Reset Form

APPLICATION FOR CHIROPRACTIC LICENSE

State Form 5174 (R13 / 6-22)
Approved by the State Board of Accounts, 2017

INDIANA STATE BOARD OF CHIROPRACTIC EXAMINERS
PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Telephone: (317) 232-2960
E-mail: pla5@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	

DO NOT WRITE ABOVE THIS LINE

BASIS FOR LICENSURE

Applying for licensure by: *(Please check appropriate box)*

☐ Examination ☐ Endorsement *(Have practiced chiropractic in another state for at least three (3) years.)*

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)*

If 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

APPLICANT INFORMATION

Name of applicant *(last, first, middle, maiden)*	Social Security Number*
Address *(number and street or rural route number)*	City, state, and ZIP code
Telephone number *(daytime)* ( )	Email address
Gender ** ☐ Male ☐ Female	Date of birth *(month, day, year)*

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). ☐ I am authorized by the Federal Government to work in the United States.

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

PREPROFESSIONAL EDUCATION				
NAME OF SCHOOL	**LOCATION**	**FROM MONTH / YEAR**	**TO MONTH / YEAR**	**DEGREE**

PROFESSIONAL EDUCATION (SCHOOL OF CHIROPRACTICS)				
NAME OF SCHOOL	**LOCATION**	**FROM MONTH / YEAR**	**TO MONTH / YEAR**	**DEGREE**

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

EXAMINATION RECORD

Have you ever failed any part of the examination given by the National Board of Chiropractic Examiners (NBCE)? ☐ Yes ☐ No

If you have, please include in your statement the location, part, and date of each unsuccessful attempt.

LIST ALL STATES, INCLUDING INDIANA, IN WHICH YOU ARE OR HAVE BEEN LICENSED TO PRACTICE ANY REGULATED HEALTH OCCUPATION, REGARDLESS OF STATUS

Verification of all licenses listed must be submitted directly from the state licensing board.

Original state of licensure	License number

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

QUESTIONS

If your answer is "Yes" to any of the following, explain fully in a signed written statement, including all related details, and provide copies of all relevant arrest or court documents, disciplinary action against your license or complaints. 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. Has disciplinary action ever been taken regarding any health license, certificate, registration or permit that you hold or have held? ☐ Yes ☐ No

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

3. *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 contendere* to any offense, misdemeanor, or felony in any state? ☐ Yes ☐ No

4. 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

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

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 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 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 information.

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

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

AFFIRMATION

I affirm, under penalties for perjury, that the foregoing representations are true.

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

AFFIRMATION OF SUPERVISION FOR TEMPORARY CHIROPRACTIC PERMIT

(Examination Candidates Only)

Part of State Form 5174 (R13 / 6-22)
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AFFIRMATION OF SUPERVISION

Complete if applying for a temporary permit.

INSTRUCTIONS: A Temporary Permit may be issued to an applicant who meets the following criteria:

- *Applicants who are applying to take the first National Board of Chiropractic Examiners (NBCE) examination Part IV after graduation from chiropractic school or college are eligible for a temporary permit.*
- *The Board may not issue a temporary permit to an individual who has failed an examination.*
- *A temporary permit issued under this section expires on the day after the Board releases the results of the Indiana chiropractic jurisprudence examination.*
- *A supervising chiropractor shall be exclusively responsible for the direct supervision of a holder of a temporary permit.*
- *A holder of a temporary permit shall not provide an independent diagnosis of a patient.*

THIS SECTION TO BE COMPLETED BY THE APPLICANT

Name of applicant *(last, first, middle, maiden)*	
Address *(number and street or rural route, city, state and ZIP code)*	Telephone number *(daytime)* ( )
I understand that as a holder of a temporary permit I may not provide an independent diagnosis of a patient.	
Signature of applicant	Date *(month, day, year)*

THIS SECTION TO BE COMPLETED BY THE SUPERVISING CHIROPRACTOR

Name of supervisor			
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 hereby swear or affirm under penalties of perjury, that I will be exclusively responsible for the direct supervision of the chiropractic graduate who is applying for this temporary permit according to IC 25-10-1-5.5, 846 IAC 1-9-1 and 846 IAC 1-10-4.

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