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KENTUCKY BOARD OF CHIROPRACTIC EXAMINERS NEW LICENSEE APPLICATION

GENERAL APPLICANT INFORMATION

MANDATORY PHOTOGRAPH REQUIREMENT

Each applicant must paste a 2" X 2" 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.

Paste 2" x 2" Photo Here

Please type or print the following information:

(All boxes must be answered or marked as "not applicable." Unanswered questions will result in the application being returned to you and will delay processing.)

1. Last Name	2. First Name	3. Full Middle Name	4. Suffix (e.g., JR, SR, etc.)
5. Current Address (If PO Box, must provide street address as well as city, county, state, zip code and country)			
6. Permanent Mailing Address including zip code (If different from current address listed above) (Must provide street address, city, county, state, zip code and country)			
7. Maiden Name, Surname, or Any Other Names or Aliases You Have Been Known By			
8. Place of Birth (List city, county, jurisdiction, zip code and country)	9. Age	10. Date of Birth MM/DD/YYYY	11. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
12. Contact Information			
(a) Telephone Numbers (including area code)			
Work:		Cell:	
Home (optional):			
(b) E-mail Address			
(c) Fax Number (optional)			
13. Social Security Number			

14. Colleges Attended Other Than Chiropractic (Attach additional page(s) if necessary)

COLLEGE OR UNIVERSITY NAME	LOCATION (City and State or Country)	DATES OF ATTENDANCE		DEGREE EARNED Total Hours
		FROM (Month/Year)	TO (Month/Year)	

15. Chiropractic College Information (Attach additional page(s) if necessary)

INSTITUTION NAME	LOCATION (City and State or Country)	DATES OF ATTENDANCE		DEGREE EARNED
		FROM (Month/Year)	TO (Month/Year)	

16. SPECIALIZED TRAINING (Professional Training, Vocation Training, Practical or Clinical Training) (Attach additional page(s) if necessary):

INSTITUTION NAME	LOCATION (City and State or Country)	DATES OF ATTENDANCE		DEGREE OR CER- TIFICATION EARNED
		FROM (Month/Year)	TO (Month/Year)	

17. Name state(s) in which you hold/held a chiropractic license, length of time, and current standing (active, inactive or other) in each state (attach additional page(s) if necessary):

State	License Number	Years of Licensure	Current Standing
		To	
		To	

18. For the last five years please list any and all practice address(es):

NAME Practice, Clinic or Institution	LOCATION PO Box, Street Address City, State, Zip, Country	CONTACT INFORMATION Area Code and Telephone Number	PERIOD OF PRACTICE	
			From (Month/Year)	To (Month/Year)

Initial Application of _____
 Applicant must print name

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HISTORICAL PROFESSIONAL / CHIROPRACTIC INFORMATION

- Please answer each of the following questions by putting a check (✓) 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.

	QUESTION	POSSIBLE ANSWERS
19.	Have you ever had any application for any professional license denied by any licensing authority?	YES <input type="checkbox"/> NO <input type="checkbox"/>
20.	Have you ever been denied the privilege of taking an examination required for any professional licensure?	YES <input type="checkbox"/> NO <input type="checkbox"/>
21.	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 <input type="checkbox"/> NO <input type="checkbox"/>
22.	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 <input type="checkbox"/> NO <input type="checkbox"/>
23.	Have you ever violated or been formally charged with a violation of the honor code of any educational facility?	YES <input type="checkbox"/> NO <input type="checkbox"/>
24.	Have you ever voluntarily surrendered your chiropractic license, allowed it to lapse, or had a limited license issued by any chiropractic licensing authority? *	YES <input type="checkbox"/> NO <input type="checkbox"/>
25.	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 <input type="checkbox"/> NO <input type="checkbox"/>
26.	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 <input type="checkbox"/> NO <input type="checkbox"/>
27.	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 <input type="checkbox"/> NO <input type="checkbox"/>
28.	To your knowledge have any complaints ever been filed against you with any health care licensing agency, which remain unresolved or pending?	YES <input type="checkbox"/> NO <input type="checkbox"/>
29.	Have you ever been convicted, pled guilty, or pled nolo contendere (no contest) to a felony (or any criminal) conviction?	YES <input type="checkbox"/> NO <input type="checkbox"/>
30.	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 <input type="checkbox"/> NO <input type="checkbox"/>

* This does not apply to a license which is voluntarily retired under normal circumstances, and which was not done under threat of, or to avoid, investigation or disciplinary action.

