Reset Form

APPLICATION FOR CHIROPRACTIC LICENSE

State Form 5174 (R11 / 9-17)
Approved by State Board of Accounts, 2017

INDIANA BOARD OF CHIROPRACTIC EXAMINERS
PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Telephone: (317) 234-2054
E-mail: pla8@pla.IN.gov
www.pla.IN.gov

INSTRUCTIONS:
1. *The fee for this application is $100.00, payable to the Indiana Professional Licensing Agency, in accordance with 846 IAC 1-4-7.*
2. *Completed application and fees should be mailed to the address listed in the upper right hand corner of this form.*
3. *All fees are non-refundable and non-transferable.*
4. *Please refer to the instructions on our website, www.pla.in.gov, for the licensing requirements.*

* This agency is requesting disclosure of your Social Security Number in accordance with IC 4-1-8-1; disclosure is mandatory and this record cannot be processed without it.
** This information is being requested for workforce statistical purposes only; disclosure is voluntary.

FOR OFFICE USE ONLY	
APPLICATION FEE	
DATE FEE PAID (*month, day, year*)	
RECEIPT NUMBER	
LICENSE NUMBER	
LICENSE ISSUANCE DATE (*month, day, year*)	
LAW EXAMINATION DATE (*month, day, year*)	
LAW EXAMINATION SCORE	

APPLICANT

Attach one (1) passport-quality photograph taken not earlier than one (1) year prior to the date of application.

DO NOT WRITE ABOVE THIS LINE

APPLICANT INFORMATION

Name of applicant (*last, first, middle*)		Social Security number *
Date of birth (*month, day, year*)	Place of birth (*city and state or country*)	
Address of applicant (*number and street or rural route*)	City, state, and ZIP code	
Telephone number (*daytime*) ( )	E-mail address	
Gender ** ☐ Male ☐ Female	Ethnicity **	Race **

Pursuant to IC 12-32-1-5 and IC 12-32-1-6, I swear under the penalty of perjury that: *(Please select one of the following.)*
☐ I am a United States Citizen. ☐ I am a qualified alien (as defined under 8 U.S.C. § 1641).

Are you the spouse of a member of the military who is assigned to a duty station in Indiana? *(Optional)* ☐ Yes ☐ No	Are you an active duty member of the military? *(Optional)* ☐ Yes ☐ No

BASIS FOR LICENSURE

Applying for licensure by: (*Please check appropriate box.*) ☐ Examination ☐ Endorsement

If applying by examination, what date will you be taking or have taken the National Board of Chiropractic Examiners - Part IV examination?	Date of examination (*month, day, year*)

TEMPORARY PERMIT (*EXAMINATION CANDIDATES ONLY - TAKING THE NBCE - PART IV EXAMINATION FOR THE FIRST TIME*)

Do you wish to apply for a temporary permit? ☐ Yes ☐ No

CHIROPRACTIC SCHOOL OF GRADUATION

NAME OF SCHOOL	LOCATION	DATE OF GRADUATION (*month, day, year*)

EXAMINATION RECORD

NATIONAL BOARD OF CHIROPRACTIC EXAMINERS

NATIONAL BOARDS	Date of most recent test (*month, day, year*)	WHERE TAKEN (*State*)	HOW MANY TIMES?
PART I			
PART II			
PART III			
PART IV			
PHYSIOTHERAPY			

EXAMINATION RECORD (*continued*)	
Have you ever failed Part IV? ☐ Yes ☐ No	*If Yes, please state the date and location.*

STATE BOARD EXAMINATION

If you are applying by endorsement, please list the State Board Examination you will be endorsing to the State of Indiana.

