Rev.March/2009

PUERTO RICO BOARD OF CHIROPRACTIC EXAMINERS

PO BOX 10200 San Juan PR 00908-0200
Tel. (787) 723-0782 Fax 724-2971 ó 725-7903
Email: lsosa@salud.gov.pr

Estado Libre Asociado de Puerto Rico
Departamento de Salud

Office of Regulations and Certification of Health Professionals

APPLICATION FOR EXAMINATION

NAME: _____
First Name | Last Name | Name | Initial

PHYSICAL ADDRESS: _____

POSTAL ADDRESS: _____

TELEPHONES: _____
Residence | Work | Cellular | Other

SOCIAL SECURITY NUM: _____ DATE OF BIRTH: _____
MONTH / DAY / YEAR

SECURELY PASTE A PASSPORT-TYPE

PHOTOGRAPH IN THIS SPACE

RIGHT THUMB PRINT
(MAY BE SELF-APPLIED)

If right thumb is missing, uses left and so indicate

AFFIDAVIT

State or of (territory) _____ country of (or city) _____, being duly sworn, says that _____ he (her) is the person referred to in this application and that the statements herein contained are true in every respect, and that the attached photograph is a true likeness of her (him) self taken within the last six months.

I hereby authorized all hospitals, institutions, or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Puerto Rico Board of Chiropractic Examiners any information, files or records requested by the Board in connection with the processing of individuals and groups listed above, any information which is material to me and 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 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 act shall constitute cause for the denial, suspension, or revocation of my license to practice chiropractic in the Commonwealth of Puerto Rico.

SUBSCRIBED AND SWORN TO BEFORE ME this _____ day of _____ 20_____. Witness my hand and seal hereunto attached.

AFFIDAVIT NUM.: _____

_____
Signature of Applicant

Notarial Seal

_____
Signature of Notary Public

PERSONAL INFORMATION OF THE APPLICANT

1. Has your name ever been changed? YES _____ NO _____
   If so, give date and place of such change: _____
   Give original name:_____

2. Place of birth _____ Age: _____

3. Are you a citizen of the United States? YES ____ NO ____ (If naturalized, give date and place of naturalization _____).

4. Are you fluent in Spanish, both written and spoken? ____ YES ____ NO

5. List all jurisdictions in which you have been issued a license to practice chiropractic: active, inactive or expired. Indicate number and date issued: _____
   _____

6. Have you ever been examined by any other licensing Board? ____YES ____NO If yes, give location _____

7. Have you ever been denied the privilege of taking an examination before any state, territory, or county licensing? ____YES ____NO

8. Have you ever been convicted of a violation of/or pled Nolo Contendere to any federal, state or local statute, regulation or ordinance, or entered into any plea bargaining relating to a felony or misdemeanor? (Excluding traffic violations, except convictions for driving under the influence). ____YES ____NO

9. Have you ever been denied voluntarily surrendered your clinical privileges while under investigation, been censured or warned, or requested to withdraw from the staff of any professional school, internship, hospital, nursing home, or other health care facility or health care provider? ____YES ____NO

10. Have you ever had any of the following disciplinary actions taken against your license to practice chiropractic (DEA permit, state controlled substances registration if applicable), Medicaid, or any such actions pending?) (a) suspension/revocation (b) probation (c) reprimand/cease and desist (d) had your practice monitored. ____YES ____NO

11. Have you ever had any membership in a state or local professional society revoked, suspended, or sanctioned? ____YES ____NO

12. Have you voluntarily withdraw from any professional society while under investigation? ____YES ____NO

13. Have you had any malpractice suits brought against you in the last ten years? If so, how many? ____YES ____NO Provide details._____

14. Have you been physically or emotionally dependent upon the use of alcohol/drugs or treated by, consulted with, or been under the care of a professional for any substance abuse within the last two years? If so, please provide a letter from the treating professional. ____YES ____NO

15. Do you have a physical disease, mental disorder, or any condition which could effect your performance of professional duties? If so, provide a letter from your treating professional to include diagnosis, treatment, prognosis and fitness to practice. ____YES ____NO

List in chronological order all professional practice since graduation, including internships and absences from work. Also list all periods of non-professional activity or employment for more than three months. Please account for all time.