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31.	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 <input type="checkbox"/> NO <input type="checkbox"/>
32.	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 <input type="checkbox"/> NO <input type="checkbox"/>
33.	If you answered yes to either question number 31 above or 32 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 <input type="checkbox"/> NO <input type="checkbox"/> N/A <input type="checkbox"/>
34.	If you answered yes to either question number 31 above or 32 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 <input type="checkbox"/> NO <input type="checkbox"/> N/A <input type="checkbox"/>
35.	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 <input type="checkbox"/> NO <input type="checkbox"/> N/A <input type="checkbox"/>
36.	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 <input type="checkbox"/> NO <input type="checkbox"/>
37.	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 <input type="checkbox"/> NO <input type="checkbox"/>
38.	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 <input type="checkbox"/> NO <input type="checkbox"/>
39.	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 <input type="checkbox"/> NO <input type="checkbox"/> N/A <input type="checkbox"/>
40.	Are you now or have you in the last 5 years been addicted to any chemical substance including alcohol (excluding tobacco and caffeine)?	YES <input type="checkbox"/> NO <input type="checkbox"/>
41.	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 <input type="checkbox"/> NO <input type="checkbox"/>
42.	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 <input type="checkbox"/> NO <input type="checkbox"/>
43.	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 <input type="checkbox"/> NO <input type="checkbox"/>
44.	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 <input type="checkbox"/> NO <input type="checkbox"/>

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WAIVER

I, _____, authorize any and all post-secondary 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 any and 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.

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Applicant must print name

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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 of Applicant

 Date

Subscribed and sworn to before me

This ____ day of _____, 20____

 Signature of Notary

(SEAL)

(This page must be signed, notarized and returned with your application.)

FOR BOARD USE ONLY:

Form Related Information	Payment Information	Received Stamp
Incomplete Form Returned To Licensee	Check #	
Date Re-received Form	Amount	
Staff Initials	Date/Initials	
CINBAD Check Results:		

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 Applicant must print name

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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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Applicant must print name

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

CHIROPRACTIC COLLEGE CERTIFICATION

Name of Applicant _____

Address _____

City _____ State _____ Zip _____

Name of College _____

Address _____

City _____ State _____ Zip _____

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 _____

Initial Application of _____

Applicant must print name

_____ Date

BOARD OF CHIROPRACTIC (MEDICAL, ETC.) EXAMINERS

SCHOOL LOGO
ADDRESS

State _____

Address _____

Phone () _____

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.****

Important Information to Know & Remember

Common Advertising Violations

1. Any time you use Dr., you must designate the type of doctor you are by using D.C. or Chiropractor. Refer to KRS 311.375.
2. You cannot use the terms Certified, Advanced, Specialty, or Specialize in any advertisement, etc. unless you are certified by the Board in one of its recognized specialties (found at kbce.ky.gov) and/or have met the terms in Board regulation 201 KAR 21:045.
3. You cannot advertise Physical Therapy unless you have a licensed Physical Therapist working in your office. KRS 312.015 defines chiropractic, in part, as "...using methods of treatment designed to augment those adjustments..." Advertising Physical Therapy is in violation of KRS 327.020 (1), (3) which governs the practice of physical therapy in Kentucky. It is recommended that you not use therapies, physiotherapy, or any terminology that makes reference to Physical Therapy.

