



**Government of the District of Columbia  
Department of Health  
Health Regulation and Licensing Administration**



**BOARD OF CHIROPRACTIC**

**NEW LICENSE APPLICATION FOR CHIROPRACTORS (D.C.)**

All applicants must complete every section of this application and submit the original application and all required supporting documents. If more space is needed to fully answer questions, attach additional sheets with typed responses. False or misleading statements will be cause for disciplinary action and could be cause for criminal prosecution pursuant to **DC Code 22-2514**. If you have any questions, call HRLA Customer Service at (202)724-4900 Monday through Friday, 8:15AM to 4:40PM EST.

**SECTION 1: LICENSE TYPE AND FEES**

SELECT LICENSURE TYPE:

- |  |          |  |                |
|--|----------|--|----------------|
| <input type="checkbox"/> Chiropractic (D.C.)         | \$568.00 | <input type="checkbox"/> Chiropractic & with 1 Ancillary Procedure   | \$839.00       |
| <input type="checkbox"/> Ancillary Procedures (only) |          | <input type="checkbox"/> Chiropractors & with 2 Ancillary Procedures | \$1110.00      |
| <input type="checkbox"/> Physiotherapy               | \$271.00 | <input type="checkbox"/> Jurisprudence Exam Retake                   | \$110.00       |
| <input type="checkbox"/> Acupuncture                 | \$271.00 |  |                |
|  |          |  | Total \$ _____ |

**SECTION 2A. APPLICANT INFORMATION**

Note: LEGAL NAME: *(Do not use any initials unless they are a part of your name)*

_____	_____	_____	_____
FIRST NAME	MI	LAST NAME	(SUFFIX: Jr., Sr. etc.)
Degree(S) <input type="checkbox"/> D.C. <input type="checkbox"/> Other		GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
____/____/____	_____	_____	____-____-____
Date of Birth	Place of Birth : State/Providence/Territory	Country if not USA	Social Security Number

**SECTION 2B. OTHER NAMES USED: (Please print clearly)**

If your name has changed at any point since you have taken exams or attended college or university, you must provide a copy of a legal name change documents for EACH time that it has changed. Acceptable documents for individuals are marriage certificates, divorce decrees, or court orders.

_____	_____	_____	_____
FIRST NAME	MI	LAST NAME	(SUFFIX: Jr., Sr. etc.)
_____	_____	_____	_____
FIRST NAME	MI	LAST NAME	(SUFFIX: Jr., Sr. etc.)

**SECTION 2C: RACE & ETHNICITY DESIGNATION: (Optional)**

**LANGUAGE(S) SPOKEN:**

- |  |   |
|--|---|
| <input type="checkbox"/> American Indian/Alaskan Native            | <input type="checkbox"/> Asian/South Asian      |
| <input type="checkbox"/> Black or African American                 | <input type="checkbox"/> Caucasian/White        |
| <input type="checkbox"/> Hispanic or Latino                        | <input type="checkbox"/> Other _____            |
| <input type="checkbox"/> Native Hawaiian or other Pacific Islander | <input type="checkbox"/> Choose not to disclose |

*Language(s) spoken other than English:*

- |                                      |   |
|--------------------------------------|---|
| <input type="checkbox"/> Spanish     | <input type="checkbox"/> Vietnamese     |
| <input type="checkbox"/> French      | <input type="checkbox"/> Tagalog        |
| <input type="checkbox"/> Amharic     | <input type="checkbox"/> Mandarin       |
| <input type="checkbox"/> Cantonese   | <input type="checkbox"/> German/ Slavic |
| <input type="checkbox"/> Other _____ |   |





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**SECTION 4A. POST SECONDARY SCHOOLS ATTENDED**

List post- secondary schools attended, in reverse chronological order, beginning with the most recent at the top.

<b>School Name, City, State, Country</b>	<b>Date of Graduation mm/yyyy</b>	<b>Degree/Certificate</b>

**SECTION 4B. CHIROPRACTIC TRAINING AND CLINICAL PRACTICE – POSTGRADUATE EXPERIENCE**

List experience covering the five (5) year period prior to the submission of the application (**MONTH & YEAR**) and all training. Include letters from employing facilities, organizations, and training. **For "TRAINING AND PRACTICE DESCRIPTIONS", use the letter key code below.** List experience in reverse chronological order, beginning with the most recent.

