BOARD OF CHIROPRACTIC MEDICINE

GENERAL INFORMATION/INSTRUCTIONS
CERTIFIED CHIROPRACTIC PHYSICIANS ASSISTANT

HOW TO APPLY FOR FLORIDA LICENSURE

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

1. FLORIDA LAWS & RULES:

You may download a copy of Section 460.4165, Florida Statutes and Rule Chapter 64B2-18, 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

2. LICENSURE INFORMATION:

Any Certified Chiropractic Physician's Assistant (CCPA) certified under this section to perform services may perform those services only:

(a) In the office of the chiropractic physician to whom the CCPA has been assigned, in which office such physician maintains his/her primary practice;

(b) Under indirect supervision of the chiropractic physician to whom she/he is assigned as defined by rule of the board;

a) In a hospital in which the chiropractic physician to whom she/he is assigned is a member of the staff; or

(d) On calls outside of the office of the chiropractic physician to whom she/he is assigned, on the direct order of the chiropractic physician to whom she/he is assigned.

Each chiropractic physician or group of chiropractic physicians utilizing CCPAs shall be liable for any act or omission of any CCPA acting under his/her or their supervision and control.

The terms "certified chiropractic physician's assistant," or "physician's assistant," or "assistant" as used herein refers to allied health personnel, certified by the Department upon approval by the Board, who are functioning in a dependent relationship with a supervising chiropractic physician and who are performing tasks or combinations of tasks traditionally performed by the chiropractic physician. A CCPA may perform case histories, diagnostic testing, physical examinations, and therapeutic procedures. However, **an assistant cannot be assigned any tasks requiring manipulative or adjustive techniques, the rendering of diagnostic results, interpretations, or treatment advice, or the taking of x-rays unless properly certified by the Radiation Control office.**

The term "supervision" means responsible supervision and control by the supervising chiropractic physician. Except in cases of emergency, supervision shall require the "easy availability" or physical presence of the licensed chiropractic physician for consultation and direction of the actions of the CCPA. "Easy availability" means the supervising physician must be in a location to enable him/her to be physically present with the CCPA within at least thirty minutes and must be available to the CCPA when needed for consultation and advice either in person or by communication devices, such as telephone, two-way radio, medical beeper or other electronic means.

Rule 64B2-18.007 Method of Performance.

(1) An assistant must clearly identify himself or herself by appropriate identification as a certified chiropractic physician's assistant to insure that he or she is not mistaken for a licensed physician (for example, a name tag).

(2) The assistant must generally function in reasonable proximity to the supervising physician. If he or she is to perform away from the supervising physician, these duties must be clearly specified in the application to the Board.

Applicants may qualify for certification as a CCPA by either:

(a) successfully completing a program approved pursuant to Rule 64B2-18.003(2), for the education and training of certified chiropractic physician's assistants, or

(b) graduating from a chiropractic college which is accredited by, or has status with the Council on Chiropractic Education or its predecessor agency, provided the applicant has never had a license to practice as a chiropractic physician subject to disciplinary action in this or any other jurisdiction, or

(c) successfully completing 24 months of chiropractic education which is accredited by, or has status with the Council on Chiropractic Education or its predecessor agency.

3. FEE SCHEDULE:

The application must be accompanied by documentation of one of the above, and a total fee of $305.

Application Fee	$100 (non-refundable)
Supervising Physician Fee	$100
License Fee	$100
Unlicensed Activity Fee	$5

NOTE: Once an application is complete, the applicant and supervisor must participate in an interview with the CCPA Committee. If the Committee approves the application, it is placed on the agenda for the next regularly scheduled board meeting for ratification. The Committee may recommend denial; in such instance, the application will be presented to the Board for review.

4. PREVENTION OF MEDICAL ERRORS COURSE:

Prevention of Medical Errors Course: A 2 hour course on the prevention of medical errors must be documented with a copy of the certificate of attendance.

5. APPLICATION INSTRUCTIONS:

The application must be completed in its entirety. If you do not have enough room to provide the answer to a question, please write on the back of the page or attach an additional page(s). Answers written on the back of a page or on additional pages should be numbered to correspond with the question being answered. All parts of the application should be legibly written or typed.

6. RETURN APPLICATION AND FEES TO: (certified check or money order)

Department of Health
Post Office Box 6330
Tallahassee, Florida 32314-6330

CERTIFIED CHIROPRACTIC PHYSICIANS ASSISTANT

INITIAL APPLICANT CHECKLIST

MAKE COPIES OF ALL DOCUMENTS for your records, prior to mailing the originals to the department. Use this worksheet to check off items as you prepare.