Please Return All Three (3) Pages

**Please Keep A Copy Of This Information
For Future Reference
Common Questions Regarding Continuing
Education**

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1. 12 hours of continuing education must be obtained before March 1 of each year with 6 hours obtained at a live, in-person course. A maximum of 8 hours can be obtained in one day.
2. All continuing education courses must be Kentucky Board approved to count toward your renewal hours.
3. In order to meet the requirements for approval, a course must be on a post-graduate level, must be located at or sponsored by an accredited chiropractic college, or sponsored by any state or national chartered organization of chiropractors. Approval must be requested at least 60 days prior to the date of the program.
4. Effective February 2021, 6 of the 12 annual CE hours may be completed online through a board-approved course.
5. Licensees who renew as inactive status are exempt from CE requirements. Licensees with an inactive license may not practice chiropractic in Kentucky.
6. New licensees are exempt from the CE requirements for their first renewal; however, new licensees MUST complete the Board's jurisprudence course in their first year of licensure.

**Any Licensee Who Does Not Meet The Requirements
For License Renewal Prior To March 1 Annually Will
Be Assessed A \$300 Late Fee**

For Your Information

1. KRS 312 requires all licensees to keep the Board informed of any CHANGE OF ADDRESS.
2. Failure to renew your license within 45 days of the delinquent notice will result in the automatic REVOCATION of your license.
3. Please familiarize yourself with the minimum standards for record keeping. You are expected to adhere to these minimum standards.
4. Peer Review: Peer review of Kentucky Chiropractic claims can only be performed by Kentucky licensed chiropractors who have completed additional educational training and have registered with the Kentucky Board of Chiropractic Examiners to perform Peer Review. Please refer to 201 KAR 21:095.
5. KRS 422.317 requires the release of one copy of patient records (including x-rays) at no charge, upon the patient's written request. Records must be provided within ten business days of receipt of the request and cannot be withheld due to non-payment of services rendered.

**APPLICATION FOR ANNUAL LICENSE RENEWAL
KENTUCKY STATE BOARD OF CHIROPRACTIC EXAMINERS**

Important Notice:

Completion of this application form is necessary for consideration for license renewal under KRS 312 of the Kentucky Revised Statutes. **All licensees 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. In addition, note the following:

1. Print legibly with black or blue ink only.
2. The renewal fee, or any part thereof, is **NOT** refundable.

Supporting Documentation and Fees:

If you are applying for license renewal as an **actively** practicing Kentucky Licensed Chiropractor you **MUST** submit the following documents and fees:

▲ ACTIVE LICENSE

- \$250 Renewal Fee
- Proof of completion of continuing education must only be submitted if requested by the Board

If you are applying for an **INACTIVE** status license renewal you **MUST** submit the following fee:

▲ INACTIVE LICENSE

- \$75 Inactive License Renewal Fee

If you are applying for a **HARDSHIP** license renewal, please provide an affidavit or letter from your doctor outlining your medical hardship.

▲ HARDSHIP LICENSE

Your application is **NOT** considered complete 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.**

NO RENEWAL WILL BE PROCESSED UNTIL ALL REQUIRED DOCUMENTATION IS RECEIVED

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

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201 KAR 21:041
Filed: March 14, 2023

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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 changes after you file this application in order to receive any further information.

1. Last Name	2. First Name	3. MI	4. Suffix (JR.)
5. Business Mailing Address including zip code (If PO Box, Must provide street address as well)			
6. Home Mailing Address including zip code			
7. Identify Preferred mailing address for Official Board Use. <input type="checkbox"/> Business <input type="checkbox"/> Home			
Note: The preferred mailing address shall be available to the public.			
8. Identify any maiden name, surname, or any other names or aliases you have been known by or used and identify the reason for your name change.			
9. County in which you Practice:	10. Date of Birth MM/DD/YYYY	11. <input type="checkbox"/> Male <input type="checkbox"/> Female	
12. Contact Information			
(a) Telephone Numbers:			
Office:			
Home:			
Cell:			
(b) Fax number:			
(c) E-mail address:			
13. Social Security Number:			
14. Name of Chiropractic facility at which you practice:			
15. Name of Owner(s) of Chiropractic facility at which you practice:			
16. Please attach a list of all shareholders of the Chiropractic facility at which you practice: (Include Name, Address, Occupation and percentage of ownership of each shareholder)			
17. If your facility employs a Management Company, please provide name and address of management company			

