



BOARD OF CHIROPRACTIC MEDICINE

GENERAL INFORMATION/INSTRUCTIONS CERTIFIED CHIROPRACTIC PHYSICIAN'S 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 <http://floridaschiropracticmedicine.gov/resources/>. 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;
- (c) 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.

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. 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.

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

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

6. FLORIDA DEPARTMENT OF LAW ENFORCEMENT

NOTICE FOR APPLICANTS SUBMITTING FINGERPRINTS WHERE CRIMINAL RECORD RESULTS WILL BECOME PART OF THE CARE PROVIDER BACKGROUND SCREENING CLEARINGHOUSE

NOTICE OF:

- **SHARING OF CRIMINAL HISTORY RECORD INFORMATION WITH SPECIFIED AGENCIES,**
- **RETENTION OF FINGERPRINTS,**
- **PRIVACY POLICY, AND**
- **RIGHT TO CHALLENGE AN INCORRECT CRIMINAL HISTORY RECORD**

This notice is to inform you that when you submit a set of fingerprints to the Florida Department of Law Enforcement (FDLE) for the purpose of conducting a search for any Florida and national criminal history records that may pertain to you, the results of that search will be returned to the Care Provider Background Screening Clearinghouse. By submitting fingerprints, you are authorizing the dissemination of any state and national criminal history record that may pertain to you to the Specified Agency or Agencies from which you are seeking approval to be employed, licensed, work under contract, or to serve as a volunteer, pursuant to the National Child Protection Act of 1993, as amended, and Section 943.0542, Florida Statutes. "Specified agency" means the Department of Health, the Department of Children and Family Services, the Division of Vocational Rehabilitation within the

Department of Education, the Agency for Health Care Administration, the Department of Elder Affairs, the Department of Juvenile Justice, and the Agency for Persons with Disabilities when these agencies are conducting state and national criminal history background screening on persons who provide care for children or persons who are elderly or disabled. The fingerprints submitted will be retained by FDLE and the Clearinghouse will be notified if FDLE receives Florida arrest information on you.

Your Social Security Number (SSN) is needed to keep records accurate because other people may have the same name and birth date. Disclosure of your SSN is imperative for the performance of the Clearinghouse agencies' duties in distinguishing your identity from that of other persons whose identification information may be the same as or similar to yours.

Licensing and employing agencies are allowed to release a copy of the state and national criminal record information to a person who requests a copy of his or her own record if the identification of the record was based on submission of the person's fingerprints. Therefore, if you wish to review your record, you may request that the agency that is screening the record provide you with a copy. After you have reviewed the criminal history record, if you believe it is incomplete or inaccurate, you may conduct a personal review as provided in s. 943.056, F.S., and Rule 11C8.001, F.A.C. If national information is believed to be in error, the FBI should be contacted at 304-625-2000. You can receive any national criminal history record that may pertain to you directly from the FBI, pursuant to 28 CFR Sections 16.30-16.34. You have the right to obtain a prompt determination as to the validity of your challenge before a final decision is made about your status as an employee, volunteer, contractor, or subcontractor.

Until the criminal history background check is completed, you may be denied unsupervised access to children, the elderly, or persons with disabilities.

The FBI's Privacy Statement follows on a separate page and contains additional information.

US Department of Justice, Federal Bureau of Investigation, Criminal Justice Information Services Division

Privacy Statement

Authority: The FBI's acquisition, preservation and exchange of information requested by this form is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include numerous Federal statutes, hundreds of State statutes pursuant to Pub.L.92-544, Presidential executive orders, regulations and/or orders of the Attorney General of the United States, or other authorized authorities. Examples include, but are not limited to: 5 U.S.C. 9101; Pub.L.94-29; Pub.L.101-604; and Executive Orders 10450 and 12968. Providing the requested information is voluntary; however, failure to furnish the information may affect timely completion of approval of your application.

Social Security Account Number (SSAN): Your SSAN is needed to keep records accurate because other people may have the same name and birth date. Pursuant to the Federal Privacy Act of 1974 (5 USC 552a), the requesting agency is responsible for informing you whether disclosure is mandatory or voluntary, by what statutory or other authority your SSAN is solicited, and what uses will be made of it. Executive Order 9397 also asks Federal Agencies to use this number to help identify individuals in agency records.

Principal Purpose: Certain determinations, such as employment, security, licensing and adoption, may be predicated on fingerprint based checks. Your fingerprints and other information contained on (and along with) this form may be submitted to the requesting agency, the agency conducting the application investigation, and/or FBI for the purpose of comparing the submitted information to available records in order to identify other information that may be pertinent to the application. During the processing of this application, and for as long hereafter as may be relevant to the activity for which this application is being submitted, the FBI(may disclose any potentially pertinent information to the requesting agency and/or to the agency conducting the investigation. The FBI may also retain the submitted information in the FBI's permanent collection of fingerprints and related information, where it will be subject to comparisons against other submissions received by the FBI. Depending on the nature of your application, the requesting agency and/or the agency conducting the application investigation may also retain the fingerprints and other submitted information for other authorized purposes of such agency(ies).

