



## BOARD OF CHIROPRACTIC MEDICINE

### GENERAL INFORMATION/INSTRUCTIONS TO MODIFY SUPERVISION FOR

### CERTIFIED CHIROPRACTIC PHYSICIANS ASSISTANT

#### HOW TO APPLY FOR FLORIDA LICENSURE

\*\*\* PLEASE TYPE OR PRINT IN BLACK INK - PLEASE READ CAREFULLY \*\*\*

#### 1. FLORIDA LAWS & RULES:

You may download a copy of Section 460.4165, Florida Statutes and Rule Chapter 64B2-18, Florida Administrative Code at [www.doh.state.fl.us/mqa/chiro/index.html](http://www.doh.state.fl.us/mqa/chiro/index.html)

#### 2. LICENSURE REQUIREMENTS:

Any Certified Chiropractic Physician's Assistant (CCPA) certified under this section to perform services may perform those services only:

- (a) In the office of the chiropractic physician to whom the CCPA has been assigned, in which office such physician maintains his/her primary practice;
- (b) Under indirect supervision of the chiropractic physician to whom she/he is assigned as defined by rule of the board;
- (c) In a hospital in which the chiropractic physician to whom she/he is assigned is a member of the staff; or
- (d) On calls outside of the office of the chiropractic physician to whom she/he is assigned, on the direct order of the chiropractic physician to whom she/he is assigned.

Each chiropractic physician or group of chiropractic physicians utilizing CCPAs shall be liable for any act or omission of any CCPA acting under his/her or their supervision and control.

The terms "certified chiropractic physician's assistant," or "physician's assistant," or "assistant" as used herein refers to allied health personnel, certified by the Department upon approval by the Board, who are functioning in a dependent relationship with a supervising chiropractic physician and who are performing tasks or combinations of tasks traditionally performed by the chiropractic physician. A CCPA may perform case histories, diagnostic testing, physical examinations, and therapeutic procedures. However, **an assistant cannot be assigned any tasks requiring manipulative or adjustive techniques, the rendering of diagnostic results, interpretations, or treatment advice, or the taking of x-rays unless properly certified by the Radiation Control office.**

The term "supervision" means responsible supervision and control by the supervising chiropractic physician. Except in cases of emergency, supervision shall require the "easy availability" or physical presence of the licensed chiropractic physician for consultation and direction of the actions of the CCPA. "Easy availability" means the supervising physician must be in a location to enable him/her to be physically present with the CCPA within at least thirty minutes and must be available to the CCPA when needed for consultation and advice either in person or by communication devices, such as telephone, two-way radio, medical beeper or other electronic means.

#### **Rule 64B2-18.007 Method of Performance.**

(1) An assistant must clearly identify himself or herself by appropriate identification as a certified chiropractic physician's assistant to insure that he or she is not mistaken for a licensed physician (for example, a name tag).

(2) The assistant must generally function in reasonable proximity to the supervising physician. If he or she is to perform away from the supervising physician, these duties must be clearly specified in the application to the Board.

**3. FEE SCHEDULE:**

The application must be accompanied by documentation of one of the above, and a total fee of \$205.

Application Fee	\$100.00 (non-refundable)
Supervising Physician Fee	\$100.00 (must be renewed annually)
Unlicensed Activity Fee	\$ 5.00
<b>TOTAL:</b>	<b>\$205.00</b>

NOTE: Once an application is complete, the applicant and supervisor must participate in an interview with the CCPA Committee. If the Committee approves the application, it is placed on the agenda for the next regularly scheduled board meeting for ratification. The Committee may recommend denial; in such instance, the application will be presented to the Board for review.

**4. APPLICATION INSTRUCTIONS:**

**The application must be completed in its entirety. If you do not have enough room to provide the answer to a question, please write on the back of the page or attach an additional page(s).**

**Answers written on the back of a page or on additional pages should be numbered to correspond with the question being answered. All parts of the application should be legibly written or typed.**

ALL NEW LICENSEES ARE REQUIRED TO SUBMIT PROOF OF COMPLETION OF A BOARD APPROVED CONTINUING EDUCATION COURSE ON THE PREVENTION OF MEDICAL ERRORS (2 hrs), IN ORDER FOR THE BOARD TO ISSUE A LICENSE. NO LICENSE WILL BE ISSUED WITHOUT THIS DOCUMENTATION.

**5. RETURN APPLICATION AND FEES TO: (certified check or money order)**

Department of Health  
Post Office Box 6330  
Tallahassee, Florida 32314-6330

## CERTIFIED CHIROPRACTIC PHYSICIANS ASSISTANT

### CHECKLIST

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MAKE COPIES OF ALL DOCUMENTS for your records, prior to mailing the originals to the department. Use this worksheet to check off items as you prepare.

