KENTUCKY BOARD OF CHIROPRACTIC EXAMINERS

PUBLIC PROTECTION CABINET – DEPARTMENT OF PROFESSIONAL LICENSING
P.O. Box 1360, Frankfort, Kentucky 40602
500 Mero Street 2SC32 Frankfort, Kentucky 40601 (Overnight Delivery Only)
Phone: (502) 782.4250 | Fax: (502) 564.4818 | Website: kbce.ky.gov | Email: KBCE@KY.GOV

APPLICATION FOR LICENSURE
GENERAL APPLICANT INFORMATION

MANDATORY PHOTOGRAPH REQUIREMENT

PASTE 2 X 2 PHOTO HERE

Each applicant must paste a 2" X 2" passport photograph of themselves to their application. Polaroid photographs will not be accepted. Photographs may be in black and white or color, must include a full- face view from the shoulders up, and must contain no images of other persons. Photographs must have been taken within six months of application.

Last Name:	First Name:	Middle Initial:	Previous Name:
Mailing Address: Street	City:	State:	Zip Code:
Business Address: Street	City:	State:	Zip Code:
Telephone Number:	Email Address:	D.O.B.	SSN (Last 4):
Present Place of Employment Telephone Number:	Present Place of Employment E-mail Address:		

GENERAL QUESTIONS

Please answer each of the following questions by putting a check (**a**) in the appropriate box on the right.
· You must answer each question with a "Yes" or "No" or "Not Applicable" ("N/A") if this option is provided. No other response is acceptable.
· All "Yes" answers MUST be explained in detail in a separate SIGNED and NOTARIZED affidavit.
· Applicants should be aware that answering "Yes" to some questions may necessitate special screening procedures by the board.
· Failure to disclose any of the requested information may result in the denial of your application or other appropriate action.

1.	Have you ever had any application for any professional license denied by any licensing authority?	☐ YES	☐ NO
2.	Have you ever been denied the privilege of taking an examination required for any professional licensure?	☐ YES	☐ NO
3.	Have you ever been dropped, suspended, placed on probation, expelled, or requested to resign from any post-secondary educational program in which you were enrolled, for reasons in whole or in part, unrelated to grades?	☐ YES	☐ NO
4.	Have you ever been placed on probation, restrictions, suspension, revocation, modification, allowed to resign, requested to leave temporarily or permanently, or otherwise acted against by any professional training program prior to completing the training, for reasons in whole or in part, unrelated to grades?	☐ YES	☐ NO
5.	Have you ever violated or been formally charged with a violation of the honor code of any educational facility?	☐ YES	☐ NO
6.	Have you ever voluntarily surrendered your chiropractic license, allowed it to lapse, or had a limited license issued by any chiropractic licensing authority? *	☐ YES	☐ NO
7.	Have you ever voluntarily surrendered any other health professional license or registration, allowed it to lapse, or had a limited license or registration issued by any health licensing authority? *	☐ YES	☐ NO
8.	Has your chiropractic license ever been revoked, or have you ever been the subject of disciplinary action, or sanctioned by any chiropractic licensing authority, including but not limited to suspended, conditioned, limited, restricted, or qualified in any way?	☐ YES	☐ NO
9.	Have you ever had any other professional license revoked or have you ever been the subject of disciplinary action by any health professional licensing agency, including the refusal to grant, or had action to revoke, suspend, condition, limit, restrict or qualify a professional license in any way?	☐ YES	☐ NO
10.	To your knowledge have any complaints ever been filed against you with any health care licensing agency, which remain unresolved or pending?	☐ YES	☐ NO

