

GENERAL INFORMATION/INSTRUCTIONS

Application for Chiropractic Examination & Initial Licensure

HOW TO APPLY FOR FLORIDA CHIROPRACTIC LICENSURE

*** PLEASE TYPE OR PRINT IN BLACK INK - PLEASE READ CAREFULLY ***

1. FLORIDA LAWS & RULES:

You may download a copy of Chapter 460, Florida Statutes and Rule Chapter 64B2, Florida Administrative Code at www.doh.state.fl.us/mqa/chiro/index.html It is important to read this in order to determine your eligibility prior to applying, and to familiarize yourself with the statutes and board rules regarding your application for licensure and the practice of the chiropractic profession within the State of Florida.

2. APPLICANT'S QUESTIONS REGARDING APPLICATION STATUS:

Within thirty (30) days after we receive your application and fee, we will send you an acknowledgment letter informing you of any deficiencies in your application and the specific items required to complete your application. If you do not receive notice that we have received your application within forty-five (45) days of the date you mailed it, or if you have questions concerning the requirements for licensure, please do not hesitate to contact this office. If you have questions concerning whether or not we have received items which we require you to arrange to be sent to this office by a third party (such as official transcripts, licensure verifications from state licensing agencies); please check with the third party first to see if the required documentation has been sent. As a reminder to all applicants, Chapter 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after initial filing with the department.

3. YES/NO QUESTIONS:

All questions with a "Yes or No" answer must be marked with either a "Yes" or "No" as no other response is acceptable. For questions which require a brief explanation or description to "Yes" answers, your responses must be sufficiently detailed to ascertain the **relevant dates**, institution/organization names, and a brief synopsis of the reasons (i.e., the final charges or substantiated allegations only) the institution/organization took the disciplinary or other action (i.e., probation, limitation, suspension, revocation, voluntary relinquishment in lieu of disciplinary action, or any other adverse action). **HOWEVER, IF A QUESTION CONTAINED IN THIS APPLICATION IS NOT APPLICABLE ANSWER "N/A" IN THE NO COLUMN. Certified or notarized documentation of final disposition to "yes" answers is required.**

4. FEE SCHEDULE:

A certified check or money order in the appropriate amount, made payable to the Department of Health, must be attached to your application. Please staple the check or money order to page 1 of the application on the upper left part of the form. Your application will not be processed without these fees. These fees are required by law and include the following:

1. Laws & Rules CBT:

Application Fee	\$100.00 (non-refundable)
Examination Fee	\$170.00
Total Fee	\$270.00

- Acupuncture Certification: (optional)

Application Fee	\$100.00 (non-refundable)
Total Fee	\$100.00

2. Criminal History Background Check:

Total Fee	\$ 48.00 (non-refundable)
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3. Initial License Fee:

Initial License Fee	\$355.00 (refundable if fail)
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5. REQUIRED EXAMINATION INFORMATION:

- Florida Laws and Rules (CBT)
- National Board of Chiropractic Examiners (NBCE) Scores: Official NBCE Scores for parts **I, II, III, IV & PT**
- CHIROPRACTIC ACUPUNCTURE CERTIFICATION (Optional): National Board of Chiropractic Examiners (NBCE)

6. SPECIAL TESTING ACCOMMODATIONS:

Special Testing Accommodations Due to Disability: Rules regarding examination procedures for candidates with disabilities are outlined in Rule 64B-1.005, F.A.C. In accordance with Rule 64B-1.005, F.A.C., the Department will provide reasonable and appropriate special testing accommodations to candidates with physical or learning disabilities to the extent permitted by cost, examination administration constraints, examination security considerations and availability of resources. Candidates requesting special testing accommodations must file a completed application with Practitioner Reporting & Examination Services. It is the responsibility of the candidate to provide adequate documentation of his/her disability.

Requests from Candidates Previously Receiving Special Testing Accommodations: Applicants who have previously received special testing accommodations for an examination and need accommodation for another examination or for a retake of the same examination in Florida must file a reapplication with Practitioner Reporting & Examination Services, Bureau of Operations each time accommodation is needed.

7. FINGERPRINT CARDS:

Two Fingerprint Cards: Two properly executed fingerprint cards are required to be submitted with the application. To obtain the fingerprint cards, please visit www.fldoh.sofn.net.

8. PREVENTION OF MEDICAL ERRORS:

A two hour course on the prevention of medical errors is required for licensure. Please refer to CEBroker's website at www.cebroker.com and click the Florida Course Search quick link for a list of approved courses.