PART II: Education Information

1. SPECIALIZED CERTIFICATION
Have you completed any specialty certification(s) consisting of 300 or more hours? YES <input type="checkbox"/> NO <input type="checkbox"/>
If Yes, Name of Specialty Certification and Certifying Agency _____

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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 License Renewal Application.

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 6 months.

1. Name of Business/ Institution:		Job Title:
Address/Phone Number of Business/Institution:		Description of Duties Performed:
Name of Supervisor:		
Date of Employment: FROM: ___/___/___ TO: ___/___/___	Hours Worked per Week: Type of Employment: <input checked="" type="checkbox"/> Full-time <input type="checkbox"/> Part-time	
2. Name of Business/ Institution:		Job Title:
Address/Phone Number of Business/Institution:		Description of Duties Performed:
Name of Supervisor:		
Date of Employment: FROM: ___/___/___ TO: ___/___/___	Hours Worked per Week: Type of Employment: <input checked="" type="checkbox"/> Full-time <input type="checkbox"/> Part-time	
3. Name of Business/ Institution:		Job Title:
Address/Phone Number of Business/Institution:		Description of Duties Performed:
Name of Supervisor:		
Date of Employment: FROM: ___/___/___ TO: ___/___/___	Hours Worked per Week: Type of Employment: <input checked="" type="checkbox"/> Full-time <input type="checkbox"/> Part-time	
4. Name of Business/ Institution:		Job Title:
Address/Phone Number of Business/Institution:		Description of Duties Performed:
Name of Supervisor:		
Date of Employment: FROM: ___/___/___ TO: ___/___/___	Hours Worked per Week: Type of Employment: <input checked="" type="checkbox"/> Full-time <input type="checkbox"/> Part-time	

PART IV. Personal History Information

Please answer each of the following questions by putting a check (b') in the appropriate box on the right. You must answer each question with a "Yes" or "No" response as no other response is acceptable. All "Yes" answers **MUST** be 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.

Please read and answer each question carefully, some of the questions have changed!

1. Have you ever had any application for a chiropractic license refused or denied by any licensing authority?	YES <input type="checkbox"/> NO <input type="checkbox"/>
2. Have you ever been refused or denied the privilege of taking an examination required for a chiropractic license?	YES <input type="checkbox"/> NO <input type="checkbox"/>
3. Have you ever voluntarily surrendered your chiropractic license?	YES <input type="checkbox"/> NO <input type="checkbox"/>
4. Have you ever allowed your chiropractic license to lapse, or had a limited license issued by any chiropractic licensing authority?	YES <input type="checkbox"/> NO <input type="checkbox"/>
5. Have you ever had any chiropractic license revoked?	YES <input type="checkbox"/> NO <input type="checkbox"/>
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 <input type="checkbox"/> NO <input type="checkbox"/>
7. Have your chiropractic privileges ever been restricted or terminated by any chiropractic licensing authority other than Kentucky?	YES <input type="checkbox"/> NO <input type="checkbox"/>
8. To your knowledge have any unresolved or pending complaints ever been filed against you with any chiropractic licensing agency other than Kentucky?	
9. Is there any disciplinary action pending against you by any licensing jurisdiction? If YES, where and when?	YES <input type="checkbox"/> NO <input type="checkbox"/>
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 <input type="checkbox"/> NO <input type="checkbox"/>
11. Have you ever been pardoned from a felony (or criminal) conviction?	YES <input type="checkbox"/> NO <input type="checkbox"/>
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 <input type="checkbox"/> NO <input type="checkbox"/>
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 law(s) or rule(s) whether or not sentence was imposed or suspended?	YES <input type="checkbox"/> NO <input type="checkbox"/>
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 <input type="checkbox"/> NO <input type="checkbox"/>
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 <input type="checkbox"/> NO <input type="checkbox"/>
16. Do you operate your chiropractic practice under a general or limited partnership? If "yes," how long has the partnership been in existence?	YES <input type="checkbox"/> NO <input type="checkbox"/>
List all the partners on additional sheet, including name, address, occupation of each partner.	
17. Do you own or work for a practice that is a sole-proprietor, S corporation, LLC, LLP, or other?	YES <input type="checkbox"/> NO <input type="checkbox"/>
18. IF YES, ARE ALL SHAREHOLDERS LICENSED CHIROPRACTORS?	YES <input type="checkbox"/> NO <input type="checkbox"/>

