



**Government of the District of Columbia
Department of Health
Health Regulation and Licensing Administration**



BOARD OF CHIROPRACTIC

NEW LICENSE APPLICATION FOR CHIROPRACTIC (D.C)

All applicants must complete every section of this application and submit the original application and all required supporting documents. If more space is needed to fully answer questions, attach additional sheets with typed responses. False or misleading statements will be cause for disciplinary action and could be cause for criminal prosecution pursuant to **DC Code 22-2514**. If you have any questions, call HPLA Customer Service at **1-877-672-2174 Monday through Friday, 8:15AM to 4:40PM EST.**

SECTION 1A. LICENSURE TYPE & FEES			
SELECT LICENSURE TYPE: <input type="checkbox"/> Chiropractic (D.C) <input type="checkbox"/> Ancillary Procedures <input type="checkbox"/> Acupuncture <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Chiropractic Re-examination	FEES <input type="checkbox"/> \$ 568 Chiropractic (D.C) <i>(Only)</i> <input type="checkbox"/> \$ 754 Chiropractic & 1 Ancillary Procedure <input type="checkbox"/> \$ 940 Chiropractic & 2 Ancillary Procedures <input type="checkbox"/> \$ 111 Chiropractic Re-examination <input type="checkbox"/> Ancillary Procedures <input type="checkbox"/> \$ 271 Acupuncture <i>(Only)</i> <input type="checkbox"/> \$ 271 Physical Therapy <i>(Only)</i>	CRIMINAL BACKGROUND CHECK <input type="checkbox"/> \$50.00 (If processed through the District.)	
SECTION 2A. APPLICANT INFORMATION			
Note: LEGAL NAME: <i>(Do not use any initials unless they are a part of your name)</i>			
_____ FIRST NAME	_____ MI	_____ LAST NAME	_____ (SUFFIX: Jr., Sr. etc.)
DEGREE(S): <input type="checkbox"/> D.C., <input type="checkbox"/> OTHER DEGREE _____			
____/____/____ Date of Birth	____-____-____ Social Security Number	GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
SECTION 2B. OTHER NAMES USED: (Please print clearly)			
If your name has changed at any point since you have taken any exams or attended college or university, you must provide a copy of a legal name change documents for EACH time that it has changed. Acceptable documents for individuals are marriage certificates, divorce decrees, or court orders.			
_____ FIRST NAME	_____ MI	_____ LAST NAME	_____ (SUFFIX: Jr., Sr. etc.)
_____ FIRST NAME	_____ MI	_____ LAST NAME	_____ (SUFFIX: Jr., Sr. etc.)
_____ Place of Birth : State/Providence/Territory		_____ Country if not USA	
SECTION 2C: RACE & ETHNICITY DESIGNATION: (Optional)	LANGUAGE(S) SPOKEN:		
<input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian/South Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Caucasian/White <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Other _____ <input type="checkbox"/> Native Hawaiian or other Pacific Islander	<i>Language(s) spoken other than English:</i> _____ _____ _____		



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SECTION 4A. PROFESSIONAL AND SECONDARY SCHOOLS ATTENDED

List post-secondary schools attended, in reverse chronological order, beginning with the most recent at the top.

School Name, City, State, Country	Date of Graduation mm/yyyy	Degree/Certificate

SECTION 4B. PROFESSIONAL TRAINING AND PROFESSIONAL PRACTICE – POSTGRADUATE EXPERIENCE

List experience covering the five (5) year period prior to the submission of the application (MONTH & YEAR) and all internship, residency, and fellowship training. Include letters from employing facilities, organizations, and training (internships, residencies, and fellowships). For "TRAINING AND PRACTICE DESCRIPTIONS", use the letter key code below. List experience in reverse chronological order, beginning with the most recent.

Organization/Institution	Start Date mm/yyyy	End Date mm/yyyy	Type of Position (Use Key Code Below)

TRAINING AND PRACTICE DESCRIPTIONS/TYPE OF POSITION KEY CODE

- A.** Fellowship **B.** Internship **C.** Residency **D.** Apprenticeship **E.** Employment
F. Private Practice ... (Attach a typed explanation on a separate sheet of paper to this form.)

SECTION 4C. PROFESSIONAL LICENSES IN OTHER STATES/JURISDICTIONS

List all states and jurisdictions in which you have ever held a license (excluding training licenses) and provide letters of verification. Use additional sheet if necessary.

Are you currently applying for licensure in any other jurisdiction? _____ If yes please list: _____

Jurisdiction	Issue Date mm/yyyy	Expiration Date mm/yyyy	License Number

SECTION 5A. PRACTICE TIME IN THE DISTRICT

Please provide practice information

- (1.) Do you plan to practice in the District of Columbia? Yes No
(2.) Please indicate if you do or will practice in: Maryland Virginia



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SECTION 5B. REQUIRED SCREENING QUESTIONS

Please answer questions A through O by placing an X in the appropriate boxes. If you answer "YES" to any question, you must provide full information and complete details **on a separate sheet of paper attaching copies of all relevant documents such as final court orders or panel review decisions.**