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11. Have you ever been convicted, pled guilty, or pled nolo contendre (no contest) to a felony (or any criminal) conviction?	☐ YES	☐ NO
12. Have you ever been named as a defendant to a civil suit related to your profession (i.e., malpractice) which has not been previously reported to the board?	☐ YES	☐ NO
13. Do you have a health-related condition that in any way may impair or limit your ability to practice chiropractic with reasonable skill and safety?	☐ YES	☐ NO
14. If you use chemical substance(s) does it in any way impair or limit your ability to practice chiropractic with reasonable skill and safety?	☐ YES	☐ NO
15. If you answered yes to either question number 14 above or 15 above, are the limitations or impairments caused by your ongoing health related condition reduced or improved because you receive ongoing treatment (with or without medications)?	☐ YES	☐ NO ☐ N/A
16. If you answered yes to either question number 14 above or 15 above, are the limitations or impairments caused by your ongoing health related condition reduced or improved because of the field of practice, the setting, or the manner in which you have chosen to practice?	☐ YES	☐ NO ☐ N/A
17. Do you participate in any professional program designed to monitor or assist in the management related to a chemical, physical, psychological, or emotional impairment?	☐ YES	☐ NO ☐ N/A
18. Within the last ten years, have you suffered from, been diagnosed with, or been treated for bipolar disorder, schizophrenia, delusional disorder (paranoia), or any other psychotic disorder?	☐ YES	☐ NO
19. Within the last ten years, have you suffered from, been diagnosed with, or been treated for any physical condition (e.g., stroke, head injury, dementia, brain tumor, heart disease) that has resulted in significant memory loss, significant loss of consciousness or significant confusion?	☐ YES	☐ NO
20. At any time in the last five years have you on a regular or occasional basis engaged in the illegal use of any controlled substance?	☐ YES	☐ NO
21. If yes to the question immediately above, are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you in order to assure that you are not illegally engaging in the use of controlled substances?	☐ YES	☐ NO ☐ N/A
22. Are you now or have you in the last 5 years been addicted to any chemical substance including alcohol (excluding tobacco and caffeine)?	☐ YES	☐ NO
23. Are you now being treated or have you in the last 5 years been treated for a drug or alcohol addiction or participated in a rehabilitation program?	☐ YES	☐ NO
24. Do you currently have any disease or condition that interferes with your ability to competently and safely perform the essential functions of your profession, including any disease or condition generally regarded as chronic by the medical community, i.e. (1) mental or emotional disease or condition; (2) alcohol or other substance abuse; and/or (3) physical disease or condition, that may presently interfere with your ability to competently and safely perform the essential functions involved in practice as a chiropractor?	☐ YES	☐ NO
25. Within the past five years, have you ever raised the issue of consumption of drugs or alcohol or the issue of mental, emotional, nervous, or behavioral disorder or condition as a defense, mitigation or explanation for your actions in the course of any administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed termination or suspension by an educational institution, employer, government agency, professional organization, or licensing authority?	☐ YES	☐ NO
26. Do you currently have any other condition or impairment, not reported in any question in this application, which in any way affects, or if left untreated might affect, your ability to practice chiropractic in a competent and professional manner?	☐ YES	☐ NO

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WAIVER

I, _____, authorize all postsecondary educational institutions, chiropractic colleges, police departments, courts or other entities maintaining records on myself, to provide said records to the Kentucky Board of Chiropractic Examiners (KBCE) upon their request. I hereby absolve said post-secondary educational institutions, chiropractic colleges, police departments, or other entities of all liabilities for providing said records pursuant to this request.

Signature of Applicant :	Date:

AFFIDAVIT

By completing this application, I hereby request that the Kentucky Board of Chiropractic Examiners approve my application for licensure and consider the information provided herein as evidence of qualification for Kentucky licensure.

I agree that while my application is pending, should any situation arise, that might contradict or alter any of the answers to the questions, listed requirements or affirmations contained in this application, I will, within five working days of such knowledge, notify the Kentucky Board of Chiropractic Examiners of that change.

I agree that I will cooperate with any necessary investigation or inquiry initiated by the Kentucky Board, prior to licensure. I agree that the Kentucky Board may assess reasonable costs for any such investigation or inquiry and acknowledge that I must remit such assessment(s) prior to the granting of a Kentucky license.

Further, I, the undersigned, being duly sworn, do state upon oath that the answers given in the application submitted herewith are true and correct, and agree, if issued a license, to abide by the laws of the state of Kentucky concerning the practice of chiropractic.

I affirm that I:

(1) Am not the subject of any current complaints or investigations in any other state or jurisdiction in which I have held a license to practice or that if I have been the subject of complaints or investigations in another state or jurisdiction, I have provided all details

regarding such complaint(s) or investigations to the KBCE. I understand that existence of such complaints or discipline matters may increase the time it takes for approval of this application.