19. Have you ever been court-martialed or discharged other than honorably from the armed service?	YES <input type="checkbox"/> NO <input type="checkbox"/>
20. Are you now, or have you ever, been in arrears with the Kentucky Higher Education Assistance Authority? If yes, please provide documentation that this matter has been resolved.	YES <input type="checkbox"/> NO <input type="checkbox"/>

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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 as set forth in this application form, that I have personally completed this form, 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 of Applicant (Do not print)

Printed Name of Applicant

Date

PLEASE RETURN ALL PAGES OF APPLICATION, INCLUDING COVER PAGE

PLEASE SEND YOUR COMPLETED APPLICATION TO:

**KENTUCKY BOARD OF CHIROPRACTIC EXAMINERS
P.O. BOX 1360
FRANKFORT, KY 40602**

KENTUCKY LAW
The Late Fee is NOW \$300!
Any license not renewed within 45 days of the mailing of a delinquent notice will be automatically revoked!

ANNUAL INACTIVE LICENSE RENEWAL APPLICATION

Due on or Before March 1

Annual License Renewal Fee: Inactive \$75

KRS 312.175 requires the annual renewal of your chiropractic license. The inactive annual renewal fee is \$75.00. Please send check or money order made payable to the Kentucky Board of Chiropractic Examiners. Please do not send cash. KRS 312.175 requires that the annual license renewal fee is paid on or before March 1 of each year.

MAIL TO: Kentucky Board of Chiropractic Examiners
PO Box 183
Glasgow, Kentucky 42142-0183

Phone: 270/651-2522 FAX: 270/651-8784
E-Mail: kychiro@glasgow-ky.com
Website: kbce.ky.gov

PLEASE INCLUDE:

NAME LICENSE #
SS# DOB HOME PHONE
E-MAIL ADDRESS (if applicable) CELL PHONE

CHANGES OR CORRECTIONS ONLY!! PLEASE NOTE ANY ADDRESS OR PHONE CORRECTIONS BELOW:

OFFICE ADDRESS CITY STATE
ZIP CODE PHONE FAX
HOME ADDRESS CITY STATE ZIP

- Inactive License Renewal: \$75.00 Fee Enclosed
Hardship License Renewal: Request exemption from Paying the Renewal Fee (Affidavit Required)

INACTIVE LICENSEES:

I certify that I am in practice in a state or jurisdiction other than Kentucky and/or that I do not intend to practice chiropractic in Kentucky during the renewal period. I further affirm that I have met the educational requirements in the state in which I practice, if applicable, and further that I shall furnish proof of compliance if requested by the Kentucky Board of Chiropractic Examiners.

ALL LICENSEES: (Renewal application will be returned if this portion is not completed and signed)

I hereby certify that my license to practice chiropractic in any state or jurisdiction has never been suspended, revoked, or is in the process of either or both. Note: If the answer is yes, an affidavit of explanation is required. I declare under penalties of perjury that the information in this application is true and correct.

