Application for Chiropractic Physician Initial Licensure

Board *of* Chiropractic Medicine
P.O. Box 6330
Tallahassee, FL 32314-6330
Website: floridaschiropracticmedicine.gov
Email: MQA.Chiropractic@flhealth.gov
Phone: (850) 245-4355
Fax: (850) 922-8876

Are you an active-duty member of the United States Armed Services?

Are you a veteran of the United States Armed Services?

Are you the spouse of a veteran of the United States Armed Services?

Are you the spouse of an active member of the United States Armed Services?

If you answered “Yes” to any of these questions, you may qualify for a reduction in your application fees. You can find information about the Florida Department of Health’s commitment to serving members and veterans of the United States Armed Forces and their families online at http://www.flhealthsource.gov/valor.

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Do Not Write in this Space
For Revenue Receipting Only

Chiropractic License (501)	**$405.00**
+ Acupuncture Certification (optional)	**$100.00**
Total Fee	**$505.00**

Total fee includes the following:

Application Fee	$100.00
Initial Licensure Fee	$300.00
Unlicensed Activity Fee	$5.00
Acupuncture Certification (optional)	$100.00

Fees must be paid in the form of a cashier's check or money order, made payable to the Department of Health. An applicant who is denied licensure or withdraws their application is entitled to a $305.00 (Licensure Fee and Unlicensed Activity Fee) refund. Requests to withdraw or for a refund must be made in writing. Fees are refundable for up to three years from the date of receipt.

1. PERSONAL INFORMATION

Name: _____ **Date of Birth:** _____
Last/Surname First Middle MM/DD/YYYY

Mailing Address: (The address where mail and your license should be sent)

_____ _____ _____
Street/P.O. Box Apt. No. City

_____ _____ _____ _____
State ZIP Country Home/Cell Telephone

Physical Location: (Required if mailing address is a P.O. Box- This address will be posted on the Department of Health's website.)

_____ _____ _____
Street (Place of Employment) Apt. No. City

_____ _____ _____ _____
State ZIP Country Work/Cell Telephone

EQUAL OPPORTUNITY DATA:

We are required to ask that you furnish the following information as part of your voluntary compliance with 41 CFR Part 60-3-Uniform Guidelines on Employee Selection Procedure (1978); 43 FR 38295 and 38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

Gender:	Male	Race:	Native Hawaiian or Pacific Islander	Hispanic or Latino	White
	Female		American Indian or Alaska Native	Black or African American	Asian
			Two or More Races		

Email Notification: To be notified of the status of your application by email, check the "Yes" box and fill in your email address on the line provided. If you choose to be notified via email you will be responsible for checking your email regularly and updating your email address with the board office.

Yes No Email Address: _____

Under Florida law, email addresses are public records. If you do not want your email address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

2. SOCIAL SECURITY DISCLOSURE

This information is exempt from public records disclosure.

Pursuant to Title 42 United States Code § 666(a)(13), the department is required and authorized to collect Social Security numbers relating to applications for professional licensure. Additionally, section (s.) 456.013(1)(a), Florida Statutes, authorizes the collection of Social Security numbers as part of the general licensing provisions.

Last Name: _____

First Name: _____

Middle Name: _____

U.S. Social Security Number: _____

Social Security Information- * Under the Federal Privacy Act, disclosure of Social Security numbers is voluntary unless specifically required by federal statute. In this instance, Social Security numbers are mandatory pursuant to Title 42 United States Code, § 653 and 654; and s. 456.013(1), 409.2577, and 409.2598, Florida Statutes. Social Security numbers are used to allow efficient screening of applicants and licensees by a Title IV-D child support agency to ensure compliance with child support obligations. Social Security numbers must also be recorded on all professional and occupational license applications and will be used for license identification pursuant to Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act. 104 Pub. L. Section 317). Clarification of the SSA process may be reviewed at www.ssa.gov or by calling 1-800-772-1213.

Name: _____

3. APPLICANT BACKGROUND

A. List any other name(s) by which you have been known in the past. Attach additional sheets if necessary.

_____

B. Enter the year you legally began to practice chiropractic medicine. This would be the year you began practicing chiropractic medicine or the year you began your postgraduate training.

_____
YYYY

C. Do you hold, or have you ever held a license to practice chiropractic medicine or any other health-related license(s)? Yes No

D. List all health-related licenses (active, inactive, or lapsed).

License Type	License #	State/Country	Original Date Issued (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)	Status of License

Submit a License Verification form to **ALL** your state(s) of licensure. License verifications must be received directly from the licensing authority regardless of the status of the license.