<b>Organization/Institution</b>	<b>Start Date mm/yyyy</b>	<b>End Date mm/yyyy</b>	<b>Type of Position (Use Key Code Below)</b>

**TRAINING AND PRACTICE DESCRIPTIONS/TYPE OF POSITION KEY CODE**

- A. INTERNSHIP B. PRECEPTORSHIP C. EMPLOYMENT D. PRIVATE PRACTICE  
E. OTHER...(Attach a typed explanation on a separate sheet of paper to this form.)**

**SECTION 4C. CHIROPRACTIC LICENSES IN OTHER STATES/JURISDICTIONS**

List all states and jurisdictions in which you have ever held a license (excluding training licenses) and provide letters of verification. Use additional sheet if necessary.

Are you currently applying for licensure in any other jurisdiction?  If yes please list: \_\_\_\_\_

<b>Jurisdiction</b>	<b>Issue Date mm/yyyy</b>	<b>Expiration Date mm/yyyy</b>	<b>License Number</b>



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**SECTION 5B. REQUIRED SCREENING QUESTIONS**

Please answer questions 1 through 15 by placing an X in the appropriate boxes. If you answer "YES" to any question, you must provide full information and complete details **on a separate sheet of paper attaching copies of all relevant documents such as final court orders or panel review decisions.**

1.	Have you ever been arrested, charged, convicted, pled guilty to, or pled no contest to the violation of any federal, state or other statute or ordinance constituting a felony or misdemeanor (including driving under the influence or while impaired, but excluding minor traffic violations)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2.	Have you ever been licensed in any healthcare field in any state or jurisdiction? If yes, please list profession(s) & jurisdiction(s). <b>HEALTH PROFESSION(S)</b> _____ <b>JURISDICTION(S)</b> _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3.	Have you been a defendant or respondent to a claim for damages or a malpractice action?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
4.	Have you ever voluntarily surrendered a license or registration certificate (or allowed it to lapse) after formal charges had been brought against you or while you were under investigation?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
5.	Have you ever surrendered your clinical privileges (voluntary or involuntary) or had your clinical privileges denied, revoked, or suspended at any hospital or health care facility or employer?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
6.	Have you ever been terminated or resigned (voluntary or involuntary) from a clinical or professional training program for any reason?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
7.	Has any licensing authority taken adverse action against your license or privileges or informed you of any pending charges?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
8.	Has any licensing authority, health facility, or peer review board informed you of any pending charge(s) or investigation(s) against you?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
9.	Are you presently or have you ever been under a corrective action plan imposed by an employer, medical facility or educational program?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
10.	Do you have a medical condition or have you become aware of any medical condition that currently impairs or limits your ability to practice chiropractic safely or that could affect your performance or impact your ability to practice your profession?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
11.	Are you currently being treated, or within the past five (5) years have you been treated, for a physical or mental condition that, but for the treatment, could impair your ability to practice your profession?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
12.	Have you ever engaged in the excessive use of alcohol, controlled substances or prescription drugs or have you received treatment or therapy for abuse of alcohol or drugs?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
13.	Within the last ten (10) years, have you voluntarily resigned, been asked to resign, been terminated, or disciplined by any employer due to practice or moral turpitude issues?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
14.	Have you ever withdrawn a license application or have you been denied a license or denied the privilege of taking a license examination by any professional licensing board or agency?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
15.	Have you ever had a professional liability policy cancelled or not renewed?	Yes <input type="checkbox"/>	No <input type="checkbox"/>



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**SECTION 6A. SUPPORTING DOCUMENTS**

Please indicate the supporting documents you have included with this package or requested to be sent to the DC Board of Chiropractic. Keep a photocopy.