(2) Have attached a copy of any order for discipline that precedes this application by five years or more.

Additionally, by completing and signing this form I further acknowledge that I have read and understand the Kentucky statutes and administrative regulations governing chiropractic in Kentucky and agree to abide by same. Furthermore, if granted a license I hereby agree to keep the Executive Secretary fully advised as to my latest address; to give such assistance as the law may require to aid in the prosecution of violations of the laws pertaining to the practice of Chiropractic.

Signature (Required) :	Date:

STATE OF _____)

COUNTY OF _____)

Subscribed to and acknowledged before me this _____ day of _____, 20___.

_____ Notary Name Printed	_____ Notary Signature	_____ Commission Expiration Date:

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INSTRUCTIONS

Please send your completed application, $350 application fee (must be a check or money order written out to Kentucky State Treasurer), and supporting documentation to the address above.

Please provide Verification of Licensure directly from each state that you currently hold, or have ever held a license to practice chiropractic in.

Please provide "Official" transcripts, directly from each undergraduate college and chiropractic college that you have attended, as well as an official transcript from the National Board of Chiropractic Examiners, Parts I, II, III and IV.

Please provide the Board with a letter from each of three individuals, not necessarily chiropractors, who are personally acquainted with the applicant, stating that, to their knowledge the applicant is not addicted to intoxicants or drugs, has not had previous license(s) suspended or cancelled, has never been convicted of a felony or any other violation of federal, state or local laws, has no prosecution or complaints to a state board responsible for the licensing of chiropractors pending and is a person of good moral character and reputation and is worthy of professional recognition and confidence. The letters should include the individual's address, phone number and occupation.

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TO BE COMPLETED BY CHIROPRACTICE COLLEGE ONLY!
(Please send to your chiropractic college for completion)

CHIROPRACTIC COLLEGE CERTIFICATION

Applicant Information:

Last Name:	First Name:	Middle Initial:	Previous Name:
Mailing Address: Street	City:	State:	Zip Code:

College Information:

Name of College:			
Mailing Address: Street	City:	State:	Zip Code:

Date of Matriculation:

Date of Graduation:

Total number of months: hours: in chiropractic college attendance.

Do you affirm that the above-named applicant has satisfactorily completed not less than sixty (60) semester hours of pre-professional study (see page 7 for specific courses) from a college or university accredited by the Southern Association of Colleges and Schools or other regional accrediting agencies as recognized by the United States Department of Education and the Council on Higher Education or their successors?

☐ YES ☐ NO

Do you affirm that the Chiropractic College of which the above-named applicant is a graduate was fully accredited by CCE or their successors at the time of the applicant's graduation?

☐ YES ☐ NO

Comments:

_____

_____

_____

Signature of Registrar:	Date:

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BOARD OF CHIROPRACTIC (MEDICAL, ETC.) EXAMINERS
State _____
Address _____
_____
Phone ( ) _____

SCHOOL LOGO
ADDRESS

CHIROPRACTIC COLLEGE CERTIFICATION

A. CERTIFICATION OF PRE-CHIROPRACTIC EDUCATION

The admissions requirements are established in cooperation with the United States Council on Chiropractic Education (CCE). The candidate for admission must be a high school graduate (or present evidence of equivalency) and have completed at least 60 semester hours (or 90 quarter hours) leading to a baccalaureate degree. Pre-chiropractic credits must be earned at institutions listed in the United States Department of Education Higher Education Directory, unless described below:

Comments:

_____
_____
_____

B. CERTIFICATION OF CHIROPRACTIC EDUCATION

I certify that _____ entered _____ on the _____ day of _____ , _____ and graduated on the _____ day of _____ , _____ , receiving the degree Doctor of Chiropractic. S/he completed _____ school terms of _____ months each, totaling _____ hours of _____ minutes each which includes transfer hours. The classroom and laboratory instruction in subjects and hours attended and completed are certified by the attachment of official chiropractic college transcripts.

_____Chiropractic College has professional accreditation by the United States Council on Chiropractic Education, granted on _____.

I hereby certify, by penalty of perjury, that the foregoing is true and correct.

_____ _____
Signature Date

_____
Typed or printed name and title

_____
College Name

_____
City State Zip College Seal

This document is null and void unless received directly from the chiropractic institution named above. *