9. UNDERGRADUATE TRANSCRIPT:

A final official transcript must be sent directly from the educational institution/college to this office. Transcripts submitted by the applicant or indicating "issued to student" are not acceptable; a copy of your diploma will not be accepted in lieu of an official transcript. Please note that it is your responsibility to follow-up with your educational institutions to ensure that they have received and complied with your requests.

10. CHIROPRACTIC COLLEGE TRANSCRIPT:

A final official transcript stating the degree and date of confirmation must be sent directly from the chiropractic school/college to this office. Transcripts submitted by the applicant or indicating "issued to student" are not acceptable. A copy of your diploma is not acceptable. Please note that it is your responsibility to follow-up with your educational institutions to ensure that they have received and complied with your requests. A student in a school or college of chiropractic accredited by the Council on Chiropractic Education or its successor in the final year of the program must have the college submit a letter with your matriculation date and anticipated date of graduation.

11. LICENSURE VERIFICATION:

The licensure verification forms included with this application package must be sent to each state or other licensing authority where you currently hold or have held a license to practice, regardless of the status of the license. These forms must be sent directly from each state licensing agency to this office. Please note that it is your responsibility to follow-up with licensing agencies to ensure that they have received and complied with your requests. **A copy of your license will not be accepted in lieu of official verification from the licensing agency.**

12. NATIONAL BOARD OF CHIROPRACTIC EXAMINERS (NBCE) SCORES:

Official NBCE Scores for parts **I, II, III, IV & PT** must be sent directly from National Board to this office. Again, please note that it is your responsibility to follow-up with NBCE to ensure that they have received and complied with your requests. The board may require an applicant who graduated from an institution accredited by the Council on Chiropractic Education more than 10 years before the date of application to the board to take the National Board of Chiropractic Examiners Special Purposes Examination for Chiropractic, or its equivalent, as determined by the board.

13. ACUPUNCTURE COURSE (Acupuncture Certification Applicants Only):

Proof of completion of and 100 hour course in acupuncture from the issuing agency and proof of completion of NBCE Acupuncture Examination.

14. FINANCIAL RESPONSIBILITY/PROFESSIONAL LIABILITY COVERAGE:

The Professional Liability section must be completed by selecting the appropriate option and submitting the required documentation. Proof of liability coverage is not required until your license is issued and must be sent directly from the company to the board office.

15. NATIONAL PRACTITIONER DATA BANK SELF-QUERY:

Applicants are required to complete a self query to the National Practitioner Data Bank (NPDB) and upon receipt of the report, provide the Board office with a copy. A fee is charged to furnish this information. You can contact NPDB @ Post Office Box 10832, Chantilly, VA 22021, telephone number (800) 767-6732, or website www.npdb-hipdb.com/welcomesq.html

PLEASE NOTE--YOUR APPLICATION IS NOT CONSIDERED COMPLETE UNTIL ALL SUPPORTING DOCUMENTS AND FEES HAVE BEEN RECEIVED BY THIS OFFICE.

Computer Based Test Information

Once you have received your notification of eligibility from the board office, you may contact Prometric to pay the CBT examination fee and schedule your examination.

COMPUTER BASED TEST FEES

Please Note—Fees are required in addition to the fees already submitted to the board.

Chiropractic Laws/Rules Fee – \$50.50

- This fee shall be paid to Prometric.
- The fee may be paid by Visa, MasterCard, American Express, or electronic check.
- Payment will be due at the time of scheduling.

SCHEDULING:

- You must schedule your examination appointment with Prometric. You may contact Prometric via telephone or Internet at the contact information listed on the last page of the Candidate Information Booklet (CIB).
- When contacting Prometric, you must select/state that you are taking a “Florida Department of Health” examination.
- **You will be required to provide your social security number (as your testing/eligibility ID) in order to schedule your examination.**
- All examination dates, times, and locations will be scheduled on a first-come first-serve basis.

RESCHEDULING:

- You may reschedule your examination appointment as needed, without penalty, up to two days prior to your examination.
- **If you attempt to reschedule your examination within two days of your appointment, you will be considered a “late cancel.” You must then wait at least three (3) days from the date of your appointment before you may reschedule your examination. You will be required to repay the examination fee.**
- One form of **valid, current, government-issued identification** with both a signature and a photo.
- Driver’s License; OR
- State I.D. card; OR
- Military I.D.; OR
- Passport

NOTE: The name on your eligibility record (from your examination application submitted to the Board Office) must match the name on the ID you present at the Prometric testing center. If these names do not match, you will not be allowed to test. To change the name on your eligibility record, contact the Board Office.