4. EMPLOYMENT HISTORY

A. List in chronological order from date of graduation to present date, all practice employment, non-employment and/or any unaccounted period of time into Chiropractic Medical School.

Name of Business	Full Mailing Address	Type of Employment	Employment Dates: From-To (MM/DD/YYYY)
			to
			to
			to

B. Have you ever had employment terminated for cause? Yes No

If you responded "Yes," provide a detailed and accurate explanation for each occurrence, including dates, on a separate sheet.

5. AVAILABILITY FOR DISASTER

Would you be willing to provide health services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster? Yes No

If you respond "Yes," your name will be added to a listing that is available to the Department of Health if a disaster is declared. If you live in an area where you may be able to help you will be called on if needed.

Name: _____

6. EDUCATION HISTORY

A. List undergraduate, graduate, and professional education, listing all schools, colleges, and universities attended whether completed or not, in chronological order.

School Name	City/State or Country	Dates of Attendance: From-To (MM/DD/YYYY)	Graduation Date (MM/DD/YYYY)	Degree Awarded
		to		
		to		
		to		
		to		

All applicants must have an official transcript or, when permitted by s. 460.406(1)(d), Florida Statutes, a credentials evaluation report from a board-approved organization forwarded for both your undergraduate and Chiropractic College directly to the board office from the issuing entity. Diplomas and student copies are not acceptable. Transcripts should be sent to:

Board *of* Chiropractic Medicine
4052 Bald Cypress Way Bin C-07
Tallahassee, FL 32399-3257

A student in a school or college of chiropractic medicine accredited by the Council of Chiropractic Education or its successor, in the final year of the program must have the college submit a letter on official letterhead with your matriculation date and anticipated date of graduation.

In accordance with Rule 64B2-11.001, Florida Administrative Code (F.A.C.), credentials evaluation reports that demonstrate an applicant's undergraduate education to be equivalent to a bachelor's degree may be accepted by the following board-approved organizations:

Center for Applied Research, Evaluation & Education, Inc.	Education Credential Evaluaters
Foreign Academic Credentials Services, Inc.	Foundation for International Services, Inc.
International Counsultants of Delaware, Inc.	International Education Research Foundation, Inc.
Josef Silny & Associates International Educational Consultants	World Education Services SE Branch
World Education Services, Inc.	
Any current member of the National Association of Credential Evaluation Services	

B. List in chronological order from date of graduation from the Chiropractic Medical School to present, all professional/postgraduate training (Internship/Residency/Fellowship).

Program Name	City/State or Country	Program Type	Specialty Area	Dates of Attendance: From-To (MM/DD/YYYY)	Credit Received
				to	Y N
				to	Y N

C. Are you certified by any specialty board recognized by the American Chiropractic Association, International Chiropractic Association, International Academy of Clinical Neurology, or the International Chiropractic Pediatric Association? Yes No

If you responded "Yes," complete the following:

Board Name	Certification / Specialty / Subspecialty	Date of Certification

If certified, you must supply a copy of each certification or a letter of verification.

Name: _____

7. ACADEMIC FACULTY APPOINTMENTS / STAFF PRIVILEGES

A. Do you currently hold a faculty appointment at a medical school? Yes No

B. Have you had the responsibility for graduate medical education within the last 10 years? Yes No

If you responded "Yes" in A-B, complete the following:

Name of Institution	City/State	Title of Appointment

For the purposes of the following questions, a "facility" includes a licensed hospital, health maintenance organization, pre-paid health clinic, ambulatory surgical center, or nursing home.

C. Do you currently hold staff privileges in any hospital, health institution, clinic, or medical facility (do not list training privileges)? Yes No

If you responded "Yes," complete the following: In-State Facility Out-of-State Facility

Name of Facility	City/State	Type of Privileges	From-To (MM/DD/YYYY)
			to
			to

D. Have you ever had any staff privileges denied, suspended, revoked, modified, restricted, or placed on probation, or have you been asked to resign or take a temporary leave of absence or otherwise acted against by any facility? Yes No

If you responded "Yes," complete the following:

Name of Facility	Address	From-To (MM/DD/YYYY)	Under Appeal?
		to	Y N
		to	Y N

E. Have you ever been asked or allowed to resign from any facility instead of facing disciplinary action or during any pending investigations into your practice? Yes No

If you responded "Yes," complete the following:

Name of Facility	Address	From-To (MM/DD/YYYY)	Under Appeal?
		to	Y N
		to	Y N

F. Have you ever had any staff privileges restricted or not renewed by any facility instead of facing disciplinary action? Yes No

If you responded "Yes," complete the following:

Name of Facility	Address	From-To (MM/DD/YYYY)	Under Appeal?
		to	Y N
		to	Y N

Name: _____

8. EXAMINATION INFORMATION

All applicants must have official National Board of Chiropractic Examiners (NBCE) Scores for parts I, II, III, IV, and PT sent directly to the Board of Chiropractic Medicine.