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\_\_\_\_\_ **1. FEES:** (certified check or money order)

- Application Fee \$100.00 (non-refundable)
- Modify Supervising Physician Fee \$100.00 (must be renewed annually)
- Unlicensed Activity Fee \$ 5.00
- TOTAL: \$205.00**

\_\_\_\_\_ **2. SOCIAL SECURITY NUMBER page is required**

\_\_\_\_\_ **3. ALL PAGES OF APPLICATION:**

- Affidavit page (last page) must contain your original signature
- All questions must be answered. Questions may not be answered with "refer to attached resume". If a particular question does not apply, please enter N/A in the appropriate field. If explanation or clarification is needed or if any of the sections do not contain sufficient space for the requested information, use an additional sheet of paper and make note on the application question that additional information is attached. Always number the additional information with the corresponding number of the question in the application.
- All "yes" answers must be supported by a certified copy of the final disposition of the case from the clerk of court in the county where the conviction took place.

\_\_\_\_\_ **4. WORK ARRANGEMENT PROPOSAL**

\_\_\_\_\_ **5. CHIROPRACTIC PHYSICIAN INFORMATION**

\_\_\_\_\_ **6. LICENSE VERIFICATIONS:**

Verification must come directly from the licensing authority; a copy of your license is not sufficient and will not be accepted in lieu of official verification, *regardless of the status of the license.*





**BOARD OF CHIROPRACTIC MEDICINE**  
**Application to Modify Supervision for**  
**Certified Chiropractic Physicians Assistant (CCPA)**  
**(Client: 503)**

**Fees: (8075)**

Please complete form and return the fees (certified check or money order) to the address below. Also print legibly or type the information.

Application Fee:	\$100.00
Supervisor Physician Fee:	\$100.00
Unlicensed Activity Fee:	\$ 5.00
<b>Total Fee:</b>	<b>\$205.00</b>

**1. APPLICATION PROFILE DATA: (completed by CCPA Applicant) License #: CI**

(Name) Last First Middle

(Mailing Address) Street Number Apt/Suite Number

City State Zip Code

( ) ( )  
Home Telephone Number Business Telephone Number

Date of Birth Place of Birth (City/State/Country)

Have you ever changed your name through marriage or through action of a court, or have you ever been known by any other name?

\_\_\_\_\_Yes \_\_\_\_\_no

If yes, list name(s) and date(s) of change below:

\_\_\_\_\_

Email Address: \_\_\_\_\_

**2. PLEASE INDICATE YOUR REQUEST(S): [Attach additional sheet(s) if necessary]**

I am ADDING this supervisor: \_\_\_\_\_ CH

I am ADDING this supervisor: \_\_\_\_\_ CH

I am ADDING this supervisor: \_\_\_\_\_ CH  
Supervisor's Name License Number

I am REMOVING this supervisor: \_\_\_\_\_ CH

I am REMOVING this supervisor: \_\_\_\_\_ CH

I am REMOVING this supervisor: \_\_\_\_\_ CH  
Supervisor's Name License Number

**Applicant Name:** \_\_\_\_\_

**3. APPLICANT – GENERAL HISTORY: [Attach additional sheet(s) if necessary]**

Have you ever been convicted or found guilty, regardless of adjudication, of a crime in any jurisdiction, or have you ever been a defendant in a military court-martial? Do not include parking or speeding violations.

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please list date, jurisdiction (state and county), offense, disposition and all relevant information:

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Have you ever been the subject of any disciplinary action by the licensing authority of any state or are you the subject of any pending investigation or disciplinary action?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, provide details and documentation:

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**Applicant Name:** \_\_\_\_\_

**(This section to be completed by each chiropractic physician who will supervise the CCPA)**

Individual Application

Group Application (make copies as needed)

(if group, each supervising chiropractic physician must complete pages 4 - 7)

**4. DATA ON SUPERVISING CHIROPRACTIC PHYSICIAN:**

\_\_\_\_\_  
(Name) Last First Middle

\_\_\_\_\_  
(Physical Address/Primary Practice Location) Street Number/Name Suite Number

\_\_\_\_\_  
City State Zip Code

\_\_\_\_\_  
Home Telephone Number **Business** Telephone Number

Chiropractic License Number: CH \_\_\_\_\_

**5. BACKGROUND: [To be completed by each supervising chiropractic physician]**

List the professional background of the chiropractic physician.

