



BOARD OF CHIROPRACTIC MEDICINE

**GENERAL INFORMATION/INSTRUCTIONS
REGISTERED CHIROPRACTIC 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, Florida Statutes and Rule Chapter 64B2, Florida Administrative Code at www.doh.state.fl.us/mqa/chiro/index.html It is important to read this in order to determine your eligibility prior to applying, and to familiarize yourself with the statutes and board rules regarding your application for licensure.

2. FEE SCHEDULE:

Registration Fee	\$25.00 (non-refundable)
Unlicensed Activity Fee	\$ 5.00
Total:	\$30.00

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

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



BOARD OF CHIROPRACTIC MEDICINE
Application for
Registered Chiropractic Assistant (RCA)
(Client: 502)

Fees: (1010)

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

Registration Fee: \$25.00
Unlicensed Activity Fee: \$ 5.00
Total Fee: \$30.00

1. APPLICATION PROFILE DATA: (completed by RCA Applicant)

(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)

E-mail Address: _____

PRIMARY PRACTICE LOCATION:

(Physical Location Address) Street Number Apt/Suite Number

City State Zip Code

() _____
Business Telephone Number E-mail Address

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) of change below:

What country are you a citizen of? _____

APPLICANT NAME: _____

2. EQUAL OPPORTUNITY DATA:

Your furnishing of the information below is voluntary. We are required to ask that you furnish this information as part of your voluntary compliance with Section 2-Uniform Guidelines on Employee Selection Procedure 43FR38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for registration.

Race: _____ White _____ Black _____ Hispanic _____ Asian/Pacific Islander
_____ Native American _____ Other (Specify race here)

Sex: _____ Male _____ Female

3. APPLICANT – GENERAL HISTORY:

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 (e)
- e. 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 _____
- f. 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 (g and h)
- g. Have you been in good standing with a state Medicaid program or the federal Medicare program for the most recent five years? Yes _____ No _____
- h. Did the termination occur at least 20 years prior to the date of this application? Yes _____ No _____

4. 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:

APPLICANT NAME: _____

- 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.

5. Do you hold or have you ever held a license in any other profession?
____YES ____NO

6. **LIST ALL FUNCTIONS THAT YOU WILL BE PERFORMING:**
(Use back of page or attach additional sheet(s) if necessary)

7. **EMPLOYER/SUPERVISOR PROFILE:**

EMPLOYER/SUPERVISOR: _____ CH/CI

EMPLOYER/SUPERVISOR: _____ CH/CI

EMPLOYER/SUPERVISOR: _____ CH/CI
Supervisor's Name License Number

APPLICANT STATEMENT

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, 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, the profession for which I am applying.

Assistant Signature (required) Date Signed

Supervisor Signature (required) Date Signed

Supervisor Signature (required) Date Signed

Supervisor Signature (required) Date Signed