Note: If you do not fill in your social security number, your application will be delayed. You must possess a social security number prior to receiving a license.

16. If the package that you are mailing to the Board Office contains money, mail to:

**DEPARTMENT OF HEALTH
Post Office Box 6330
Tallahassee, Florida 32314-6330**

17. If the package that you, or anyone on your behalf, is mailing to the Board Office does NOT contain money, mail to:

**Board of Chiropractic Medicine
4052 Bald Cypress Way, Bin #C07
Tallahassee, Florida 32399-3257**

You can also visit the board's web site for additional information at www.doh.state.fl.us/mqa/chiro/index.html

NOTE: Language interpretation services are available to applicants for licensure who have limited-English proficiency or a hearing/speech impairment. If you need an interpreter in order to talk with your application processor, please indicate that information when you call the board office. An interpreter and the processor will call you back shortly in order to handle your call.

FEDERAL PRIVACY ACT:

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, Sections 653 and 654: and sections 456.013, 409.257(7) and 409.259(8), F. S.** Social security numbers are used to allow efficient screening of applicants and licensees by a Title IV-D child support agency to assure 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 verification pursuant to, unless exempt as outlined in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act), 104 Pub. L. 193, Section 317.

CHIROPRACTIC MEDICINE

INITIAL APPLICANT CHECKLIST

1. **FEES:** Please include ALL FEES in "ONE Certified Check or Money Order" made payable to the DEPARTMENT OF HEALTH.
- _____ **Examination Application Fee: \$673.00**
 - _____ **Acupuncture Certification Fee: (optional) \$100.00**
2. **SOCIAL SECURITY NUMBER** page is required
3. **CHIROPRACTIC COLLEGE TRANSCRIPT:** (sent directly from school)
4. **UNDERGRADUATE HOURS/DEGREE:** (sent directly from school)
5. **LICENSE VERIFICATIONS:** (sent directly from the licensing authority)
6. **NATIONAL BOARD SCORES (I, II III, IV & PT), and (ACUPUNCTURE),** if applicable.
7. **NPDB SELF-QUERY: National Practitioner Data Bank Self-Query:**
(visit www.npdb-hipdb.com/welcomesq.html)
8. **COMPLETION OF ACUPUNCTURE COURSE (if applicable):** Board approved 100 hour course in acupuncture
9. **2 HOUR PREVENTION of MEDICAL ERRORS COURSE:** (visit www.cebroker.com)
10. **STATEMENT OF FINANCIAL RESPONSIBILITY**
11. **LIABILITY CLAIMS:** If you answer any of these questions "yes" you must complete an **EXHIBIT 1 REPORT ON PROFESSIONAL LIABILITY CLAIMS AND ACTIONS** form for each claim.
12. **TWO FINGERPRINT CARDS:** To obtain the fingerprint cards, please visit www.fldoh.sofn.net.

PLEASE NOTE:

- All questions must be answered.
- All "yes" answers must be supported by a certified copy of the final disposition of the case from the clerk of court in the county where the conviction took place.

RE-EXAMINATION APPLICANT CHECKLIST

1. **FEES:** Please include ALL FEES in "ONE Certified Check or Money Order" made payable to the DEPARTMENT OF HEALTH.
- _____ **Re-Examination Fee: \$270.00**
2. **SOCIAL SECURITY NUMBER** page is required

PLEASE NOTE:

- All questions must be answered.
- All "yes" answers must be supported by a certified copy of the final disposition of the case from the clerk of court in the county where the conviction took place.

If reapplying within one year from the original application DOCUMENTATION DOES NOT NEED TO BE RESUBMITTED.



**CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS
DISCLOSURE**

**Florida Department of Health
Board of Chiropractic Medicine**

This page is exempt from public records disclosure. The Department of Health is required and authorized to collect Social Security Numbers relating to applications for professional licensure pursuant to Title 42 USCA § 666 (a)(13). For all professions regulated under Chapter 456, Florida Statutes, the collection of Social Security Numbers is required by section 456.013 (1)(a), Florida Statutes.