\_\_\_\_\_  
\_\_\_\_\_

**6. DESCRIPTION OF PRACTICE & UTILIZATION OF CCPA:**

**(attach additional sheets as necessary to complete your descriptions)**

Describe your practice and the way in which the CCPA is to be utilized; be specific, give details.

\_\_\_\_\_  
\_\_\_\_\_

**7a.** Is this CCPA going to be performing services away from the primary practice location of the supervisor? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, indicate the specific reason for sending the CCPA to see patients outside your primary practice location:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Applicant Name:** \_\_\_\_\_

**7b.** What are the specific duties you have assigned the CCPA when seeing patients outside your primary practice location?

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**7c.** What is your specific method of supervision and communication with the CCPA when outside the office?

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**8.** List by name and license number all CCPAs you are currently supervising:  
(use additional sheets if necessary)

<b>CCPA Name</b>	<b>License Number</b>
_____	_____
_____	_____
_____	_____
_____	_____

**7a.** List the physical practice address/practice location where each of the above CCPAs work:

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**9.** List all additional practice locations including any location where the chiropractic physician serves as medical director (use additional sheets if necessary):

<b>Physical Address</b>	<b>Medical Director</b>
_____	[ ] Yes [ ] No
_____	[ ] Yes [ ] No
_____	[ ] Yes [ ] No

**BOARD OF CHIROPRACTIC MEDICINE  
CERTIFIED CHIROPRACTIC PHYSICIANS ASSISTANT**

**WORK ARRANGEMENT PROPOSAL BETWEEN:**

**CCPA Name:** \_\_\_\_\_, and

**DC Name:** \_\_\_\_\_ **License Number:** CH\_\_\_\_\_

**PLACE of PRACTICE: (Address where this work arrangement will take place)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is this clinic licensed under Part X of Chapter 400, F.S.? \_\_\_\_\_Yes \_\_\_\_\_No

**Work hours:** From: \_\_\_\_\_AM TO: \_\_\_\_\_PM

**Workdays:** (Circle all that apply) Mon Tues Wed Thur Fri Sat Sun

**Describe the duties the CCPA will be performing:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Describe how the supervising physician will oversee the work being performed by the CCPA:**

\_\_\_\_\_  
\_\_\_\_\_

By signing this document, we agree to be bound by this work arrangement until such time as this agreement is modified and approved by the Florida Board of Chiropractic Medicine.

\_\_\_\_\_, DC, Supervising Chiropractic Physician  
Signature

\_\_\_\_\_, CCPA  
Signature

\_\_\_\_\_ Date signed

**Applicant Name:** \_\_\_\_\_

**APPLICANT SIGNATURE**

I hereby authorize all hospitals, institutions, organizations, my references, personal physicians, employers (past and present), all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Department of Health, any information, files or records requested by the Department in connection with the processing of this application. I further authorize the Department to release to the organizations, individuals and groups listed above any information which is material to my application.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare, under penalty of perjury, that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such acts shall constitute cause for the denial, suspension or revocation of any license to practice in the State of Florida. I have carefully read and understand the applicable Florida laws and rules that pertain to the supervising chiropractic physician and certified chiropractic physician's assistant in Florida Statutes chapter 460 and in Florida Administrative Code rule 64B2-18.

\_\_\_\_\_  
CCPA Signature (required)

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Supervising Chiropractic Physician Signature (required)

\_\_\_\_\_  
Date Signed



LICENSURE VERIFICATION FORM

TO: State Licensing Agency

FROM: \_\_\_\_\_  
(Applicant's Name)

DATE: \_\_\_\_\_  
(Date sent to state board)

NOTE: IMMEDIATE ATTENTION PLEASE

I am applying for a Certified Chiropractic Physicians Assistant in the State of Florida. The Florida Board of Chiropractic Medicine requires verification of licensure by each jurisdiction in which I hold or have ever held licensure. Please complete the verification of licensure section below and mail to the address at the bottom of this form.

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VERIFICATION OF LICENSURE

State of: \_\_\_\_\_

Name of Licensee: \_\_\_\_\_

License Number: \_\_\_\_\_

Issue Date: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

Status of License: \_\_\_\_\_

HAS THIS LICENSE EVER BEEN DISCIPLINED BY YOUR BOARD?

( ) YES ( ) NO

If YES, please attach certified copies of official documentation of action taken.

\_\_\_\_\_  
Signature of Person Verifying

(State Seal)  
Not valid without Seal

\_\_\_\_\_  
Print Name of Above Person

\_\_\_\_\_  
Title of Person Verifying

\_\_\_\_\_  
Date Signed

Department of Health, Board of Chiropractic Medicine  
4052 Bald Cypress Way, Bin #C07 • Tallahassee, FL 32399-3257