Routine Uses: The fingerprints and information reported on this form may be disclosed pursuant to your consent, and may also be disclosed by the FBI without your consent as permitted by the Federal Privacy Act of 1974 (5 USC 552a(b)) and all applicable routine uses as many be published at any time in the Federal Register, including the routine uses for the FBI Fingerprint Identification Records System (Justice, FBI-009) and the FBI's Blanket Routine Uses (Justice/FBI-BRU). Routine uses include, but are not limited to, disclosures to: appropriate governmental authorities responsible for civil or criminal law enforcement counterintelligence, national security or public safety matters to which the information may be relevant; to State and local governmental agencies and nongovernmental entities for application processing as authorized by Federal and State legislation, executive order, or regulation, including employment, security, licensing, and adoption checks; and as otherwise authorized by law,

treaty, executive order, regulation, or other lawful authority. If other agencies are involved in processing the application, they may have additional routine uses.

Additional Information: The requesting agency and/or the agency conducting the application investigation will provide you additional information pertinent to the specific circumstances of this application, which may include identification of other authorities, purposes, uses, and consequences of not providing requested information. In addition, any such agency in the Federal Executive Branch has also published notice.



Electronic Fingerprinting

Take this form with you to the Live Scan service provider. Please check the service provider’s requirements to see if you need to bring any additional items.

- Background screening results are obtained from the Florida Department of Law Enforcement and the Federal Bureau of Investigation by submitting to a fingerprint scan using the Livescan method;
- You can find a Livescan service provider at: <http://www.floridahealth.gov/licensing-and-regulation/background-screening/livescan-service-providers.html>
- Failure to submit background screening will delay your application;
- Applicants may use any Livescan service provider approved by the Florida Department of Law Enforcement to submit their background screening to the department;
- If you do not provide the correct Originating Agency Identification (ORI) number to the Livescan service provider the Board office will not receive your background screening results;
- You must provide accurate demographic information to the Livescan service provider at the time your fingerprints are taken, *including your Social Security number (SSN)*;
- The ORI number for the Board of Pharmacy is **EDOH4680Z**.
- Typically background screening results submitted through a Livescan service provider are received by the Board within 24-72 hours of being processed.
- If you obtain your livescan from a service provider who does not capture your photo you may be required to be reprinted by another agency in the future.

Name: _____ SSN#: _____ - _____ - _____

Aliases: _____

Address: _____ Apt. Number: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: ____/____/____ Place of Birth: _____
(MM/DD/YYYY)

Weight: _____ Height: _____ Eye Color: _____ Hair Color: _____

Race: _____ Sex: _____
(W-White/Latino(a); B-Black; A-Asian; (M=Male; F=Female)
NA-Native American; U-Unknown)

Citizenship: _____

Transaction Control Number (TCN#): _____
(This will be provided to you by the Live Scan Service provider.)

Keep this form for your records.

**CERTIFIED CHIROPRACTIC PHYSICIAN'S 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. COMPLETE ELECTRONIC FINGERPRINTING**



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 Physician's 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 (non-refundable)
Supervisor Physician Fee:	\$100.00
License Fee:	\$100.00
Unlicensed Activity Fee:	\$ 5.00
Total Fee:	\$305.00

APPLICANT PROFILE: (completed by CCPA 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)

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

4. EDUCATION/TRAINING HISTORY: (Please list the school(s) or college(s) of chiropractic/training program from which you graduated/completed) Attach a certificate of completion of the program you completed or were graduated.

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

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 any 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)
------------------	---------	-------------------------	----------------	---------------------

7. CRIMINAL INFORMATION:

- a. 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)

- b. I have **been provided and read** the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the “Privacy Statement” document from the Federal Bureau of Investigation. YES NO

IMPORTANT NOTICE: Applicants for licensure, certification or registration and candidates for examination who were arrested or charged with certain felonies after July 1, 2009 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
- 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.** Are you under investigation or prosecution for a crime in any jurisdiction? YES NO
- 14.** Are you under investigation or pending administrative action by the licensing authority of any jurisdiction, including its agencies and subdivisions? YES NO

15. 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

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)

16. 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 _____

17. BACKGROUND:

List the professional background of the chiropractic physician.

18. 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?

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

CCPA Name

License Number

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

21. 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 PHYSICIAN'S 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 Signature

I swear or affirm that the responses to the felony conviction and previous license revocation or denial are true.

STATE OF FLORIDA
COUNTY OF _____

Sworn to and subscribed before me this ____ day of _____, 20____, by

_____.

Notary Signature

Commissioned Name of Notary

SEAL or information required for electronic notarization (as set forth in Section 117.021(3), FS)

Personally Known _____ OR Produced Identification _____
Type of Identification Produced _____

I recognize that providing false information may result in denial of licensure, disciplinary action against my license or criminal penalties pursuant to Sections 456.067, 456.072, 460.413, 775.082, 775.083 and 775.084, Florida Statutes.

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

Additional Supervising Chiropractic Physician Signature (required if applicable)

Date Signed

Additional Supervising Chiropractic Physician Signature (required if applicable)

Date Signed