Application for Chiropractic Dry Needling Certification

Board of Chiropractic Medicine
4052 Bald Cypress Way Bin C-07
Tallahassee, FL 32399-3257
Website: www.floridaschiropracticmedicine.gov
Email: MQA.Chiropractic@flhealth.gov
Phone: (850) 245-4355
FAX: (850) 922-8876

DH-MQA 5099, 8/2024, Rule 64B2-17.004, F.A.C.

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Chiropractic Dry Needling Certification (3031)

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 ☐ Female

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

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.

Name: _____

2. APPLICANT BACKGROUND

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

_____

B. To be eligible for this certification, each applicant must hold a current, valid license to practice chiropractic medicine in the state of Florida.

Provide your Florida Chiropractic License #: CH _____

3. DRY NEEDLING TRAINING

To qualify for certification, the chiropractor must have completed a certification course that meets the requirements of section 460.4085(1), Florida Statutes, and Rule 64B2-17.004, Florida Administrative Code (F.A.C.).

Select the appropriate option below that applies to your dry needling coursework.

☐	I am a licensed chiropractic physician **certified in chiropractic acupuncture** and have completed **24 hours** of in-person approved continuing education and passage of a written and practical examination.
☐	I am a licensed chiropractic physician, **not certified in chiropractic acupuncture** and have completed **40 hours** of in-person continuing education and passage of a written and practical examination.
☐	I am a licensed chiropractic physician with coursework completed prior to July 1, 2024, and am requesting that the board review my coursework to be approved to satisfy the coursework requirements.

Note: Online or distance-based courses do not qualify as approved hours to meet the dry needling certification requirements.

Provide the following information for the dry needling coursework you have completed.

Provider Name	Provider Number	Date of Completion (MM/DD/YYYY)	Certificate Number

☐ **Provide a copy of the certificate of completion or other proof that the coursework requirement has been met.**

4. SUPERVISION AND COMPETENT PRACTICE

Pursuant to section 460.4085(1)(b), Florida Statutes, and Rule 64B2-17.004, F.A.C., to qualify for certification, the chiropractor must have completed at least 10 patient sessions of dry needling under the supervision of a licensed chiropractic physician, allopathic or osteopathic physician, or physical therapist holding a Doctor of Physical Therapy degree who has actively performed dry needling for a least one year.

Have you completed at least 10 supervised patient sessions of dry needling? ☐ Yes ☐ No

☐ **Submit the "Supervision and Competency of Dry Needling Practice" form following the application as proof that the supervision and competency requirements have been satisfied.**

Name: _____

5. APPLICANT SIGNATURE

I, the undersigned, state that I am the person referred to in this application for certification 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 certification 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 out the application and sign it or sign digitally. MM/DD/YYYY

Complete forms must be sent directly to
MQA.Chiropractic@flhealth.gov
or mailed to:

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

Board *of* Chiropractic Medicine
Supervision and Competency of Dry Needling Practice

Part I: Applicant Information

Applicant Name: _____

Chiropractic Physician License #: _____ Telephone Number: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Have you submitted the Application for Chiropractic Dry Needling Certification? ☐ Yes ☐ No

Date of Application: _____
(MM/DD/YYYY)

Part II: Supervisor Information

Supervisor Name: _____

Profession: _____ License #: _____

Telephone Number: _____

Dates of Supervised Practice: From: _____ To: _____
(MM/DD/YYYY) (MM/DD/YYYY)

Total Patient Sessions: _____

I state the information provided on this form is true and correct and attest that the chiropractic physician has demonstrated competency and does not need additional supervision to perform dry needling.

Supervisor Signature _____ Date _____
(MM/DD/YYYY)