary compliance with 41 CFR Part 60-3-Uniform Guidelines on Employee Selection Procedure (1978); 43 FR 38295 and 38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

Gender: Male Female

Race: Native Hawaiian or Pacific Islander; American Indian or Alaska Native; Two or More Races; Hispanic or Latino; Black or African American; White; Asian

**Email Notification:** To be notified of the status of your application by email, check the "Yes" box and fill in your email address on the line provided. If you choose to be notified via email you will be responsible for checking your email regularly and updating your email address with the board office.

Yes No Email Address: _____

Under Florida law, email addresses are public records. If you do not want your email address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

2. SOCIAL SECURITY DISCLOSURE

**This information is exempt from public records disclosure.**

Pursuant to Title 42 United States Code § 666(a)(13), the department is required and authorized to collect Social Security numbers relating to applications for professional licensure. Additionally, section (s.) 456.013(1)(a), Florida Statutes (F.S.), authorizes the collection of Social Security numbers as part of the general licensing provisions.

**Last Name:** _____

**First Name:** _____

**Middle Name:** _____

**Social Security Number:** _____
(Input without dashes)

**Social Security Information-** * Under the Federal Privacy Act, disclosure of Social Security numbers is voluntary unless specifically required by federal statute. In this instance, Social Security numbers are mandatory pursuant to Title 42 United States Code § 653 and 654; and s. 456.013(1), 409.2577, and 409.2598, F.S. Social Security numbers are used to allow efficient screening of applicants and licensees by a Title IV-D child support agency to ensure compliance with child support obligations. Social Security numbers must also be recorded on all professional and occupational license applications and will be used for license identification pursuant to Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act. 104 Pub. L. Section 317). Clarification of the SSA process may be reviewed at www.ssa.gov or by calling 1-800-772-1213.

Name: _____

## 3. APPLICANT BACKGROUND

A. List any other name(s) by which you have been known in the past. Attach additional sheets if necessary.

_____

B. Do you hold, or have you ever held a license to practice Chiropractic Medicine or any other health-related license(s)? Yes No

C. List all health-related licenses (active, inactive or lapsed).

| License Type | License # | State/Country | Original Date Issued (MM/DD/YYYY) | Expiration Date (MM/DD/YYYY) | Status of License |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**Submit a License Verification** form to **ALL** your state(s) of licensure. License verifications must be received directly from the licensing authority regardless of the status of the license.

D. Have you ever been a defendant in a military court-martial? Do not include parking or speeding violations.
Yes No

## 4. EDUCATION HISTORY

A. List undergraduate, graduate, and professional education, listing all schools, colleges and universities attended, whether completed or not, in chronological order.

| School Name | City/State | Dates of Attendance: From-To (MM/DD/YYYY) | Graduation Date (MM/DD/YYYY) | Degree Awarded |
|---|---|---|---|---|
| | | to | | |
| | | to | | |
| | | to | | |
| | | to | | |

**All applicants must have an official transcript forwarded from the Chiropractic College directly to the board office from your educational program. Diplomas and student copies are not acceptable. Transcripts should be sent to:**

Board *of* Chiropractic Medicine
4052 Bald Cypress Way Bin C-07
Tallahassee, FL 32399-3257

B. List all professional/postgraduate training you completed from the date of graduation of the Chiropractic Medical School to the present.

| Program Name | City/State or Country | Dates of Attendance: From-To (MM/DD/YYYY) | Program Type | Specialty Area | Credit Rec'd |
|---|---|---|---|---|---|
| | | to | | | Y N |
| | | to | | | Y N |
| | | to | | | Y N |
| | | to | | | Y N |

Name: _____

**This information is exempt from public records disclosure.**

## 5. HEALTH HISTORY

The board and the department, as part of its responsibility to protect the health, safety, and welfare of the public, must assess whether an applicant manifests any physical, mental health, or substance use issue that impairs the applicant's ability to meet the eligibility requirements for a health care practitioner as defined in chapter (ch.) 456, F.S., and the applicable statutory practice acts.