_____**1. FEES:** (certified check or money order)

- Application Fee $100.00 (non-refundable)
- Supervising Physician Fee $100.00
- License Fee $100.00
- Unlicensed Activity Fee $ 5.00

TOTAL: $305.00

_____**2. SOCIAL SECURITY NUMBER page is required**

_____**3. ALL PAGES OF APPLICATION:**

- Applicant Signature (last page) must contain your original signature
- All questions must be answered. Questions may not be answered with "refer to attached resume". If a particular question does not apply, please enter N/A in the appropriate field. If explanation or clarification is needed or if any of the sections do not contain sufficient space for the requested information, use an additional sheet of paper and make note on the application question that additional information is attached. Always number the additional information with the corresponding number of the question in the application.
- 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.

_____**4. EDUCATION**

Applicants may qualify for certification as a CCPA by either:

a) successfully completing a program approved pursuant to Rule 64B2-18.003(2), for the education and training of certified chiropractic physician's assistants, or

b) graduating from a chiropractic college which is accredited by, or has status with the Council on Chiropractic Education or its predecessor agency, provided the applicant has never had a license to practice as a chiropractic physician subject to disciplinary action in this or any other jurisdiction, or

c) successfully completing 24 months of chiropractic education which is accredited by, or has status with the Council on Chiropractic Education or its predecessor agency.

_____**5. WORK ARRANGEMENT PROPOSAL**

_____**6. CHIROPRACTIC PHYSICIAN INFORMATION**

_____**7. 2-HOUR PREVENTION of MEDICAL ERRORS COURSE:**

All new licensees are required to provide proof of completion of a 2 hour prevention of medical errors course to have the initial license issued.

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
Application for
Certified Chiropractic Physicians Assistant (CCPA)
(Client: 503)

Fees: (1010)

Please complete form and return the fees (certified check or money order) to the address below. Also print legibly or type the information.

Application Fee:	$100.00
Supervisior Physician Fee:	$100.00
License Fee:	$100.00
Unlicensed Activity Fee:	$ 5.00
Total Fee:	**$305.00**

APPLICANT PROFILE: (completed by CCPA Applicant)

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

Applicant Name: _____

5. EDUCATION/TRAINING HISTORY: (Please list the school(s) or college(s) of chiropractic/training program from which you graduated/completed)

(School Name)	(City/State)	(Degree/Certification)	(Date of Graduation/Certification)

6. APPLICANT-GENERAL HISTORY:
(Attach additional sheet(s) if necessary)

Have you ever been convicted or found guilty, regardless of adjudication, of a crime in any jurisdiction, or have you ever been a defendant in a military court-martial? Do not include parking or speeding violations. [ ] YES [ ] NO

If yes, please list date, jurisdiction (state and county), offense, disposition and all relevant information:

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

7. LICENSURE ACTIONS: Have you ever had <u>any</u> disciplinary action by the licensing authority of any state or are you the subject of any pending investigation or disciplinary action? [ ] 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)

IMPORTANT NOTICE: Applicants for licensure, certification or registration and candidates for examination may be excluded from licensure, certification, or registration if their felony conviction falls into certain timeframes as established in Section 456.0635(2), Florida Statutes.. If you answer YES to any of the following questions, please provide a written 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 to the address below. Supporting documentation includes court dispositions or agency orders where applicable.

8. Have you been convicted of, or entered a plea of guilty or nolo contendere, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction? **(If you responded NO, skip to 9)** [ ] YES [ ] NO

a. If "yes" to 8, for felonies of the first or second degree, has it been more than 15 years before the date of the plea, sentence and completion of any subsequent probation? [ ] YES [ ] NO

b. If "yes" to 8, for felonies of the third degree, has it been more than 10 years before the date of the plea, sentence and completion of any subsequent probation? (This question does not apply to felonies of the third degree under Section 893.13(6)(a), Florida Statutes). [ ] YES [ ] NO

Applicant Name: _____

c. If "yes" to 8, for felonies of the third degree under Section 893.13(6)(a), Florida Statutes, has it been more than 5 years from the date of the plea, sentence and completion of any subsequent probation? [ ] YES [ ] NO

d. If "yes" to 8, 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", please provide supporting documentation)** [ ] YES [ ] NO

9. 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 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)? [ ] YES [ ] NO

a. If "yes" to 9, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation of such conviction or plea ended? [ ] YES [ ] NO

10. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? **(If "No", do not answer 10a.)** [ ] 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

11. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? **(If "No", do not answer 11a or 11b.)** [ ] YES [ ] NO

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

12. Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities? [ ] YES [ ] NO

13. If "yes" to any of the questions 8 through 12 above, on or before July 1, 2009, were you enrolled in an educational or training program in the profession in which you are seeking licensure that was recognized by this profession's licensing board or the Department of Health? **(If "yes", please provide official documentation verifying your enrollment status.)** [ ] YES [ ] NO

14. EMPLOYER/SUPERVISOR PROFILE: (Please provide the name and license number of the chiropractic physician who will supervise your duties)

EMPLOYER/SUPERVISOR: _____ CH _____
Supervisor's Name License Number

EMPLOYER/SUPERVISOR: _____ CH _____
Supervisor's Name License Number

EMPLOYER/SUPERVISOR: _____ CH _____
Supervisor's Name License Number

Applicant Name: _____

CHIROPRACTIC PHYSICIAN INFORMATION:

(Section completed by each chiropractic physician who will supervise the CCPA)

[ ] Individual Application
[ ] Group Application (Each supervising chiropractic physician must complete the form)

15. DATA ON SUPERVISING CHIROPRACTIC PHYSICIAN:

a. NAME:_____
(Last) (First) (Middle)

b. PRIMARY PRACTICE/PHYSICAL ADDRESS:

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

c. TELEPHONE: _(_____)_____ _(_____)_____
Home: Area Code/Phone Number Business: Area Code/Phone Number

d. EMAIL ADDRESS: _____ **e. CHIROPRACTIC LICENSE NUMBER: CH_____**

16. BACKGROUND:

List the professional background of the chiropractic physician.

_____

_____

17. DESCRIPTION OF PRACTICE & UTILIZATION OF CCPA:

a. Describe your practice and the way in which the CCPA will be utilized; be specific, give details.

_____

_____

b. Is this CCPA going to be performing services away from the primary practice location of the supervisor? [ ] YES [ ] NO

If yes, indicate the specific reason for sending the CCPA to see patients outside your primary practice location:

_____

_____

_____

c. What are the specific duties you have assigned the CCPA when seeing patients outside your primary practice location?

_____

_____

_____

_____

d. What is your specific method of supervision and communication with the CCPA when outside the office?

_____

_____

_____

_____

18. List by name and license number all CCPAs you are currently supervising: (use additional sheets if necessary)

CCPA Name	**License Number**

19. List the physical practice address/practice location where each of the above CCPAs work:

_____

_____

_____

_____

20. List all additional practice locations including any location where the chiropractic physician serves as medical director (use additional sheets if necessary):

Physical Address	**Medical Director**
_____	[ ] YES [ ] NO
_____	[ ] YES [ ] NO

BOARD OF CHIROPRACTIC MEDICINE
CERTIFIED CHIROPRACTIC PHYSICIANS ASSISTANT

WORK ARRANGEMENT PROPOSAL BETWEEN:

CCPA NAME:_____
(Last) (First) (Middle)

and

DC NAME:_____
(Last) (First) (Middle)

License Number: CH_____

PLACE of PRACTICE: (Address where work arrangement will take place)

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

Is this clinic licensed under Part X of Chapter 400, FS? [ ] YES [ ] NO

Work hours: From: _____AM TO: _____PM

Workdays: (Circle all that apply) Mon Tues Wed Thur Fri Sat Sun

Describe the duties the CCPA will be performing:

_____

_____

_____

_____

Describe how the supervising physician will oversee the work being performed by the CCPA:

_____

_____

_____

_____

By signing this document, we agree to be bound by this work arrangement until such time as this agreement is modified and approved by the Florida Board of Chiropractic Medicine.

_____**, DC, Supervising Chiropractic Physician**
Signature

_____**, CCPA**
Signature

_____
Date signed

Applicant Name: _____

APPLICANT SIGNATURE

I hereby authorize all hospitals, institutions, organizations, my references, personal physicians, employers (past and present), all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Department of Health, any information, files or records requested by the Department in connection with the processing of this application. I further authorize the Department to release to the organizations, individuals and groups listed above any information which is material to my application.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare, 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 acts shall constitute cause for the denial, suspension or revocation of any license to practice in the State of Florida.

_____

CCPA Signature (required) **Date Signed**

_____

Supervising Chiropractic Physician Signature (required) **Date Signed**

_____

Supervising Chiropractic Physician Signature (required) **Date Signed**

_____

Supervising Chiropractic Physician Signature (required) **Date Signed**