You can find more information from NBCE at https://mynbce.org/score/transcript/.

The board may require an applicant who graduated from an institution accredited by the Council on Chiropractic Education more than 10 years before the date of application to the board to take the National Board of Chiropractic Examiners Special Purposes Examination for Chiropractors, or its equivalent, as determined by the board.

Have you taken and passed the Florida Laws and Rules Examination? Yes No

All applicants must have official Florida Laws and Rules Examination scores sent from NBCE directly to the Board of Chiropractic Medicine.

You can find more information from NBCE at https://mynbce.org/prepare/state/florida-exam/.

9. OTHER ITEMS REQUIRED

A. **National Practitioner Data Bank (NPDB) Self-Query- All applicants** are required to complete a self-query to the NPDB and upon receipt of the report, provide the board office with a copy. A fee is charged by the NPDB to provide the self-query. You can contact NPDB at http://www.npdb.hrsa.gov/.

B. **Acupuncture Course-** This is **ONLY required for applicants who are applying for Acupuncture Certification**. Applicants applying for Acupuncture Certification must provide proof of completion of a 100-hour course in acupuncture issued from the approved provider and proof of completion of the NBCE Acupuncture Examination from NBCE.

Documents in this section must be mailed to:

Board *of* Chiropractic Medicine
4052 Bald Cypress Way Bin C-07
Tallahassee, FL 32399-3257

Name: _____

This information is exempt from public records disclosure.

10. HEALTH HISTORY

Physical and Mental Health Disorders Impacting Ability to Practice

A. During the last two years, have you been treated for or had a recurrence of a diagnosed physical or mental disorder that impaired or would impair your ability to practice? Yes No

B. In the last two years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental or physical disorder that impaired your ability to practice? Yes No

Substance-Related Disorders Impacting Ability to Practice

C. During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol or drug) disorder that impaired or would impair your ability to practice? Yes No

D. During the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol or drug) disorder or, if you were previously in such a program, did you suffer a relapse? Yes No

E. During the last five years, have you been enrolled in, required to enter, or participated in any substance-related (alcohol or drug) recovery program or impaired practitioner program for treatment of drug or alcohol abuse? Yes No

If a "Yes" response was provided to any of the questions in this section, provide the following documents directly to the board office:

A letter from a Licensed Health Care Practitioner, who is qualified by skill and training to address the condition identified, which explains the impact the condition may have on the ability to practice the profession with reasonable skill and safety. The letter must specify that the applicant is safe to practice the profession without restrictions or specifically indicate the restrictions that are necessary. Documentation provided must be dated within one year of the application date.

A written self-explanation, identifying the medical condition(s) or occurrence(s); and current status

Name: _____

11. DISCIPLINE HISTORY

A. Have you ever had any professional license or license to practice revoked, suspended, placed on probation, or received a disciplinary action in any state, territory, or country? Yes No

B. Have you ever had an application for a professional license, or any application to practice chiropractic medicine, denied by any state board or governmental agency (state or country)? Yes No

C. Are you currently under investigation or prosecution for any crime, or under investigation or subject to disciplinary proceedings by any regulatory agency? Yes No

If you responded "Yes" in A-C, complete the following:

Name of Agency	State	Action Date (MM/DD/YYYY)	Final Action	Under Appeal?
				Y N
				Y N
				Y N
				Y N

D. Have you ever had any final disciplinary action(s) taken against you by a specialty board recognized by the department? Yes No

If you responded "Yes" to D, complete the following:

Specialty Board	Action Date (MM/DD/YYYY)	Final Action	Under Appeal?
			Y N
			Y N

If you responded "Yes" to any of the questions in this section, you must provide the following:

A written self-explanation, describing in detail the circumstances surrounding the disciplinary action.

A copy of the **Administrative Complaint** and **Final Order**.