STATE	EXAMINATION DATE (*month, day, year*)	LICENSE CURRENT?
		☐ Yes ☐ No

PRE-PROFESSIONAL EDUCATION

NAME OF SCHOOL	LOCATION	FROM MONTH/YEAR	TO MONTH/YEAR	DEGREE

PROFESSIONAL EDUCATION (SCHOOL OF CHIROPRACTIC)

NAME OF SCHOOL	LOCATION	FROM MONTH / YEAR	TO MONTH / YEAR	DEGREE

Original state of licensure	License number

LIST ALL STATES INCLUDING INDIANA IN WHICH YOU HAVE BEEN LICENSED TO PRACTICE CHIROPRACTIC

STATE	LICENSE NUMBER	DATE ISSUED *(month, day, year)*	DATE EXPIRES *(month, day, year)*	ISSUED BY EXAMINATION OR ENDORSEMENT?

LICENSED FOR THREE (3) YEARS

If you are applying by endorsement, please list the states where you have been licensed for three (3) years under qualifications substantially equivalent to Indiana.

STATE	LICENSE NUMBER	DATE ISSUED *(month, day, year)*	DATE EXPIRES *(month, day, year)*

LIST ALL PLACES YOU HAVE LIVED SINCE GRADUATION FROM CHIROPRACTIC SCHOOL

GENERAL LOCATION	DATE *(month, day, year)*

LIST ALL PLACES OF EMPLOYMENT SINCE GRADUATION FROM CHIROPRACTIC SCHOOL		
NAME AND ADDRESS OF EMPLOYER	**RESPONSIBILITIES**	**DATES OF EMPLOYMENT** ***(month, day, year)***

If your answer is "Yes" to any of the following, explain fully in a sworn affidavit, including all related details, and provide copies of all relevant arrest or court documents. Describe the event including the location, date and disposition. Falsification of any of the following is grounds for permanent revocation of the license or permit issued pursuant to this application.

1. Have you ever previously filed an application in the State of Indiana? ☐ Yes ☐ No

2. Has disciplinary action ever been taken regarding any health license, certificate, registration or permit you hold or have held? ☐ Yes ☐ No

3. Have you ever been denied a license, certificate, registration or permit to practice chiropractic or any regulated health occupation in any state (*including Indiana*) or country? ☐ Yes ☐ No

4. *Except for minor violations of traffic laws resulting in fines, and arrests or convictions that have been expunged by a court,*
   (1) have you ever been arrested; ☐ Yes ☐ No
   (2) have you ever entered into a prosecutorial diversion or deferment agreement regarding any offense, misdemeanor, or felony in any state; ☐ Yes ☐ No
   (3) have you ever been convicted of any offense, misdemeanor, or felony in any state; ☐ Yes ☐ No
   (4) have you ever pled guilty to any offense, misdemeanor, or felony in any state; or ☐ Yes ☐ No
   (5) have you ever pled *nolo contendre* to any offense, misdemeanor, or felony in any state? ☐ Yes ☐ No

5. Do you have any condition or impairment (including a history of alcohol or substance abuse) that currently interferes, or if left untreated may interfere, with your ability to practice in a competent and professional manner? ☐ Yes ☐ No

6. Have you ever had a malpractice judgment against you or settled any malpractice action? ☐ Yes ☐ No

APPLICATION AFFIRMATION

I hereby swear or affirm, under the penalties of perjury, that the statements made in this application are true, complete and correct.

Signature of applicant	Date signed (*month, day, year*)

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize, request and direct any person, firm, officer, corporation , association, organization or institution to release to the Professional Licensing Agency and the Indiana Board of Chiropractic Examiners any files, documents, records or other information pertaining to the undersigned requested by the Agency, or any of its authorized representatives in connection with processing my application for chiropractic licensure.

I hereby release the aforementioned persons, firms, officers, corporations, associations, organizations and institutions from any liability with regard to such inspection or furnishing of any such information.

I further authorize the Professional Licensing Agency to disclose to the aforementioned organizations, persons, and institutions any information which is material to my application, and I hereby specifically release the Agency and Board from any and all liability in connection with such disclosure.

A photostatic copy of the authorization has the same force and effect as the original.