Name: _____
Last First Middle

Social Security Number: _____

APPLICANT HISTORY: (If you answer YES to the following questions, please provide additional sheets, the relevant dates and circumstances of such treatment and/or addiction along with the names and addresses of the medical practitioners or hospitals who performed such treatment.)

1. In the last five years, have you been enrolled in, required to enter into, or participated in any drug and/or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse that occurred within the past five years? [] YES [] NO
2. In the last five years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental disorder or impairment? [] YES [] NO
3. During the last five years, have you been treated for or had a recurrence of a diagnosed mental disorder or that has impaired your ability to practice within the past five years? [] YES [] NO
4. During the last five years, have you been treated for or had a recurrence of a diagnosed physical disorder that has impaired your ability to practice? [] YES [] NO
5. In the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol/drug) disorder or, if you were previously in such a program, did you suffer a relapse within the last five years? [] YES [] NO
6. During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol/drug) disorder that has impaired your ability to practice within the last five years? [] YES [] NO

Board of Chiropractic Medicine
4052 Bald Cypress Way, Bin #C07
Tallahassee, FL 32399-3257

BOARD OF CHIROPRACTIC MEDICINE
APPLICATION FOR LICENSURE
(Client: 501)

READ/DOWNLOAD APPLICATION INSTRUCTIONS FOR IMPORTANT INFORMATION

1. APPLICATION CATEGORY/APPLICABLE FEES: (TYPE OR PRINT LEGIBLY IN BLACK INK)

INITIAL EXAMINATION (1010)

- Laws/Rules **TOTAL: \$673.00**
- Including -Acupuncture Certification (optional) **TOTAL: \$773.00**

RE-EXAMINATION (1011)

- Laws/Rules **TOTAL: \$270.00**

APPLICANT PROFILE:

2. NAME:

(Last) (First) (Middle)

Have you ever changed your name through marriage, naturalization or action of a court, or been known by any other name?
 YES NO

If yes, provide the following: Name(s) (Last, First, Middle)

3. ADDRESS:

a. MAILING ADDRESS (where you receive mail):

(Street and number or PO Box) (City) (State/Province) (Zip/Postal Code) (Country)

b. PRIMARY PRACTICE/PHYSICAL ADDRESS (where you can be located-NO PO BOX):

(Street and number) (City) (State/Province) (Zip/Postal Code) (Country)

c. TELEPHONE:

Primary: Area Code/Phone Number Business: Area Code/Phone Number

d. EMAIL ADDRESS: _____

4. PERSONAL DATA:

BIRTH DATE: _____ BIRTH PLACE: _____
(Month/Day/Year) (City)(State/Province)(Country)

CITIZENSHIP: _____

We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniformed Guidelines on Employee Selection Procedure (1978) 43 FR38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

RACE: White Black Hispanic Asian/Pacific Islander Native American Other

SEX: Male Female

- Would you be willing to provide health services in special needs to shelters or to help staff disaster medical assistance teams during time of emergency or major disaster? YES NO

FOR OFFICE USE ONLY-DO NOT WRITE BELOW THIS LINE

EXAM DATE: _____ CANDIDATE NO: _____

INITIAL or RE-TAKE # _____

NAME : _____

EMPLOYMENT:

5. PRACTICE/EMPLOYMENT: List in chronological order from date of graduation to present date, all practice employment, non-employment and/or any unaccounted period of time into Chiropractic Medical school.

(Name of Business)	(Full Mailing Address)	(Type of Employment)	(From: MM/DD/YYYY To: MM/DD/YYYY)
(Name of Business)	(Full Mailing Address)	(Type of Employment)	(From: MM/DD/YYYY To: MM/DD/YYYY)
(Name of Business)	(Full Mailing Address)	(Type of Employment)	(From: MM/DD/YYYY To: MM/DD/YYYY)

EDUCATION and TRAINING:

6. UNDERGRADUATE/GRADUATE/PROFESSIONAL EDUCATION: Please provide undergraduate, graduate, and professional education, listing all schools, colleges and universities attended, whether completed or not, in chronological order.

(School Name)	(City/State)	(From: MM/DD/YYYY – To: MM/DD/YYYY)	(Graduation Date) (Degree Awarded)
(School Name)	(City/State)	(From: MM/DD/YYYY – To: MM/DD/YYYY)	(Graduation Date) (Degree Awarded)
(School Name)	(City/State)	(From: MM/DD/YYYY – To: MM/DD/YYYY)	(Graduation Date) (Degree Awarded)
(School Name)	(City/State)	(From: MM/DD/YYYY – To: MM/DD/YYYY)	(Graduation Date) (Degree Awarded)

7. POSTGRADUATE TRAINING: List in chronological order from date of graduation from the **Chiropractic Medical School** to the present, all professional/postgraduate training (Internship/Residency/Fellowship).