Name: _____

12. CRIMINAL HISTORY

*For the question below, you **must include** all misdemeanors and felonies, even if adjudication was withheld. Reckless driving, driving while license suspended or revoked (DWLSR), driving under the influence (DUI) or driving while impaired (DWI) are **not** minor traffic offenses for purposes of this question.*

*Pursuant to s. 943.0585(6)(b), Florida Statutes, and s. 943.059(6)(b), Florida Statutes, an applicant seeking to be licensed by the Department of Health **must disclose** expunged and sealed criminal history records.*

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 you responded "Yes" in this section, complete the following:

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

If you responded "Yes," you must provide the following:

A written self-explanation, describing in detail the circumstances surrounding each offense; including date, city and state, charges and final results.

Final Dispositions and **Arrest Records** for all offenses. The Clerk of the Court in the arresting jurisdiction will provide you with these documents. Unavailability of these documents must come in the form of a letter from the Clerk of the Court.

Completion of Sentence Documents. You may obtain documents from the Department of Corrections. The report must include the start date, end date, and that the conditions were met.

13. CRIMINAL AND MEDICAID / MEDICARE FRAUD QUESTIONS

IMPORTANT NOTICE: Applicants for licensure, certification, or registration and candidates for examination may be excluded from licensure, certification, or registration if their felony convictions fall into certain timeframes as established in s. 456.0635(2), Florida Statutes.

1. Have you been convicted of, or entered a plea of guilty or nolo contendere, regardless of adjudication, to a felony under chapter (ch.) 409, Florida Statutes (relating to social and economic assistance), ch. 817, Florida Statutes (relating to fraudulent practices), ch. 893, Florida Statutes (relating to drug abuse prevention and control), or a similar felony offense(s) in another state or jurisdiction? Yes No

If you responded "No" to the question above, skip to question 2.

a. If "Yes" to 1, for the 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 1, for the felonies of the third degree, has it been more than 10 years from the date of the plea, sentence, and completion of subsequent probation (this question does not apply to felonies of the third degree under s. 893.13(6)(a), Florida Statutes)? Yes No

c. If "Yes" to 1, for the felonies of the third degree under s. 893.13(6)(a), Florida Statutes, has it been more than five years from the date of the plea, sentence, and completion of any subsequent probation?
Yes No

d. If "Yes" to 1, 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," provide supporting documentation)?
Yes No

Name: _____

2. Have you been convicted of, or entered a plea of guilty or nolo contendere, 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

If you responded "No" to the question above, skip to question 3.

   a. If "Yes" to 2, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended? Yes No

3. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to s. 409.913, Florida Statutes? Yes No

If you responded "No" to the question above, skip to question 4.

   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

4. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? Yes No

If you responded "No" to the question above, skip to question 5.

   a. Have you been in good standing with a state Medicaid program for the most recent five years? Yes No

   b. Did termination occur at least 20 years before the date of this application? Yes No

5. Are you currently listed on the United States Department of Health and Human Services' Office of the Inspector General's List of Excluded Individuals and Entities (LEIE)? Yes No

   a. If you responded "Yes" to the question above, are you listed because you defaulted or are delinquent on a student loan? Yes No

   b. If you responded "Yes" to question 5.a., is the student loan default or delinquency the only reason you are listed on the LEIE? Yes No

If you responded "Yes" to any of the questions in this section, you must provide the following:

A written self-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.

Supporting documentation including court dispositions or agency orders where applicable.

Documentation for sections 10 and 11 must be sent to the board office at MQA.Chiropractic@flhealth.gov or mailed to:

Board *of* Chiropractic Medicine
4052 Bald Cypress Way Bin C-07
Tallahassee, FL 32399-3257

Documentation for sections 12 and 13 must be sent to the Background Screening Unit at MQA.BackgroundScreen@flhealth.gov or mailed to:

Background Screening Unit
Florida Department of Health
4052 Bald Cypress Way, Bin BSU-01
Tallahassee, FL 32399

Name: _____

14. LIVESCAN PRIVACY STATEMENT

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 (found in the forms following this application).

The board will not receive your Livescan results if you do not confirm the above statement by checking the box.

Electronic Fingerprinting: (Required for ALL applicants)

All applicants, including out-of-state applicants, are required to submit their fingerprints electronically. The Department of Health accepts electronic fingerprinting offered by Livescan service providers that are approved by the Florida Department of Law Enforcement. For a list of approved vendors, visit our website at: http://www.flhealthsource.gov/background-screening.

