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 ANNUAL LICENSE RENEWAL

Instructions:

Completion of this application form is necessary for consideration for license renewal under KRS 312 of the Kentucky Revised Statutes. All licenses have an obligation to update and supplement the information and responses on file with the Board office if they change. Failure to supplement the information and responses provided on this application may result in denial or other appropriate action.

Carefully follow the directions on this application form. Print legibly with black or blue ink only.

Supporting Documentation and Fees:

- **Active License** - $250 Renewal Fee, certificate of twelve (12) hours of board-approved continuing education
- **Inactive License** - $75 Renewal Fee

Please return all pages of application, including cover page. Please send your completed application, fee (must be a check or money order written out to Kentucky State Treasurer), and required certificates of continuing education to the address above.

Your application in **NOT** considered completed until **ALL** supporting documents and fees have been received by the Kentucky Board of Chiropractic Examiners. **INCOMPLETE RENEWAL APPLICATIONS WILL BE RETURNED TO THE LICENSEE.**

THERE WILL BE A $300 LATE FEE ASSESSED TO ANY LICENSE NOT RENEWED PRIOR TO MARCH 1. ABSOLUTELY NO EXCEPTIONS.

PART I: Applicant Identifying Information

Complete this section of the form by providing all of the requested information. You must notify the Kentucky Board of Chiropractic Examiners, in writing, of any address change after you file this application in order to receive any further information.

Last Name:	First Name:	Middle Initial:	Suffix, Maiden, Surname, Alias:
Home Mailing Address: Street	City:	State:	Zip Code:
Business Address: Street	City:	State:	Zip Code:
Preferred Mailing Address (Circle One): Home / Business	County in Which You Practice:	Circle One: Male / Female / Non-Binary / Other: _____	
Telephone Number:	Email Address:	D.O.B.	SSN:

Name of Chiropractic Facility at Which You Practice:	Indicate the type of practice you own or work for (ex: sole-proprietor, S corporation, LLC, LLP, etc.):

Name of owner(s) of chiropractic facility at which you practice:

Please attach a list of all shareholders of the chiropractic facility at which you practice and indicate which shareholders are license chiropractors (Include name, address, occupation, and percentage of ownership of each shareholder)

Indicate if you operate your chiropractic practice under a general or limited partnership:	If YES, how long has the partnership been in existence?	List all partners on an additional sheet including name, address, and occupation of each partner.

If your facility employs a management company, please provide the name and address of the management company:

PART II: Education Information

Specialized Certification: Have you completed any specialty certification(s) consisting of 300 or more hours?	If yes, name of specialty certification and certifying agency:

PART III: Work History/Practical Experience

This section must be completed by ALL NEW LICENSEES and all licensees who have changed work locations since the last renewal application.

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

Complete each of the following items. List all CHIROPRACTIC RELATED employment chronologically for the past five (5) years to the present, beginning with your present employment. If you have never been employed, insert "N/A" for not applicable in box 1. You are authorized to photocopy this form if additional space is required. Explain any breaks in employment history of greater than six (6) months.

1. Name of Business/Institution:		Job Title:	Name of Supervisor:
Date of Employment (Start to End):	Circle One: Full-Time / Part-Time	# of Hours Worked:	Reason for Termination:
2. Name of Business/Institution:		Job Title:	Name of Supervisor:
Address: Street	City:	State:	ZIP Code:
Date of Employment (Start to End):	Circle One: Full-Time / Part-Time	# of Hours Worked:	Reason for Termination:
3. Name of Business/Institution:		Job Title:	Name of Supervisor:
Address: Street	City:	State:	ZIP Code:
Date of Employment (Start to End):	Circle One: Full-Time / Part-Time	# of Hours Worked:	Reason for Termination:

PART IV: Personal History

Please answer each of the following questions by marking yes or no where indicated or writing the information in. You must answer each question. All "yes" answers *MUST* by explained in detail in a separate *SIGNED* and *NOTARIZED* affidavit. The affidavit should include all relevant dates and identify the relevant jurisdiction and/or entity involved. Failure to disclose any of the requested information may result in the denial of your application or other appropriate action.

An asterisk (*) next to a question denotes that supporting documentation is not needed if this item was previously reported and is on file with the Board.

1.	*Have you ever had any application for chiropractic license refused or denied by any licensing authority?	☐ YES	☐ NO
2.	*Have you ever been refused or denied the privilege of taking an examination required for a chiropractic license?	☐ YES	☐ NO
3.	*Have you ever voluntarily surrendered your chiropractic license?	☐ YES	☐ NO
4.	*Have you ever allowed your chiropractic license to lapse, or had a limited license issued by any chiropractic licensing authority?	☐ YES	☐ NO
5.	*Have you ever had any chiropractic license revoked?	☐ YES	☐ NO
6.	*Have you ever been the subject of disciplinary action with regard to your chiropractic license or been sanctioned by any chiropractic licensing authority other than Kentucky?	☐ YES	☐ NO
7.	*Have your chiropractic privileges ever been restricted or terminated by any chiropractic licensing authority other than Kentucky?	☐ YES	☐ NO
8.	*To your knowledge, have any unresolved or pending complaints ever been filed against you with any chiropractic licensing agency other than Kentucky?	☐ YES	☐ NO
9.	*Is there any disciplinary action pending against you by any licensing jurisdiction? If YES, when and where?	☐ YES	☐ NO
10.	*Have you ever been charged with or convicted (including a nolo contendere plea or guilty plea) of a felony or criminal offense in any state or in federal court (other than minor traffic violations) whether or not sentence was imposed or suspended? If YES, in addition to the affidavit, attach a certified copy of the court records regarding your conviction, the nature of the offense, date of discharge, if applicable, as well as a statement from the probation or parole officer.	☐ YES	☐ NO

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

11. *Have you ever been pardoned from a felony or criminal conviction?	☐ YES	☐ NO
12. *Have you ever been charged with or convicted (including a nolo contendere plea or guilty plea) of any violation of any local, state, or federal law whether or not sentence was imposed or suspended? (Excluding minor traffic violations)	☐ YES	☐ NO
13. *Have you ever been charged with or convicted (including a nolo contendere plea or guilty plea) of a violation of any federal or state drug laws or rules whether or not sentence was imposed or suspended?	☐ YES	☐ NO
14. *Do you currently have any disease or condition that interferes with your ability to competently and safely perform the essential functions of chiropractic?	☐ YES	☐ NO
15. *Have you ever been named as a defendant to a civil suit related to your profession (i.e. malpractice)? If YES, please provide Patient Name, Date, etc.	☐ YES	☐ NO
16. *Have you ever been court-martialed or discharged other than honorably from the armed services?	☐ YES	☐ NO

Attach additional sheets if necessary to explain answers to above questions.

PART V: Certifying Statement

By virtue of filing this application, I do solemnly swear or affirm that I am of good moral character, and that I understand the instructions and terms set forth in this application form, that I have personally completed this form, and that the information given in this application is true, correct, and complete to the best of my knowledge. I hereby authorize the Kentucky Board of Chiropractic Examiners to verify any and all information contained in this application.

Signature (Required) :	Date:
Printed Name:	