(Program Name)	(City/State or Country)	(Program Type)	(Specialty Area)	(From: MM/DD/YYYY – To: MM/DD/YYYY)	(Credit Received) Y/N
(Program Name)	(City/State or Country)	(Program Type)	(Specialty Area)	(From: MM/DD/YYYY – To: MM/DD/YYYY)	(Credit Received) Y/N

8. ACADEMIC/FACULTY APPOINTMENTS:

- a. Do you currently hold a faculty appointment at a medical school? YES NO
- b. Have you had responsibility for graduate medical education within the last 10 years? YES NO
(If yes, please complete the following information)

(Name of Institution)	(City/State)	(Title of Appointment)
(Name of Institution)	(City/State)	(Title of Appointment)

9. STAFF PRIVILEGES: Do you currently hold staff privileges in any hospital, health institution, clinic or medical facility? (DO NOT LIST TRAINING PRIVILEGES) YES NO

If yes, please complete the following: In-State Facility Out-of-State Facility

(Name of Facility)	(City/State)	(Type of Privileges)	(From: MM/DD/YYYY To: MM/DD/YYYY)
(Name of Facility)	(City/State)	(Type of Privileges)	(From: MM/DD/YYYY To: MM/DD/YYYY)

NAME : _____

SPECIALTY BOARD CERTIFICATION:

10. SPECIALTY BOARD CERTIFICATION: Are you certified by any Specialty Board recognized by the American Chiropractic Association or International Chiropractic Association? YES NO

(If yes, please provide the following information and enclose a copy of each certification or letter of verification)

(Board Name)	(Certification/Specialty/SubSpecialty)	(Date of Certification)
(Board Name)	(Certification/Specialty/SubSpecialty)	(Date of Certification)

LICENSURE INFORMATION:

11. LICENSURE INFORMATION: Do you hold or have you ever held a license to practice Chiropractic Medicine or any other profession in any U.S. State or territory, or foreign country? YES NO

(If yes, please list the year where you legally began to practice. This would be the date you began practicing chiropractic medicine and could be the date you began your postgraduate training.)

Year Began Practicing

_____ License Type	_____ License Number	_____ State/Country	_____/_____/_____ Original Date Issued	_____/_____/_____ Expiration Date
_____ License Type	_____ License Number	_____ State/Country	_____/_____/_____ Original Date Issued	_____/_____/_____ Expiration Date
_____ License Type	_____ License Number	_____ State/Country	_____/_____/_____ Original Date Issued	_____/_____/_____ Expiration Date

PLEASE NOTE: Verification of each license must be received directly from the licensing authority, regardless of status of license.

ALL AFFIRMATIVE ANSWERS MUST BE EXPLAINED IN DETAIL ON A SEPARATE SHEET. DOCUMENTATION SUBSTANTIATING THE EXPLANATION IS REQUIRED.

PROCEEDINGS and/or ACTIONS

APPLICATION ACTIONS:

12. APPLICATION:

- a. Have you had any application for professional license or any application to practice Chiropractic Medicine denied by any state board or other governmental agency of any state or country? YES NO
- b. Have you ever been notified to appear before any licensing agency for a hearing on a complaint of any nature including, but not limited to, a charge or violation of the Chiropractic Medicine practice act, unprofessional or unethical conduct? YES NO

If YES, please complete the following:

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

NAME : _____

EDUCATION AND TRAINING:

13. EDUCATION/POSTGRADUATE TRAINING:

Have you ever been placed on probation, restrictions, suspension, revocation modification, allowed to resign, requested to leave, temporarily or permanently or otherwise acted against by a Chiropractic/Professional training program prior to completion of training?

YES NO

If YES, list in chronological order from date of graduation from a Chiropractic/Professional college all professional/postgraduate training disciplinary actions to the present.

(Program Name and full mailing address required) (Institution/Hospital) From: MM/DD/YYYY To: MM/DD/YYYY

(Program Name and full mailing address required) (Institution/Hospital) From: MM/DD/YYYY To: MM/DD/YYYY

CRIMINAL HISTORY:

14. CRIMINAL INFORMATION: 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?

YES NO

If YES, you must include all misdemeanors and felonies, even if adjudication was withheld by the court so that you would not have a record of conviction. Driving under the influence or driving while impaired is not a minor traffic offense for purposes of this question.