Typically background results submitted by Livescan are received by the board within 24-72 hours of being processed. The board's ORI number is **EDOH2016Z**. The board cannot accept hard fingerprint cards or results. All results must be submitted electronically by the Livescan service provider.

The Florida Department of Health retains fingerprints on any applicant in the Care Provider Clearinghouse. One of the requirements for your Livescan to be retained in the Care Provider Clearinghouse is a photograph must be taken by the Livescan service provider at the time of fingerprinting. Your background screening results will be retained for five years. Licensees will be notified when their retention date is approaching and will be provided with instructions on how to retain their fingerprints to avoid having to submit a new background screening.

15. DRUG ENFORCEMENT AGENCY

A. Have you ever been warned or called before the Drug Enforcement Agency (DEA)? Yes No

B. Have you ever been made an offer to compromise or entered into any other arrangement or other plea or agreement in lieu of federal prosecution for a drug violation regulated by the DEA? Yes No

C. Have you ever been denied or surrendered a DEA registration? Yes No

If you responded "Yes" to any of the questions in this section, you must provide a detailed and accurate explanation on a separate sheet.

16. LIABILITY CLAIMS

A. Have you been insured continuously during the last 10 years? Yes No

B. Within the last 10 years, have you had any liability claim(s) or action(s) for damages for personal injury settled or finally adjudicated in an amount that exceeds $100,000? Yes No

If you responded "Yes" to question B, you must complete the Exhibit 1 form found following this application.

Name: _____

17. APPLICANT SIGNATURE

I, the undersigned, state that I am the person referred to in this application for licensure in the state of Florida.

I recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to s. 456.067, Florida Statutes.

Florida law requires me to immediately inform the board of any material change in any circumstances or condition stated in the application which takes place between the initial filing and the final granting or denial of the license and to supplement the information on this application as needed.

Section 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after the initial filing with the department.

Applicant Signature _____ Date _____
You may print this application and sign it or sign digitally. MM/DD/YYYY

Florida Board *of* Chiropractic Medicine
Financial Responsibility

This form is required for ALL applicants.

Name: _____

The Financial Responsibility options are divided into two categories: coverage and exemptions. **Choose only ONE** option that best describes your situation, unless you choose **option 3** in the **"Financial Responsibility Coverage"** section. If you provided financial responsibility information to a hospital or elsewhere, be consistent when choosing.

Be advised, failing to choose an option or choosing more than one option will make this form invalid and will delay your licensure. Department staff is unable to advise you on which option to choose. If you have questions regarding an option, consult your personal legal counsel, insurance company or financial institution for advice.

FINANCIAL RESPONSIBILITY COVERAGE

1. I have obtained and will maintain professional liability coverage in an amount not less than $100,000, and in compliance with Rule 64B2-17.009(1), F.A.C. (proof of coverage must come directly from the company).

2. I have obtained and will maintain an unexpired irrevocable letter of credit as defined in ch. 675, Florida Statutes, in an amount no less than $100,000 per claim, with a minimum aggregate availability of credit not less than $300,000, and in compliance with Rule 64B2-17.009(2), F.A.C.

3. I am exempt from financial responsibility coverage. ***(If you choose this option you must choose one option from the exemption category below.)***

EXEMPTION CATEGORIES OF FINANCIAL RESPONSIBILITY COVERAGE

1. I practice exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or subdivisions.

2. I practice only in conjunction with my teaching duties at an accredited school or in its main teaching hospitals.

3. I have no malpractice exposure because I do not practice in the state of Florida.

Section 456.067, Florida Statutes – Penalty for giving false information: In addition to, or in lieu of, any other discipline imposed pursuant to s. 456.072, Florida Statutes, the act of knowingly giving false information in the course of applying for or obtaining a license for the department, or any board thereunder, with intent to mislead a public servant in the performance of his or her duties, or the act of attempting to obtain or obtaining a license from the department, or any board thereunder, to practice a profession by knowingly misleading statements or knowing misrepresentations constitutes a felony of the third degree, punishable in s. 775.082, s. 775.083, or s. 775.084, Florida Statutes.

Applicant Signature _____ Date _____
MM/DD/YYYY

FLORIDA DEPARTMENT OF LAW ENFORCEMENT

NOTICE FOR ALL APPLICANTS SUBMITTING FINGERPRINTS WHERE CRIMINAL RECORDS 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 to be employed, licensed, work under contract, or 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 Person 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 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 your 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, Florida Statutes, and Rule 11C-8.001, 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, disclosure 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 additional information 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.