A.	Have you ever been arrested, convicted, pled guilty to, or pled no contest to the violation of any federal, state or other statute or ordinance constituting a felony or misdemeanor (including driving under the influence or while impaired, but excluding minor traffic violations)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
B.	Have you ever been licensed in any healthcare field in any state or jurisdiction? If yes, please list profession(s) & jurisdiction(s). HEALTH PROFESSION(S) _____ _____ JURISDICTION(S) _____ _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
C.	Have you been a defendant or respondent to a claim for damages or a malpractice action?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
D.	Have you ever voluntarily surrendered a license or registration certificate (or allowed it to lapse) after formal charges had been brought against you or while you were under investigation?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
E.	Have you ever surrendered your clinical privileges (voluntary or involuntary) or had your clinical privileges denied, revoked, or suspended at any hospital or health care facility?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
F.	Have you ever been terminated or resigned (voluntary or involuntary) from a clinical or professional training program for any reason?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
G.	Has any licensing authority taken adverse action against your chiropractic license or privileges or informed you of any pending charges?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
H.	Has any licensing authority, health facility, or peer review board informed you of any pending charge(s) or investigation(s) against you?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
I.	Are you presently or have you ever been under a corrective action plan imposed by an employer, health facility or educational program?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
J.	Do you have a medical condition or have you become aware of any medical condition that currently impairs or limits your ability to practice medicine safely or that could affect your performance or impact your ability to practice your profession?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
K.	Are you currently being treated, or within the past five (5) years have you been treated, for a physical or mental condition that, but for the treatment, could impair your ability to practice your profession?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
L.	Have you ever engaged in the excessive use of alcohol, controlled substances or prescription drugs or have you received treatment or therapy for abuse of alcohol or drugs?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
M.	Within the last ten (10) years, have you voluntarily resigned, asked to resign, been terminated, or disciplined by any employer due to practice or moral turpitude issues?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
N.	Have you ever withdrawn a license application or have you been denied a license or denied the privilege of taking a license examination by any professional licensing board or agency?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
O.	Have you ever had a professional liability policy cancelled or not renewed?	Yes <input type="checkbox"/>	No <input type="checkbox"/>



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SECTION 6A. SUPPORTING DOCUMENTS

Please indicate the supporting documents you have included with this package or requested to be sent to the DC Board of Chiropractic. Keep a photocopy.

- Two recent and identical passport-type photos of the applicant's face (approx. 2"X2") with applicant's name printed on the back.**
The photos must be original photos and cannot be computer-generated copies or paper copies.
- One (1) character reference form**
Please have form completed by an employer/training program director or licensed chiropractor with whom you worked/trained; within the past five years.
- Verification(s) of licensure** – *These should be provided in a sealed envelope from the issuing jurisdiction(s) for each license identified in Section 4C.*
- All undergraduate, graduate, medical, and professional school transcripts.**
Transcripts should be provided in a sealed envelope from the issuing institution for each school that you attended and listed in Section 4A.
- Documentation of all experience covering the five (5) year period prior to the submission of the application and all internships, residencies, apprenticeships, and fellowship training.**
Proof of experience should be submitted as a letter on official letterhead from the overseeing institution/organization.
- Examination scores** – *In a sealed envelope from the examination contractor or administrator.*
- Criminal Background Check (CBC)** - *To access form and instructions go to www.hpla.doh.dc.gov/boc or contact the CBC unit at 202.727.9855.*

SECTION 6B. PAYMENT/MAILING INFORMATION

Make **CHECK** or **MONEY ORDER** payable to:
DC Treasurer.

A charge of \$65.00 will be imposed for dishonored checks (Public Law 89-208)

MAIL YOUR APPLICATION PACKAGE TO:

District of Columbia Health Professional Licensing
Administration
Attention: Processing Department – Board of Medicine
899 North Capitol St. NE 1st Floor
Washington, D.C. 20002



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SECTION 7A.

Clean Hands Before Receiving a License or Permit Act of 1996 Certification Form Requirement

Please read the information below carefully before responding to this yes or no question, as **any false information provided requires that the Department of Health proceed immediately to revoke your License or Permit** for which you are now applying, and fine you one thousand dollars (\$1,000.00), pursuant to D.C. Official Code § 47-2864 (2001).

IF YOU ANSWER "YES" TO THIS QUESTION, PLEASE SUBMIT PROOF OF THE ARRANGEMENTS YOU HAVE MADE TO PAY THE OUTSTANDING DEBT. IF YOU DO NOT HAVE AN APPROVED PAYMENT SCHEDULE TO PAY THE AMOUNT YOU OWE OR IF NO APPEAL IS PENDING, THE LAW REQUIRES THAT YOUR NEW LICENSE APPLICATION BE DENIED.

As of this date, do you owe more than one hundred dollars (\$100.00) to the District of Columbia Government as a result of any of the following:

- Fines, penalties, or interest assessed pursuant to **D.C. Official Code Title 8, Chapter 8** (Litter Control Administrative Act of 1985);
- Fines or interest assessed pursuant to **D.C. Official Code Title 8, Chapter 9** (Illegal Dumping Enforcement Act of 1994);
- Fines, penalties, or interest assessed pursuant to **D.C. Official Code Title 2, Chapter 18** (Civil Infractions Act of 1985);
- Past due taxes;
- Past due District of Columbia Water and Sewer Authority service fees; or
- Fines or penalties assessed pursuant to **D.C. Official Code Title 50, Chapter 23** (Traffic Adjudication)?

Yes No

The information presented above is in compliance with the requirement to submit with your application for licensure or permit under the *Clean Hands Before Receiving a License or Permit Act of 1996*, effective May 11, 1996 (**D.C. Law 11-118, D.C. Code §47-2861 et seq.**).

SECTION 7B. APPLICANT AFFIDAVIT

I hereby attest that the information given in this application, including all writings and exhibits attached hereto, is true and complete to the best of my knowledge. I understand that the making of a false statement on this application, including all writings and exhibits attached hereto, is punishable by criminal penalties.

APPLICANT SIGNATURE

PRINT NAME

DATE

Update 12/14/11