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

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

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

DISCIPLINE ACTIONS HISTORY:

15. SPECIALTY BOARD CERTIFICATION: Have you ever had any final disciplinary actions taken against you by a specialty board recognized by the department.

YES NO

If YES, please complete the following:

(Specialty Board) (Action Date: MM/DD/YYYY) (Final Action) (Under Appeal? Y/N)

(Specialty Board) (Action Date: MM/DD/YYYY) (Final Action) (Under Appeal? Y/N)

LICENSURE ACTIONS:

16. LICENSURE ACTIONS: Have you ever had any professional license or license to practice Chiropractic Medicine revoked, suspended, placed on probation, received a citation, or other disciplinary action taken in any state, territory or country?

YES NO

If YES, please complete the following:

(Name of Agency) (State) (Action Date: MM/DD/YY) (Final Action) (Under Appeal? Y/N)

(Name of Agency) (State) (Action Date: MM/DD/YY) (Final Action) (Under Appeal? Y/N)

(Name of Agency) (State) (Action Date: MM/DD/YY) (Final Action) (Under Appeal? Y/N)

NAME : _____

The following questions are being asked below. A FACILITY is defined as a licensed hospital, health maintenance organization, pre-paid health clinic, ambulatory surgical center, or nursing home.

FACILITY HISTORY:

17. FACILITY HISTORY:

- a. Have you ever had any staff privileges denied, suspended, revoked, modified, restricted, or placed on probation, or have you been asked to resign or take a temporary leave of absence or otherwise acted against by any facility? [] YES [] NO

If YES, please complete the following:

(Name of Facility)	(Address of Facility)	(Action Date: MM/DD/YYYY)	(Final Action)	(Under Appeal? Y/N)
(Name of Facility)	(Address of Facility)	(Action Date: MM/DD/YYYY)	(Final Action)	(Under Appeal? Y/N)

- b. Have you ever been asked or allowed to resign from any facility instead of disciplinary action or during any pending investigations into your practice? [] YES [] NO

If YES, please complete the following:

(Name of Facility)	(Address of Facility)	(Action Date: MM/DD/YYYY)	(Final Action)	(Under Appeal? Y/N)
(Name of Facility)	(Address of Facility)	(Action Date: MM/DD/YYYY)	(Final Action)	(Under Appeal? Y/N)

- c. Have you ever had any staff privileges restricted or not renewed by any facility instead of disciplinary action? [] YES [] NO

If YES, please complete the following:

(Name of Facility)	(Address of Facility)	(Action Date: MM/DD/YYYY)	(Final Action)	(Under Appeal? Y/N)
(Name of Facility)	(Address of Facility)	(Action Date: MM/DD/YYYY)	(Final Action)	(Under Appeal? Y/N)

EMPLOYMENT HISTORY:

18. Have you ever had employment terminated for cause? [] YES [] NO

DRUG ENFORCEMENT AGENCY (DEA):

19. Have you ever been warned or called before the Drug Enforcement Agency (DEA)? [] YES [] NO

20. Have you ever been made an offer to compromise or entered into any other arrangement or other plea or agreement in lieu of a Federal prosecution for a drug violation regulated by the DEA? [] YES [] NO

21. Have you ever been denied, or surrendered a DEA Registration? [] YES [] NO

NAME : _____

Pursuant to Section 456.0635(2), Florida Statutes, the following questions are being asked. If you answer yes to any of the following questions, explain on a separate sheet providing accurate details and submit copies of supporting documentation.

22. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, Chapter 817, or Chapter 893, Florida Statutes; or 21 U.S.C. ss. 801-970 or 42 U.S.C. ss.1395-1396? YES NO
(If NO, do not answer 22a.)
- a. Has it been more than 15 years prior to the date of this application since the sentence and completion of any subsequent period of probation for each such conviction? YES NO
23. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? **(If NO, do not answer 23a.)** YES NO
- 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
24. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state or federal government, from any other state Medicaid program or the federal Medicare program? **(If NO, do not answer 24a and b.)** YES NO
- a. Have you been in good standing with a state Medicaid program or the federal Medicare program for the most recent five years? YES NO
- b. Did the termination occur at least 20 years prior to the date of this application? YES NO

FINANCIAL RESPONSIBILITY:

25. **STATEMENT OF FINANCIAL RESPONSIBILITY:** (READ ALL OPTIONS/CHECK APPROPRIATE CATEGORY)
PROVIDING FALSE INFORMATION MAY RESULT IN DISCIPLINARY ACTION OR CRIMINAL PENALTIES AS PROVIDED IN SECTIONS 456.066, 456.067, 456.072, 775.082, 775.083 AND/OR 775.084, FLORIDA STATUTES.

