



BOARD OF CHIROPRACTIC MEDICINE

**GENERAL INFORMATION/INSTRUCTIONS
REGISTERED CHIROPRACTIC 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, 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.

2. FEE SCHEDULE:

Registration Fee	\$25.00 (non-refundable)
Unlicensed Activity Fee	\$ 5.00
Total:	\$30.00

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

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



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

4052 Bald Cypress Way, Bin # C07
Tallahassee, Florida 32399-3257



BOARD OF CHIROPRACTIC MEDICINE
Application for
Registered Chiropractic Assistant (RCA)
(Client: 502)

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.

Registration Fee: \$25.00
Unlicensed Activity Fee: \$ 5.00
Total Fee: \$30.00

APPLICATION PROFILE DATA: (completed by RCA Applicant)

1. 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)

2. 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:

3. PERSONAL DATA:

BIRTH DATE: (Month/Day/Year) BIRTH PLACE: (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 []

APPLICANT NAME: _____

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.

APPLICANT – GENERAL HISTORY:

4. 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 5)** YES NO
- a. If “yes” to 4, 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 4, 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 4, 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 4, 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
5. 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 5, 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
6. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? **(If “No”, do not answer 6a.)** 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
7. 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 7a or 7b.)** 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
8. 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
9. If “yes” to any of the questions 4 through 8 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 NAME: _____

LICENSURE INFORMATION:

10. LICENSURE INFORMATION: Do you hold or have you ever held a license to practice in any other profession in any U.S. State or territory, or foreign country? [] YES [] NO
If YES, please complete the following:

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.

CRIMINAL HISTORY:

11. 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)

LICENSURE ACTIONS:

12. 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)

13. ALL FUNCTIONS THAT YOU WILL BE PERFORMING:

A registered chiropractic assistant assists with patient care management, executes administrative and clinical procedures, and often performs managerial and supervisory functions. Competence in the field also requires that a registered chiropractic assistant adhere to ethical and legal standards of professional practice, recognize and respond to emergencies, and demonstrate professional characteristics.

DUTIES – Perform clinical procedures which include; preparing patients for the chiropractic physician’s care; taking vital signs; observing and reporting patients signs or symptoms; administrator first aid; assist with patient examinations or treatments other than manipulations or adjustments; operate office equipment; collect routine laboratory specimens as directed; perform office procedures, all of which is under the direct supervision of the chiropractic physician or certified chiropractic physician’s assistant.

AGREE [] YES [] NO

14. EMPLOYER/SUPERVISOR PROFILE:

EMPLOYER/SUPERVISOR: _____	CH/CI
EMPLOYER/SUPERVISOR: _____	CH/CI
EMPLOYER/SUPERVISOR: _____	CH/CI
Supervisor’s Name	License Number

APPLICANT NAME: _____

15. APPLICANT STATEMENT

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, the profession for which I am applying.

Assistant Signature (required) Date Signed

Supervisor Signature (required) Date Signed

Supervisor Signature (required) Date Signed

Supervisor Signature (required) Date Signed