BOARD OF CHIROPRACTIC MEDICINE

Application Instructions for Chiropractic Medical Faculty Certificate

Fees: Please send a total fee of $205.00 (certified check or money order) payable to the Department of Health.

Application fee:	$100.00
Licensure fee:	$100.00
ULA fee:	$ 5.00
TOTAL:	**$205.00**

SUPPORTING DOCUMENTS:

1. **Mail fees and application to:**
   Department of Health
   Post Office Box 6330
   Tallahassee, FL 32314-6330

2. **Final Official Chiropractic College 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.

3. **Official 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.**

4. **Certification of Appointment:**
   A letter from the Dean of the appointing college confirming the full-time faculty appointment to teach in a program of chiropractic medicine.

Florida Board of Chiropractic Medicine
4052 Bald Cypress Way, Bin C07
Tallahassee, Florida 32399-3257
850/245-4355

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

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BOARD OF CHIROPRACTIC MEDICINE
Application for
Chiropractic Medical Faculty Certificate
(Client: 506)

1. Fees: (1010)

Please complete form and return the fees (certified check or money order) to the address below. : (TYPE OR PRINT LEGIBLY IN BLACK INK)

Application Fee	**$100.00**
Licensure Fee	**$100.00**
Unlicensed Activity Fee	**$ 5.00**
Total Fees:	**$205.00**

2. APPLICANT PROFILE:

Name: _____
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 [ ]

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Applicant Name: _____

5. 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)

6. 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)

EDUCATION and TRAINING:

7. 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)

8. POSTGRADUATE TRAINING: List in chronological order from date of graduation from the **Chiropractic Medical School** to the present, all professional/postrgraduate 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

9. EMPLOYMENT INFORMATION:
Please list the Florida based school/college where you have been offered and have accepted a full-time faculty appointment to teach in a program of chiropractic. **(Please submit a letter from the Dean confirming the appointment)**

_____
(School Name)

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Applicant Name: _____

APPLICANT HISTORY (ATTACH ADDITIONAL SHEETS IF NECESSARY)

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.

10. 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 11)** [ ] YES [ ] NO

a. If "yes" to 10, for 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 10, for felonies of the third degree, has it been more than 10 years from 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

c. If "yes" to 10, 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 10, 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

11. 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 11, 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

12. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? **(If "No", do not answer 12a.)** [ ] 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

13. 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 13a or 13b.)** [ ] 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

14. 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

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15. If "yes" to any of the questions 10 through 14 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

APPLICANT SIGNATURE:

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

I have carefully read the questions in the foregoing application and have answered them completely, without reservations 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, for the profession for which I am applying.

_____ _____
Applicant Signature Date Signed

***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
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