- Two recent and identical passport-type photos of the applicant's face (approx. 2"X2") with applicant's name printed on the back.  
*The photos must be original photos and cannot be computer-generated copies or paper copies.*
- Submit one (1) clear photocopy of a government issued photo ID, such as your valid driver's licensed, as proof of identity.
- Criminal Background Check (CBC) *To access form and instructions go to [www.doh.dc.gov/bomed](http://www.doh.dc.gov/bomed) or contact the CBC unit at 1-877-783-4187.*
- Social Security Number or Sworn Affidavit
- One (1) character reference form  
*Please have form completed by a licensed Chiropractor in good standing or MD/DO in good standing, with a minimum of five years of practice.*
- Letter of Recommendation from a previous employer or training program.  
*Please provide a recommendation letter from a previous employer/training program within the last 5 years. Letter must be on company/school letterhead.*
- Verification(s) of licensure  
*These should be provided in a sealed envelope from the issuing jurisdiction(s) for each license.*
- Undergraduate/Professional School transcripts  
*These should be provided in a sealed envelope from the issuing jurisdiction(s) for each license.*
- Documentation of all experience covering the five (5) year period prior to the submission of the application. (Section 4B)  
*Proof of experience should be submitted as a letter on official letterhead from the overseeing institution/organization.*
- Examination Scores (NBCE Parts I-IV)  
*Please provide a copy of your test scores. If you are applying for ancillary procedures, also provide test scores.*

**SECTION 6B. PAYMENT/MAILING INFORMATION**

Make CHECK or MONEY ORDER payable to "DC Treasurer":  
*A charge of \$65.00 will be imposed for dishonored checks  
(Public Law 89-208)*

MAIL YOUR APPLICATION PACKAGE AND CHECK TO:  
Board of Chiropractic-New Application  
HRLA 1  
PO Box 37801  
Washington, DC 20013



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**SECTION 7A. CLEAN HANDS**

**Clean Hands Before Receiving a License or Permit Act of 1996 Certification Form Requirement**

Please read the information below carefully before responding to this yes or no question, as **any false information provided requires that the Department of Health proceed immediately to revoke your License or Permit** for which you are now applying, and fine you one thousand dollars (\$1,000.00), pursuant to D.C. Official Code § 47-2864 (2001).

**IF YOU ANSWER "YES" TO THIS QUESTION, PLEASE SUBMIT PROOF OF THE ARRANGEMENTS YOU HAVE MADE TO PAY THE OUTSTANDING DEBT. IF YOU DO NOT HAVE AN APPROVED PAYMENT SCHEDULE TO PAY THE AMOUNT YOU OWE OR IF NO APPEAL IS PENDING, THE LAW REQUIRES THAT YOUR NEW LICENSE APPLICATION BE DENIED.**

**As of this date, do you owe more than one hundred dollars (\$100.00) to the District of Columbia Government as a result of any of the following:**

- Fines, penalties, or interest assessed pursuant to **D.C. Official Code Title 8, Chapter 8** (Litter Control Administrative Act of 1985);
- Fines or interest assessed pursuant to **D.C. Official Code Title 8, Chapter 9** (Illegal Dumping Enforcement Act of 1994);
- Fines, penalties, or interest assessed pursuant to **D.C. Official Code Title 2, Chapter 18** (Civil Infractions Act of 1985);
- Past due taxes;
- Past due District of Columbia Water and Sewer Authority service fees; or
- Fines or penalties assessed pursuant to **D.C. Official Code Title 50, Chapter 23** (Traffic Adjudication)?

**Yes    No**  
   

The information presented above is in compliance with the requirement to submit with your application for licensure or permit under the *Clean Hands Before Receiving a License or Permit Act of 1996*, effective May 11, 1996 (**D.C. Law 11-118, D.C. Code §47-2861 et seq.**).

**SECTION 7B. LICENSEE AFFIDAVIT**

*I hereby attest that the information given in this application, including all writings and exhibits attached hereto, is true and complete to the best of my knowledge. I understand that the making of a false statement on this application, including all writings and exhibits attached hereto, is punishable by criminal penalties.*

\_\_\_\_\_  
**LICENSEE SIGNATURE**

\_\_\_\_\_  
**PRINT NAME**

\_\_\_\_\_  
**DATE**

Update by MR: 2/23/15