Board of Chiropractic Checklist

- ☐ Application
- ☐ Application Fee
- ☐ National Boards, Parts I, II, III, IV
- ☐ Undergraduate Transcript
- ☐ Transcript
- ☐ 3 Letters of Recommendation

FOR OFFICE USE ONLY
Application Approved:
License Number:
Issue Date:
Board Member Signatures
Signature of Board Administrator
ID#:
Receipt #:

Rhode Island
Board of Chiropractic Physicians

Room 104
3 Capitol Hill
Providence, RI 02908-5097

Instructions and Application For

License As A

☐ Chiropractor

☐ Chiropractor with Physiotherapy

☐ **Endorsement**
(From Another State)

☐ **Examination**

MILITARY STATUS ELIGIBILITY *(Documentation Required) see next page for instructions*

Please check ONE of the following criteria for expedited application:

- ☐ I am in active military duty or a reservist
- ☐ I am a military veteran with honorable discharge
- ☐ I am the spouse of someone in active military duty or the spouse of a reservist

Applicant - Print Name

LAST NAME	*FIRST NAME*	*MI*

Phone: (401) 222-2828 **TTY/TDD: (800) 745-5555** **Fax: (401) 222-1272**

Revised 10/26/2018 jcp

LICENSURE REQUIREMENTS

- ☐ Completed Application with Cover Page - Applications are valid for 1 year from the day they are received at RIDOH. If you are not licensed within the year you must submit a new application.
- ☐ Check or money order (preferred), made payable (in U.S. funds only) to the RI General Treasurer in the amount of $210.00 and attached to the upper left-hand corner of the first (Top) page of the application. THIS APPLICATION FEE IS NONREFUNDABLE.
- ☐ Official undergraduate transcript (sent directly from the college).
- ☐ Official professional transcript (sent directly from the Chiropractic school or college).
- ☐ Results National Board Results (Parts I, II, III, IV,) sent directly from the testing service. If applicable, results of the Physiotherapy portion of the National Boards.

NATIONAL BOARD OF CHIROPRACTIC EXAMINERS (NBCE)
901 54TH Street
Greeley, CO 80634

- ☐ Three letters from licensed chiropractic physicians attesting to the applicant's moral character.
- ☐ If you have ever been licensed in another state, license verification(s) must be sent directly from the state(s) in which you hold or have held a license. (Interstate Verification Form included in this application can be used for that pur pose) To obtain other state address and contact information please visit: **http://www.fclb.org**
- ☐ If applying for expedited military status you must include one of the following: Leave Earning Statement (LES), Letter from Command, Copy of Orders or DD-214 showing honorable discharge.

Licensure Information

Please visit the RIDOH website at http://www.health.ri.gov/licenses to Verify your license, download Rules and Regualtions/ Laws for your profession, download change of address forms, other licensing forms or obtain our contact information.

HEALTH will not, for any reason, accelerate the processing of one applicant at the expense of others.

Applications must be complete 30 days prior to a Board meeting in order to be considered for licensure.

License Certificates

RIDOH will be providing wallet license cards ONLY on issuance of licenses. If you wish to receive a license certificate, suitable for framing, please check the box below and attach a separate check in the amount of $30.00 made payable to RI General Treasurer.

- ☐ I would like to receive a license certificate. I have enclosed a separate check in the amount of $30.00

State of Rhode Island and Providence Plantations
Board of Chiropractic Physicians

Application for License as a Chiropractor/Chiropractor with Physiotherapy

Refer to the Application Instructions when completing these forms. Type or block print only. Do not use felt-tip pens.

1. Name(s)

This is the name that will be printed on your License/Permit/Certificate and reported to those who inquire about your License/ Permit/ Certificate. Do not use nicknames, etc.

NOTE:
It is your responsibility to notify the Department of Health Board of any name changes.

Title (i.e., Mr., Mrs., Ms., etc.)

First Name

Middle Name

Surname, (Last Name)

Suffix (i.e., Jr., Sr., II, III)

Maiden Name, if applicable

Name(s) under which originally licensed in another state, if different from above (First, Middle, Last).

2. Social Security Number

U.S. Social Security Number

"Pursuant to Title 5, Chapter 76, of the Rhode Island General Laws, as amended, I attest that I have filed all applicable tax returns and paid all taxes owed to the State of Rhode Island, and I understand that my Social Security Number (SSN) will be transmitted to the Divison of Taxation to verify that no taxes are owed to the State."

3. Gender

☐ Male ☐ Female

4. Date of Birth

Month Day Year

5. Home Address

It is your responsibility to notify the board of all address changes.

No professional licensee's address (residence or business/ employment) will be posted on the Department's Web site.

1st Line Address (Apartment/Suite/Room Number, etc.)

2nd Line Address (Number and Street)

City State Zip Code

Country, If NOT U.S. Postal Code. If NOT U.S.

Home Phone Home Fax

Email Address (Format for email address is Username@domain e.g. applicant@isp.com)

6. Business Address (ONLY if it is RELATED to your license.)

It is your responsibility to notify the board of all address changes.

This address will appear on the Department of Health web site.

Name of Business/Work Location

1st Line Address (Department/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City State Zip Code

Country, If NOT U.S. Postal Code, If NOT U.S.

Business Phone Extension Business Fax

7. Preferred Mailing Address

Please check ONE

☐ Please use my **Home Address** as my preferred mailing address

☐ Please use my **Business Address** as my preferred mailing address

NOTE: The preferred mailing address that you indicate is the address that will be released for all requests for that information.

