



BOARD OF CHIROPRACTIC MEDICINE
Application Instructions for
Chiropractic Medical Faculty Certificate

Fees: Please send a total fee of \$205.00 (certified check or money order) payable to the Dept of Health.

Application fee:	\$100.00
Licensure fee:	\$100.00
ULA fee:	\$ 5.00
TOTAL:	\$205.00

SUPPORTING DOCUMENTS:

1. Mail fees and application to:

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

2. Final Official Chiropractic College Transcript:

A final official transcript must be sent directly from the educational institution/college to this office. Transcripts submitted by the applicant or indicating "issued to student" are not acceptable; a copy of your diploma will not be accepted in lieu of an official transcript. Please note that it is your responsibility to follow-up with your educational institutions to ensure that they have received and complied with your requests.

3. Official Licensure Verification:

The licensure verification forms included with this application package must be sent to each state or other licensing authority where you currently hold or have held a license to practice, regardless of the status of the license. These forms must be sent directly from each state licensing agency to this office. Please note that it is your responsibility to follow-up with licensing agencies to ensure that they have received and complied with your requests. **A copy of your license will not be accepted in lieu of official verification from the licensing agency.**

4. Certification of Appointment:

A letter from the Dean of the appointing college confirming the full-time faculty appointment to teach in a program of chiropractic medicine.

Applicant Name: _____

1. APPLICANT HISTORY (ATTACH ADDITIONAL SHEETS IF NECESSARY)

Pursuant to Section 456.0635(2), Florida Statutes, the following questions are being asked. If you answer yes to any of the following questions, explain on a separate sheet providing accurate details and submit copies of supporting documentation.

- a. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, Chapter 817, or Chapter 893, Florida Statutes; or 21 U.S.C. ss. 801-970 or 42 U.S.C. ss. 1395-1396? YES NO
(If no, do not answer b.)
- b. Has it been more than 15 years prior to the date of this application since the sentence and completion of any subsequent period of probation for each such conviction?
 YES NO
- c. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? YES NO (If no, do not answer d.)
- d. If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years? YES NO
- e. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state or federal government, from any other state Medicaid program or the federal Medicare program? YES NO (If no, do not answer f. and g.)
- f. Have you been in good standing with a state Medicaid program or the federal Medicare program for the most recent five years? YES NO
- g. Did the termination occur at least 20 years prior to the date of this application?
 YES NO

2. APPLICANT-GENERAL HISTORY (ATTACH ADDITIONAL SHEETS IF NECESSARY)

- a. 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:

- b. 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.

Applicant Name: _____

PLEASE LIST EDUCATION:

3. Are you a graduate of an accredited school/college of chiropractic accredited by the Council on Chiropractic Education?

_____ Yes _____ No

School (Name & Location) _____

Degree: _____

Date of Graduation: _____

LICENSURE HISTORY:

4. Do you hold or have you ever held a valid license to practice chiropractic medicine in another jurisdiction in the United States? _____ Yes _____ No

Please list the state(s) and license number(s) below: _____

5. Have you committed any act or offense in any jurisdiction which would constitute the basis for discipline? _____ Yes _____ No (If yes, please explain below and attach supporting documentation)

EMPLOYMENT INFORMATION:

6. Please list the Florida based school/college where you have been offered and have accepted a full-time faculty appointment to teach in a program of chiropractic.

(Please submit a letter from the Dean confirming the appointment)

(Name of School)

Applicant Name: _____

APPLICANT SIGNATURE:

As a reminder to all applicants, please understand that Section 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after initial filing with the department.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations and I declare, 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, for the profession for which I am applying.

Applicant Signature

Date Signed

Mail Application and Fees (certified check or money order) to:

Department of Health
Post Office Box 6330
Tallahassee, Florida 32399-6330