The board and the department support applicants seeking treatment and views effective treatment by a licensed professional as enhancing the applicant's ability to meet the eligibility requirements to practice a health care profession.

Seeking assistance with stress, mild anxiety, situational depression, family or marital issues will not adversely affect the outcome of a Florida health care practitioner application. The board and the department do not request that applicants disclose such assistance.

1. During the last two years, have you been treated for or had a recurrence of a diagnosed physical or mental disorder that impaired or impairs your ability to practice? Yes No
2. During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol or drug) disorder that impaired or impairs your ability to practice? Yes No

**If a "Yes" response was provided** to any of the questions in this section, provide the following documents directly to the board office:

**A letter from a licensed health care practitioner**, who is qualified by skill and training to address the condition identified, which explains the impact the condition may have on the ability to practice the profession with reasonable skill and safety. The letter must specify that the applicant is safe to practice the profession without restrictions or specifically indicate the restrictions that are necessary. Documentation provided must be dated within one year of the application date.

**A written self-explanation**, identifying the medical condition(s) or occurrence(s); and current status.

Name: _____

## 6. DISCIPLINE HISTORY

A. Have you ever had any disciplinary action taken by the licensing authority of any state or are you the subject of any pending investigation or disciplinary action? Yes No

**If you responded "Yes," complete the following:**

| Name of Agency | State | Action Date (MM/DD/YYYY) | Final Action | Under Appeal? |
|---|---|---|---|---|
| | | | | Y N |
| | | | | Y N |
| | | | | Y N |

**If you responded "Yes" to any of the questions in this section, you must provide the following:**

**A written self-explanation**, describing in detail the circumstances surrounding the disciplinary action.

A copy of the **Administrative Complaint** and **Final Order**.

## 7. CRIMINAL HISTORY

Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to any crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies, even if adjudication was withheld.

Reckless driving, driving while license suspended or revoked (DWSLR), driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question. Yes No

**If you responded "Yes," complete the following:**

| Offense | Jurisdiction | Date (MM/DD/YYYY) | Final Disposition | Under Appeal? |
|---|---|---|---|---|
| | | | | Y N |
| | | | | Y N |
| | | | | Y N |

**If you responded "Yes" to any of the questions in this section, you must provide the following:**

**A written self-explanation**, describing in detail the circumstances surrounding each offense; including dates, city and state, charges and final results.

**Final Dispositions** and **Arrest Records** for all offenses. The Clerk of the Court in the arresting jurisdiction will provide you with these documents. Unavailability of these documents must come in the form of a letter from the Clerk of the Court.

**Completion of Sentence Documents**. You may obtain documents from the Department of Corrections. The report must include the start date, end date, and that the conditions were met.

Name: _____

## 8. CRIMINAL AND MEDICAID/MEDICARE FRAUD QUESTIONS

**IMPORTANT NOTICE:** Applicants for licensure, certification, or registration and candidates for examination may be excluded from licensure, certification, or registration if their felony convictions fall into certain timeframes as established in s. 456.0635(2), F.S.

1. Have you been convicted of, or entered a plea of guilty or nolo contendere, regardless of adjudication, to a felony under chapter (ch.) 409, F.S. (relating to social and economic assistance), ch. 817, F.S. (relating to fraudulent practices), ch. 893, F.S. (relating to drug abuse prevention and control), or a similar felony offense(s) in another state or jurisdiction? Yes No

**If you responded "No" to the question above, skip to question 2.**

   a. If "Yes" to 1, for the felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence, and completion of any subsequent probation? Yes No

   b. If "Yes" to 1, for the felonies of the third degree, has it been more than ten years from the date of the plea, sentence, and completion of subsequent probation (this question does not apply to felonies of the third degree under s. 893.13(6)(a), F.S.)? Yes No

   c. If "Yes" to 1, for the felonies of the third degree under s. 893.13(6)(a), F.S., has it been more than five years from the date of the plea, sentence, and completion of any subsequent probation? Yes No

   d. If "Yes" to 1, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or the charges dismissed (if "Yes," provide supporting documentation)? Yes No

2. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, to a felony under 21 U.S.C. ss. 801-970 or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)? Yes No

**If you responded "No" to the question above, skip to question 3.**

   a. If "Yes" to 2, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended? Yes No

3. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to s. 409.913, F.S.? Yes No

**If you responded "No" to the question above, skip to question 4.**

   a. If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years? Yes No

4. Have you ever been terminated for cause, pursuant to the appeals procedure established by the state, from any other state Medicaid program? Yes No

**If you responded "No" to the question above, skip to question 5.**

   a. Have you been in good standing with a state Medicaid program for the most recent five years? Yes No

   b. Did the termination occur at least 20 years before to the date of this application? Yes No

Name: _____

5. Are you currently listed on the United States Department of Health and Human Services' Office of the Inspector General's List of Excluded Individuals and Entities (LEIE)? Yes No

   a. If you responded "Yes" to the question above, are you listed because you defaulted or are delinquent on a student loan? Yes No

   b. If you responded "Yes" to question 5.a., is the student loan default or delinquency the only reason you are listed on the LEIE? Yes No

**If you respond "Yes" to any of the questions in this section, you must provide the following:**

**A written self-explanation** for each question including the county and state of each termination or conviction, date of each termination or conviction, and copies of supporting documentation.

**Supporting documentation** including court dispositions or agency orders where applicable.

**Documents in sections 5, 6, 7 and 8 must be mailed to:**

Board *of* Chiropractic Medicine
4052 Bald Cypress Way Bin C-07
Tallahassee, FL 32399-3257

## 9. PRACTICE INFORMATION

List the Florida-based school/college where you have been offered and accepted a full-time faculty appointment to teach in a program of Chiropractic Medicine.

**You must submit a letter on letterhead from the Dean of the program confirming the appointment.**

_____
(School /College Name)

## 10. APPLICANT SIGNATURE

I, the undersigned, state that I am the person referred to in this application for licensure in the state of Florida.

I recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to s. 456.067, 775.083 and 775.084, F.S.

Florida law requires me to immediately inform the board of any material change in any circumstances or condition stated in the application which takes place between the initial filing and the final granting or denial of the license and to supplement the information on this application as needed.

Section 456.013(1)(a), F.S., provides that an incomplete application shall expire one year after the initial filing with the department.

Applicant Signature _____ Date _____
*You may print out the application and sign it or sign digitally.* MM/DD/YYYY

**Complete verifications must be mailed directly from the licensing agency to:**

**Board *of* Chiropractic Medicine**
4052 Bald Cypress Way Bin C-07
Tallahassee, FL 32399-3257

# Florida Board *of* Chiropractic Medicine License Verification Request

**Part I: To be completed by applicant** (Florida requires verification of all your current and previously held licenses.)

Name: _____

Address: _____

Name original license was issued under: _____

License Number: _____ State: _____

*I hereby authorize release of any information regarding my licensure status to the Florida Board of Chiropractic Medicine.*

Applicant Signature: _____ Date: _____
MM/DD/YYYY

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**Part II: To be completed by state licensing agency**

All verifications must be in English and include the following criteria:

* Typed on an official state form or letterhead
* Include an official board seal
* Signature and title of state board official

The following information must be included in all verifications:

* Licensee name
* License number
* State or jurisdiction of licensure
* Licensure status
* Is license in good standing?
* Date of issuance/expiration
* Licensure method (examination, reciprocity/endorsement)
* Has this license ever been encumbered (denied, revoked, suspended, surrendered, limited, placed on probation)?
* If this license has ever been encumbered, please provide certified copies of documentation regarding the action with the completed license verification.