- I have obtained and will maintain professional liability coverage in an amount of not less than \$100,000, and in compliance with Rule 64B2-17.009(1), F.A.C. (Proof of coverage must come directly from the company)
- I have obtained and will maintain an unexpired, irrevocable letter of credit, established pursuant to Chapter 675, F.S., in an amount of not less than \$100,000 per claim, with a minimum aggregate availability of credit not less than \$300,000, and in compliance with Rule 64B2-17.009(2), F.A.C.
- I am exempt from demonstrating financial responsibility because I practice exclusively as an officer, employee or agent of the federal government, or of the state or its agencies or subdivisions.
- I am exempt from demonstrating financial responsibility because I practice only in conjunction with my teaching duties at an accredited chiropractic medicine school/college or its main teaching hospital.
- I am exempt from demonstrating financial responsibility because I do not practice in the State of Florida.
- I am exempt from demonstrating financial responsibility because I have no malpractice exposure in the State of Florida.

26. LIABILITY CLAIMS:

- a. Have you been insured continuously during the last 10 years? YES NO
- b. Within the last ten years have you had a liability claim(s) or action(s) for damages for personal injury settled or finally adjudicated in an amount that exceeds \$100,000? YES NO

If yes, please complete and attach a copy of EXHIBIT 1 for each occurrence.

NAME: _____

EXHIBIT 1 – REPORT ON PROFESSIONAL LIABILITY CLAIMS AND ACTIONS

Include information relating to liability actions occurring within the previous 10 years. The actions are required to be reported under section 456.039 F.S. You must submit a completed form for each occurrence.

Date of occurrence: ____/____/____ Date reported to licensee: ____/____/____ Date claim reported to insurer or self-insurer ____/____/____

Injured person's name: (last, first, middle initial) _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Age: _____ Sex: _____

Date of suit, if filed: ____/____/____

List other defendants with their health care provider license number involved in this claim:

1. _____ 2. _____

3. _____ 4. _____

Date of final claim disposition: ____/____/____

Date and amount of judgment or settlement, if any: _____

Was there an itemized verdict? [] Yes [] No (If "YES", attach copy of settlement verdict)

Indemnity paid on behalf of this defendant: \$ _____

Loss adjustment expense paid to defense counsel: \$ _____

All other loss adjustment expense paid: \$ _____

The date and reason for final disposition, if no judgment or settlement: _____

Name of institution at which the injury occurred: _____

Location of injury occurrence:

- ____ Patient's Room ____ Physical Therapy Dept. ____ Radiology ____ Labor & Delivery Room
- ____ Operating Suite ____ Nursery ____ Emergency Room
- ____ Special Procedure Room ____ Recovery Room ____ Critical Care Unit
- ____ Other _____

Final diagnosis for which treatment was sought or rendered. _____

Describe misdiagnosis made, if any, of the patient's actual condition. _____

Describe the operation, diagnostic or treatment procedure causing the injury. Use nomenclature and/or descriptions of the procedures used. Include method of anesthesia, or name of drug used for treatment, with detail of administration.

Describe the principal injury giving rise to the claim. Use nomenclature and/or descriptions of the injury. Include type of adverse effect from drugs where applicable. _____

Safety management steps taken by the licensee to make similar occurrences less likely. _____

I represent that these statements are true and correct pursuant to s. 837.06, Florida Statutes. I recognize that providing any false statements made in writing with the intent to mislead the Department staff in the performance of their official duties, shall be punishable as provided in s. 775.082 and 775.083, Florida Statute.

Signature of Physician: _____

NAME : _____

27. APPLICANT SIGNATURE:

I state that these statements are true and correct. I recognize that providing false information may result in denial of licensure, disciplinary action against my license or criminal penalties pursuant to Sections 456.067, 456.072, 460.413, 775.082, 775.083 and 775.084, Florida Statutes.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present) and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Florida Board of Chiropractic Medicine information which is material to my application for licensure.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind. I state that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice Chiropractic Medicine in the State of Florida. If there are any changes to my status or any change that would affect any of my answers to this application I must notify the board within 30 days.