FROM	TO	NAME, LOCATION AND POSITION HELD
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
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_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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CLAIMS HISTORY SHEET

If you answered YES to question #14 on page two (2) of the application, please either have your attorney submit a letter regarding malpractice suits and complete one of these sheets for each case you have been involved in. **(Make additional copies of this form as needed)**

Applicant Name:_____

Claimant:_____

Date of Incident:_____ Date Claim Made:_____

Name of all Defendants, Persons or Entities against whom claim was made:_____

_____

_____

City, County and State of Suit:_____

Name and Address of Defense Attorney:_____

_____

Statement Amount (If any):_____ Veredict Amount:_____ Date case closed:_____

Current Status of Claim (Indicate insurance company reserve if case is not closed):_____

_____

_____

Name of involved Insurance Company:_____

_____

Policy Number:_____ Detailed Description of claim (use reverse side if necessary):_____

_____

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize any person, company, insurer, hospital or other organization to release any and all information, privilege, or in their dominion, custody, or control, regarding insurance applications by me, professional liability issued to me, as well as information obtained by any attorneys who are now representing, or have in the past presented me.

_____	_____	_____
Date	Print Name	Signature

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AUTORIZATION TO VERIFY CIN-BAD STATUS

(AUTORIZACION PARA VERIFICAR SU ESTADO EN CIN-BAD)

I, _____ authorize the Puerto Rico Board of Chiropractic Examiners to verify my CIN-BAD (Chiropractic Information Network-Board Databank) status.

Yo, _____ autorizo a la Junta Examinadora de Quiroprácticos de Puerto Rico a verificar mi estatus en CIN-BAD ("Chiropractic Information Network-Board Action Databank").

_____ _____

Name (Nombre en letra de molde) **Date (Fecha)**

_____

Signature (Firma)

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AUTORIZATION FOR RELEASE OF INFORMATION

(AUTORIZACION PARA DIVULGAR INFORMACION)

☐ **I authorize (Autorizo)**

☐ **I do not authorize (No autorizo)**

…the Department of Health to offer information regarding my professional license status to employers, private or government agencies, educational institutions, professional institutions, health insurance companies, malpractice insurance companies and examining boards.

…al Departamento de Salud a ofrecer información sobre el estado de mi licencia profesional a patronos, agencias públicas y/o privadas, instituciones educativas, instituciones profesionales, compañías aseguradoras de salud, compañías de seguros de impericia y juntas examinadoras.

_____ _____

Name (Nombre en letra de molde) **Date (Fecha)**

_____

Signature (Firma)

PUERTO RICO BOARD OF CHIROPRACTIC EXAMINERS

TO BE COMPLETED BY THE PUERTO RICO BOARD OF CHIROPRACTIC EXAMINERS

(Please don't write in this space)

DATE THIS APPLICATION WAS RECEIVED:_____

____APPLICATION APPROVED **____APPLICATION DENIED**

REASON:_____

_____

_____

_____

_____

_____

_____

APPLICATION EVALUATED FROM:

_____ **LICENSE NUM.:_____**
President

_____ **DATE:_____**
Member

_____
Member

PUERTO RICO BOARD OF CHIROPRACTIC EXAMINERS

REQUIREMENTS TO PRESENTS WITH THIS APPLICATION
PLEASE SUBMIT THE FOLLOWING DOCUMENTATION

1. Official application for examination dully fulfilled.

2. OFFICIAL transcript form the University or College where you realized Pre-Chiropractic and Chiropractic studies to be sent directly to the Board of Chiropractic of Puerto Rico, at the following address:

PUERTO RICO BOARD OF CHIROPRACTIC EXAMINERS
PO BOX 10200
San Juan, PR 00908-0200

3. Official copy of Doctor of Chiropractic Diploma.

4. OFFICIAL National Board of Chiropractic Examiners Transcript (Parts I, II, III, IV, and PT (if taken).

5. SPECIALTIES. A certification from any specialty, diplomate and/or fellowship from any recognized association and/or council (ACA, ICA, or any other), if applicable.

6. ORIGINAL Birth Certificate.

7. Evidence of U.S. Citizenship, U.S. National Status, or Alien Status (Birth certificate, US Passport, other).

8. ORIGINAL Certificate of Penal Records from your State Police or State Law Enforcement Agency where you have been living during the last six (6) months.

9. ORIGINAL certificate of *"No Outstanding Fees for Child Alimony"* from your State Health and Family Service Department.

10. SIGNED authorization to verify your CIN-BAD (Chiropractic Information Network- Board Action Databank) status.

REQUIREMENTS TO PRESENTS WITH THIS APPLICATION
(Continuation)

11. Three (3) ORIGINAL letters of recommendation (with letterhead). One must be from active licensed doctor of chiropractic with active practice in the Commonwealth of Puerto Rico. The other two recommendation letters can be form active doctors of chiropractic practicing outside the Commonwealth of Puerto Rico.

12. Copy of current Cardio Pulmonary Resuscitation (CPR) card and/or certificate.

13. Evidence malpractice carrier coverage (if applicable).

14. Postal or Bank Money Order, ATM service, or certified check for the amount of **$35.00** (US Currrency) payable to the Secretary of Treasury of Puerto Rico. (***Fee is non-refundable.***)