Have you ever been convicted of a felony or misdemeanor that you have not previously disclosed to the Board in writing?
YES NO If the answer is yes, an affidavit of explanation is required.

I hereby certify that I am not in arrears with the Kentucky Higher Education Assistance Authority.

Signature of Licensee

Date

Dirty

Dirty

Kentucky Board of Chiropractic Examiners
P.O. Box 1360
Frankfort, KY 40602
Phone: (502) 892-4250
Fax: (502) 564-4818

APPLICATION FOR ACTIVATION/REINSTATEMENT
OF KENTUCKY LICENSE

(For Non-Resident, Inactive, Revoked or Voluntarily Resigned Licenses)

APPLICATION CANNOT BE PROCESSED UNLESS
ALL INFORMATION REQUESTED BELOW IS PROVIDED

LICENSE NO. _____ E-MAIL _____

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____ FAX _____

~ I hereby certify that my license to practice chiropractic in any state or jurisdiction has never been suspended, revoked, or is in the process of either or both. **NOTE:** If the answer is yes, an affidavit of explanation is required. Please provide a verification of licensure from any state in which you are currently or have ever been licensed.

Have you ever been convicted of a felony or misdemeanor that you have not previously disclosed to the Board in writing? ~ YES ~ NO
If answer is yes, an affidavit of explanation is required.

Are you now, or have you ever been in arrears with the Kentucky Higher Education Assistance Authority (KHEA)? ~ YES ~ NO

Have you had any action against any chiropractic license in another state or jurisdiction that has not been previously reported to the Board? ~ YES ~ NO

I declare under penalties of perjury that the information in this application is true and correct.

Signature of Licensee

Date



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" 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?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
2. Have you ever been denied the privilege of taking an examination required for any professional licensure?	<input type="checkbox"/> YES	<input type="checkbox"/> 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?	<input type="checkbox"/> YES	<input type="checkbox"/> 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?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
5. Have you ever violated or been formally charged with a violation of the honor code of any educational facility?	<input type="checkbox"/> YES	<input type="checkbox"/> 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? *	<input type="checkbox"/> YES	<input type="checkbox"/> 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? *	<input type="checkbox"/> YES	<input type="checkbox"/> 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?	<input type="checkbox"/> YES	<input type="checkbox"/> 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?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
10. To your knowledge have any complaints ever been filed against you with any health care licensing agency, which remain unresolved or pending?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

Clean



KENTUCKY BOARD OF CHIROPRACTIC EXAMINERS

PUBLIC PROTECTION CABINET – DEPARTMENT OF PROFESSIONAL LICENSING

P.O. Box 1360, Frankfort, Kentucky 40602

500 Mero Street 25C32 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 convicted, pled guilty, or pled nolo contendere (no contest) to a felony (or any criminal) conviction?	<input type="checkbox"/> YES	<input type="checkbox"/> 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?	<input type="checkbox"/> YES	<input type="checkbox"/> 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?	<input type="checkbox"/> YES	<input type="checkbox"/> 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?	<input type="checkbox"/> YES	<input type="checkbox"/> 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)?	<input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> 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?	<input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> 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?	<input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> 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?	<input type="checkbox"/> YES	<input type="checkbox"/> 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?	<input type="checkbox"/> YES	<input type="checkbox"/> 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?	<input type="checkbox"/> YES	<input type="checkbox"/> 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?	<input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> 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)?	<input type="checkbox"/> YES	<input type="checkbox"/> 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?	<input type="checkbox"/> YES	<input type="checkbox"/> 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?	<input type="checkbox"/> YES	<input type="checkbox"/> 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?	<input type="checkbox"/> YES	<input type="checkbox"/> 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?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

WAIVER



KENTUCKY BOARD OF CHIROPRACTIC EXAMINERS

PUBLIC PROTECTION CABINET – DEPARTMENT OF PROFESSIONAL LICENSING

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500 Mero Street 2SC32 Frankfort, Kentucky 40601 (Overnight Delivery Only)

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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____.