AFFIRMATION

I hereby swear or affirm that I have read the above statements and agree to same.

Signature of applicant	Date signed (*month, day, year*)

APPLICATION FOR CHIROPRACTIC TEMPORARY PERMIT (Examination Candidates Only)

Part of State Form 5174 (R11 / 9-17)
Approved by State Board of Accounts, 2017

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INSTRUCTIONS: 1. The fee for a temporary permit is $50.00, payable to the Indiana Professional Licensing Agency, in accordance with 846 IAC 1-4-7.

* This agency is requesting disclosure of your Social Security Number in accordance with IC 4-1-8-1; disclosure is mandatory and this record cannot be processed without it.

FOR OFFICE USE ONLY

Temporary permit fee	Date fee paid (*month, day, year*)	Receipt number
Temporary permit number	Date issued (*month, day, year*)	

DO NOT WRITE ABOVE THIS LINE

THIS SECTION TO BE COMPLETED BY THE APPLICANT

Name of applicant (*last, first, middle, maiden*)		Social Security number*	
Address (*number and street or rural route*)			
City		State	ZIP code
Telephone number (*daytime*) ( )		Date of birth (*month, day, year*)	
School of graduation		Date of graduation (*month, day, year*)	
What date will you be sitting for the National Board of Chiropractic Examiners - Part IV Examination?	Date of examination (*month, day, year*)	Have you ever failed the National Boards - Part IV Examination? ☐ Yes ☐ No	

I understand that as a holder of a temporary permit I may not provide an independent diagnosis of a patient.

Signature of applicant	Date signed (*month day, year*)

THIS SECTION TO BE COMPLETED BY THE SUPERVISING CHIROPRACTOR

Name of supervisor		Social Security number*	
Address (*number and street or rural route*)			
City		State	ZIP code
Telephone number ( )	Indiana license number	Expiration date of license (*month day, year*)	

PRACTICE LOCATION

Name of practice			
Address (*number and street or rural route*)			
City	State	ZIP code	Telephone number ( )

I will be exclusively responsible for the direct supervision of the chiropractic graduate who is applying for this temporary permit.

Signature of supervisor	Date signed (*month day, year*)

VERIFICATION OF CHIROPRACTIC STATE LICENSURE

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INSTRUCTIONS:
1. *Type or print and complete the top section.*
2. *Make copies to send to each state you hold or have held a license.*
3. *Request the state(s) to complete and send directly to:*

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APPLICANT INFORMATION

Name of applicant	Social Security number*

Address (*number and street or rural route*)

City, state, and ZIP code

Date of birth (*month, day, year*)	License number	Date of issue (*month, day, year*)

Telephone number ( )	E-mail address

I hereby authorize the State of _____ to furnish the Professional Licensing Agency with the information below.

Signature of applicant	Date signed (*month, day, year*)

License number	Date of issuance (*month, day, year*)	Expiration date (*month, day, year*)

Has the license been subject to disciplinary action? (*Please attach copies of any disciplinary action taken by your board.*)
☐ Yes ☐ No

LICENSED BY

☐ Examination ☐ Endorsement ☐ Other

☐ National Boards ☐ Part I ☐ Part II ☐ Part III (WCCE) ☐ Part IV ☐ Physiotherapy

State examination administered?	Date of examination (*month, day, year*)
☐ Yes ☐ No	

STATE EXAMINATION SUBJECTS AND SCORES

AREA	ORAL / PRACTICAL	APPLICANT'S SCORE	PASSING SCORE
Chiropractic Technique	☐ Yes ☐ No		
Orthopedic Testing	☐ Yes ☐ No		
Neurological Testing	☐ Yes ☐ No		
Physical Diagnosis	☐ Yes ☐ No		
X-Ray Interpretation	☐ Yes ☐ No		
Case Management	☐ Yes ☐ No		

Name	**Please Affix Board Seal**
Title	
State Board	
Date (*month, day, year*)	