8. Qualifying Under-Graduate Education

Please list the name and information about your undergraduate education that qualifies you for this license.

Type of School (University, College, etc.)

Name of School

Date Graduated Month Year

Degree Received

9. Qualifying Post-Graduate Education

Please list the name and information about your post-graduate education that qualifies you for this license.

Type of School (University, College, etc.)

Name of School

Date Graduated Month Year

Is school accredited by the Council on Chiropractic Education? ☐ Yes ☐ No

Degree Received

10. Other State License(s)

Please answer the question and list state(s), if applicable

Have you ever held, or do you currently hold, a license in another state? ☐ Yes ☐ No

If the answer to this question is ***"yes"***, enter all other state licenses in Question 10 (below):

11. Licensure

List all states or countries in which you are now, or ever have been licensed to practice your profession*.

State/Country:			State/Country:		
	☐ Active	☐ Inactive		☐ Active	☐ Inactive
	☐ Active	☐ Inactive		☐ Active	☐ Inactive
	☐ Active	☐ Inactive		☐ Active	☐ Inactive
	☐ Active	☐ Inactive		☐ Active	☐ Inactive
	☐ Active	☐ Inactive		☐ Active	☐ Inactive
	☐ Active	☐ Inactive		☐ Active	☐ Inactive
	☐ Active	☐ Inactive		☐ Active	☐ Inactive
	☐ Active	☐ Inactive		☐ Active	☐ Inactive
	☐ Active	☐ Inactive		☐ Active	☐ Inactive

(*You must also request a License Verification (page 10) from all states that are listed above*)

12. Criminal Convictions

Respond to the question at the top of the section, then list any criminal conviction(s) in the space provided.

If necessary, you may continue on a separate 8½ x 11 sheet of paper.

Have you ever been convicted of a violation, plead Nolo Contendere, or entered a plea bargain to any federal, state or local statute, regulation, or ordinance or are any formal charges pending? ☐ Yes ☐ No

Abbreviation of State and Conviction[1] (e.g. CA - Illegal Possession of a Controlled Substance):

	Month	Year

13. Disciplinary Questions

Check either Yes or No for each question.

1. Has any Health Professional license, certificate, registration, or permit you hold or have held, been disciplined or are any formal charges pending? ☐ Yes ☐ No

2. Have you ever been denied a license, certificate, registration or permit in any state? ☐ Yes ☐ No

Note: If you answer "Yes" to any question, you are **required** to furnish complete details, including date, place, reason and disposition of the matter. You may use the space below or, if needed, on a separate sheet of paper.

14. Affidavit of Applicant

Complete this section and sign.

Make sure that you have completed all components accurately and completely.

I, _____, being first duly sworn, depose and say that I am the person referred to in the foregoing application and supporting documents.

I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. I further certify that I am at least 23 years of age. 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 as a Chiropractor in the State of Rhode Island.

I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Board of Chiropractic Physicians of any change in the answers to these questions after this application and this affidavit is signed.

_____ _____

Signature of Applicant Date of Signature (MM/DD/YY)

Substitute forms are not acceptable, One (1) form is required for each state in which you hold, or have held a license. Copy this form as needed.

Rhode Island Board of Chiropractic Physicians
Room 104, 3 Capitol Hill
Providence, RI 02908-5097
(401) 222-2828

INTERSTATE VERIFICATION FORM - OTHER STATE LICENSE(S) (One form for each state)

I am applying for a license to practice as a Licensed Chiropractor in the State of Rhode Island. The Rhode Island Board of Chiropractic Physicians requires that the following form be completed by the jurisdiction(s) in which I hold or have held a license. This constitutes authority for you to release all information in your files, favorable or otherwise, directly to the Rhode Island Board of Chiropractic Physicians at the above address.

Print/Type Full Name

Signature _____ Date _____

Previous Names Used

Social Security Number _____ Date of Birth _____

License Number _____ Date Issued _____

Chiropractic Board Information **http://www.fclb.org**

THIS SECTION TO BE COMPLETED BY THE BOARD OF CHIROPRACTIC MEDICINE

Directions for State Board: Please complete and return this form to the address above .
Please verify requirements met in your state:

Chiropractic Degree from Accredited School?	Licensed by Examination?	If not by examination, how was license obtained?
☐ Yes ☐ No	☐ Yes ☐ No	Endorsement _____ (State) Other _____ (Explain)

Applicant has completed and passed the National Certification Exam:	License Status:	Original Date Issued:	Expiration Date:
☐ Yes ☐ No Score_____ Level of Exam:_____	☐ Active ☐ Inactive ☐ Lapsed		

Questions:

1. Has this licensee ever been investigated by your Board? ☐ Yes ☐ No
2. Has this licensee incurred any disciplinary proceedings in your state, or is any action pending? ☐ Yes ☐ No
3. Has the applicant's license ever been denied, surrendered, reprimanded, suspended, revoked or placed on probation? ☐ Yes ☐ No
4. Do you know of any information that may discredit this person? ☐ Yes ☐ No

If you answer "Yes" to questions 1-4, please provide a written explanation below, and attach a copy of all supporting documentation (e.g., Board order, complaint, etc.).

_____

_____

_____

Certification:

Signature _____ Date _____

Type or Print Name _____

Title _____

Full Name of Licensing Board _____

Please Affix
Board Seal Here

Please return directly to the Board at the above address. Thank you for your prompt cooperation.