Florida Board *of* Chiropractic Medicine
Electronic Fingerprinting

Take this form with you to the Livescan service provider. 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 a fingerprint scan using the Livescan method.
- You can find Livescan service providers at: http://www.flhealthsource.gov/background-screening.
- 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.
- The ORI number for the Board of Chiropractic Medicine is **EDOH2016Z**.
- You must provide accurate demographic information to the Livescan service provider at the time your fingerprints are taken, **including your Social Security number (SSN)**.
- 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#: _____
Last First Middle

Aliases: _____

Address: _____ Apt. Number: _____

City: _____ State: _____ ZIP: _____

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; NA-Native American; U-Unknown) (M= Male; F=Female)

Citizenship: _____

Transaction Control Number (TCN#): _____
(This will be provided to you by the Livescan service provider.)

Keep this form for your records.

Florida Board *of* Chiropractic Medicine
Exhibit I- Report on Professional Liability Claims and Actions

Include information relating to liability actions occurring within the previous 10 years. The actions are required to be reported under s. 456.039, Florida Statutes. You must submit a completed form for each occurrence.

Date of occurrence: _____ MM/DD/YYYY

Date reported to licensee: _____ MM/DD/YYYY

Date claim reported to insurer or self-insurer: _____ MM/DD/YYYY

Injured person's full name: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Age: _____ Sex: _____

List other defendants with their health care provider license number involved in this claim:

Defendant	Health Care Provider License #

Date of suit, if filed: _____ MM/DD/YYYY

Date of final claim disposition: _____ MM/DD/YYYY

Date of judgment/settlement, if any: _____ MM/DD/YYYY

Amount of judgment/settlement, if any: $_____

Was there an itemized verdict? Yes No **If "Yes," attach a copy of the settlement verdict.**

Indemnity paid on behalf of the defendant: $_____

Loss Adjustment expense paid to defense counsel: $_____

All other loss adjustment expense paid: $_____

If no judgment or settlement, provide the following: Date: _____ MM/DD/YYYY Reason: _____

Name of institution where the injury occurred: _____

Location of injury occurrence:

Critical Care Unit	Emergency Room	Labor & Delivery Room
Nursery	Operating Suite	Patients Room
Physical Therapy Dept.	Radiology	Recovery Room
Special Procedures Room	Other: _____	

Final diagnosis for which treatment was sought or rendered: _____

Describe misdiagnosis made, if any, of the patient's actual condition: _____

Florida Board *of* Chiropractic Medicine
Exhibit I- Report on Professional Liability Claims and Actions

Describe the operation, diagnostic, or treatment procedure causing the injury. Use nomenclature and/or description of the procedures used. Include method of anesthesia, or name of drug used for treatment, with detail of administration.

_____

_____

Describe the principal injury giving rise to the claim. Use nomenclature and/or description of the injury. Include type of adverse effect from drugs where applicable.

_____

_____

Safety management steps taken by the licensee to make similar occurrences less likely.

_____

_____

I represent that these statements are true and correct pursuant to s. 837.06, Florida Statutes. I recognize that providing any false statements made in writing with the intent to mislead the department staff in the performance of their official duties shall be punishable as provided in s. 775.082 and s. 775.083, Florida Statutes.

Applicant Name _____

Applicant Signature _____ Date _____
MM/DD/YYYY

Complete verifications must be mailed directly from the licensing agency to:

Board *of* Chiropractic Medicine
4052 Bald Cypress Way Bin C-07
Tallahassee, FL 32399-3257

Florida Board *of* Chiropractic Medicine License Verification Request

Part I: To be completed by applicant (Florida requires verification of all your current and previously held licenses.)

Name: _____

Address: _____

Name original license was issued under: _____

License Number: _____ State: _____

I hereby authorize release of any information regarding my licensure status to the Florida Board of Chiropractic Medicine.

Applicant Signature: _____ Date: _____
MM/DD/YYYY

Part II: To be completed by state licensing agency

All verifications must be in English and include the following criteria:

* Typed on an official state form or letterhead
* Include an official board seal
* Signature and title of state board official

The following information must be included in all verifications:

* Licensee name
* License number
* State or jurisdiction of licensure
* Licensure status
* Is license in good standing?
* Date of issuance/expiration
* Licensure method (examination, grandfathering, reciprocity/endorsement)
* Has this license ever been encumbered (denied, revoked, suspended, surrendered, limited, placed on probation)?
* If this license has ever been encumbered, please provide certified copies of documentation regarding the action with the completed license verification.