KENTUCKY BOARD OF CHIROPRACTIC EXAMINERS

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

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.



KENTUCKY BOARD OF CHIROPRACTIC EXAMINERS

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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.

I 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:



KENTUCKY BOARD OF CHIROPRACTIC EXAMINERS

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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. ****



KENTUCKY BOARD OF CHIROPRACTIC EXAMINERS

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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, with a minimum of six (6) hours obtained at a live, in-person event.
- **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 is **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

Clean



KENTUCKY BOARD OF CHIROPRACTIC EXAMINERS

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This section must be completed by **ALL NEW LICENSEES** and **all licensees who have changed work locations** since the last renewal application. 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** be 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?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
2. *Have you ever been refused or denied the privilege of taking an examination required for a chiropractic license?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
3. *Have you ever voluntarily surrendered your chiropractic license?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
4. *Have you ever allowed your chiropractic license to lapse, or had a limited license issued by any chiropractic licensing authority?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
5. *Have you ever had any chiropractic license revoked?	<input type="checkbox"/> YES	<input type="checkbox"/> 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?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
7. *Have your chiropractic privileges ever been restricted or terminated by any chiropractic licensing authority other than Kentucky?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
8. *To your knowledge, have any unresolved or pending complaints ever been filed against you with any chiropractic licensing agency other than Kentucky?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
9. *Is there any disciplinary action pending against you by any licensing jurisdiction? If YES, when and where?	<input type="checkbox"/> YES	<input type="checkbox"/> 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	<input type="checkbox"/> YES	<input type="checkbox"/> NO



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from the probation or parole officer.		
11. *Have you ever been pardoned from a felony or criminal conviction?	<input type="checkbox"/> YES	<input type="checkbox"/> 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)	<input type="checkbox"/> YES	<input type="checkbox"/> 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?	<input type="checkbox"/> YES	<input type="checkbox"/> 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?	<input type="checkbox"/> YES	<input type="checkbox"/> 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.	<input type="checkbox"/> YES	<input type="checkbox"/> NO
16. *Have you ever been court-martialed or discharged other than honorably from the armed services?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
17. *Are you now or have you ever been in arrears with the Kentucky Higher Education Assistance Authority? If YES, please provide documentation that this matter has been resolved.	<input type="checkbox"/> YES	<input type="checkbox"/> 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:



KENTUCKY BOARD OF CHIROPRACTIC EXAMINERS

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APPLICATION FOR ACTIVATION/REINSTATEMENT OF KENTUCKY LICENSE

Instructions:

For Non-Resident, Inactive, Revoked, or Voluntarily Resigned Licenses. Application cannot be processed unless all information requested below is provided.

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

Please provide a verification of licensure from any state in which you are currently or have ever been licensed.

Please send your completed application, \$250 fee (must be a check or money order written out to Kentucky State Treasurer), and supporting documentation to the address above.

GENERAL 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:
Telephone Number:	Email Address:	License #:	

GENERAL QUESTIONS

1. Have you ever been convicted of a felony or misdemeanor that you have not previously disclosed to the Board?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
2. Are you now, or have you ever been in arrears with the Kentucky Higher Education Assistance Authority (KHEA)?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
3. Have you had any action against any chiropractic license in another state or jurisdiction	<input type="checkbox"/> YES	<input type="checkbox"/> NO

If you answer YES to any of the above questions, an affidavit of explanation is required. Attach additional sheets if necessary to explain answers to above questions.

CERTIFYING STATEMENT

I hereby certify that my license to practice chiropractic in any state of jurisdiction has never been suspended, revoked, or is in the process of either or both. If the answer is yes, an affidavit of explanation is required. I declare under penalties of perjury that the information in this application is true and correct.

Signature (Required):	Date:
-----------------------	-------

Printed Name:

201 KAR 21:041, clean
Filed: March 14, 2023