I understand that my records are protected under the federal and state regulations governing Confidentiality of Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that my records are protected under the federal and state regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it.

APPLICANT'S SIGNATURE

DATE

*As a reminder to all applicants, Chapter 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after initial filing with the department.

Please make certified check or money order payable to the Department of Health. Return application and fees to:

Department of Health
Revenue Services
Post Office Box 6330
Tallahassee, Florida 32399-6330

Mail all supporting documents/correspondence to: (documents sent separate from application/no money)

Department of Health
Board of Chiropractic Medicine
4052 Bald Cypress Way, Bin #C07
Tallahassee, Florida 32399-3257



LICENSE VERIFICATION

INSTRUCTIONS TO THE APPLICANT:

- 1. Complete the information in Part I only.
- 2. This form must be returned by the state Board or agency which issued your license.

PART I: TO BE COMPLETED BY APPLICANT

Name: _____ DOB: ___/___/___

Address: _____

Title of License: _____ License No.: _____

PART II: TO BE COMPLETED BY THE STATE BOARD OFFICE

The individual listed above has applied for licensure in Florida as a Doctor of Chiropractic Medicine. Before further consideration is given to this application, we require the information requested on this form. The Board may submit their standard verification form in lieu of completing this form, as long as you indicate whether or not discipline has been taken against the license, and affix the Board seal. **Please return the requested information to: Florida Board of Chiropractic Medicine, 4052 Bald Cypress Way, Bin #C07, Tallahassee, Florida 32399-3257**

Name: _____
Title of License: _____
Original Issue Date: _____
License Number: _____

THIS LICENSE IS CURRENTLY:

Active Inactive Temporary Other (Explain)

THIS LICENSE WAS OBTAINED BY:

Examination Grandfathering Reciprocity/Endorsement

ACTION TAKEN AGAINST LICENSE:

No Disciplinary Action Taken Disciplinary Action Taken*

Signature: _____ Title: _____

Date: _____ State Board: _____

Please Affix Board Seal

* If disciplinary action has been taken against this licensee, please provide certified copies of documentation regarding any disciplinary actions directly to the Florida Board of Chiropractic Medicine.

Board of Chiropractic Medicine
4052 Bald Cypress Way, Bin #C07
Tallahassee, FL 32399-3257



PREVENTION OF MEDICAL ERRORS CONTINUING EDUCATION

TO: Florida Board of Chiropractic Medicine
4052 Bald Cypress Way, Bin #C07
Tallahassee, FL 32399-3257

FROM: _____
(Please type or print)

I have completed a board approved educational course on the "Prevention of Medical Errors", as required by Florida Statutes.

I understand that these statements are true and correct. I further understand and acknowledge that providing false information may result in the denial of my application, disciplinary and/or criminal penalties as provided in Florida Statutes 456.072, 456.067, 775.082, 775.083, or 775.084.

COURSE TITLE

DATE COURSE COMPLETED

Signature (Required)

Date (of signature)

Board of Chiropractic Medicine
4052 Bald Cypress Way, Bin #C07
Tallahassee, FL 32399-3257



**REQUEST FOR AN APPLICATION FOR
SPECIAL TESTING ACCOMMODATIONS**

To apply for special testing accommodations you may:

- 1) mail this request to our office and an application will be mailed to you;
- 2) fax this request to our office at (850) 487-9537 and an application will be mailed to you or
- 3) visit our website at www.doh.state.fl.us to download the application.

This form is not an application for special testing accommodations. Please mail the application to the address below. The Department or its testing provider will make the arrangements for special testing accommodations only if your application is approved.

Please print or type the following information.

Name _____

Address _____

Telephone Number (W) () _____ (H) () _____

Profession for which you are requesting testing accommodations for: _____

Disability Request? ____ Yes ____ No

Religious Conflict Request? ____ Yes ____ No

English as Second Language ____ Yes ____ No (Not an option for all professions)

Have you received special testing accommodations for the State of Florida before? ____ Yes ____ No

RETURN THIS FORM TO:

**Department of Health
Bureau of Operations, Practitioner Reporting & Examination Services
ATTN: Special Testing Coordinator
4052 Bald Cypress Way, Bin #C90
Tallahassee, FL 32399-3260
(850) 245-4252 Phone
(850) 487-9537 FAX
(Do not send this request to the Board Office)**