



DEPARTMENT OF HEALTH  
SOUTH DAKOTA BOARD OF CHIROPRACTIC EXAMINERS  
407 Belmont Avenue  
Yankton, SD 57078

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### GENERAL INFORMATION

Name of Board:	South Dakota Board of Chiropractic Examiners
Type of Board:	Chiropractic
Matriculation Dates:	Contact board office or refer to meeting dates on website
<b>Application deadline:</b>	<b>15 days prior to matriculation date</b>
Application fee:	\$100.00 non-refundable
Acupuncture Certification:	Anyone wishing to be certified for acupuncture must pass the acupuncture test administered by the National Board of Chiropractic Examiners
<b>Official address:</b>	<b>Marcia Walter, Executive Director</b> <b>407 Belmont Avenue</b> <b>Yankton, SD 57078</b>
Telephone:	605-668-9017
E-mail:	<a href="mailto:sdbce@iw.net">sdbce@iw.net</a>
Website:	<a href="http://chiropractic.sd.gov">http://chiropractic.sd.gov</a>

If you need accommodations the night before the meeting, please contact this office two weeks in advance.

**Eligibility:** High school graduate. Two years pre-chiropractic in a regionally accredited college. Graduate of a C.C.E. Fully Accredited Chiropractic College. Person of good moral character. The minimum requirements for licensure of any person graduating on or after January 1, 2011 shall be a baccalaureate degree in addition to a doctor of chiropractic degree. The baccalaureate degree may be granted by an accredited undergraduate program or by a chiropractic college or university that can offer a dual degree.

#### Accompanying Documents:

- Transcripts sent directly from your two-year pre-chiropractic institute.
- Transcripts and copy of graduate diploma sent from your Chiropractic College.
- Official grade transcripts sent directly from the National Board of Chiropractic Examiners including National Board
  - \* Part I
  - \* Part II
  - \* Part III
  - \* Physiotherapy
  - \* Part IV
- Letters of recommendation from two Doctors of Chiropractic.
- Letters of good standing from all states where you have been licensed or currently hold a license
- Fingerprint cards

**License Fees:** Active license fee is currently \$200.00 and inactive license fee is currently \$50.00. Renewal on or before the 31<sup>st</sup> of December of each year.

**Criminal Background Investigation of Applicants for Licensure.** Effective July 1, 2007, each applicant for licensure as a chiropractor, in this state shall submit to a state and federal criminal background investigation by means of fingerprint checks by the Division of Criminal Investigation and the Federal Bureau of Investigation. Upon application, the Board of Chiropractic Examiners shall submit completed fingerprint cards to the Division of Criminal Investigation. Upon completion of the criminal background check, the Division of Criminal Investigation shall forward to the board all information obtained as a result of the criminal background check. This information shall be obtained prior to permanent licensure of the applicant. The Board of Chiropractic Examiners may require a state and federal criminal background check for any licensee who is the subject of a disciplinary investigation by the board. Failure to submit or cooperate with the criminal background investigation is grounds for denial of an application or may result in revocation of a license. The applicant shall pay for any fees charged for the cost of fingerprinting or the criminal background investigation.

**Please contact the board office for fingerprint cards.**

**Continuing Education:** 40 hours of continued education are required within a 2-year period.

**Malpractice Insurance:** Article 20:41:05:10. Financial responsibility also indicates that each chiropractor is required to obtain and maintain professional liability coverage in an amount not less than \$100,000 per claim with a minimum annual aggregate of not less than \$300,000 as a prerequisite for licensure or license renewal.

**South Dakota Board of Examiners** requires Part IV in lieu of State board exam; Part IV results are released to the board in January and July.

The Board meets at least 4 times a year to matriculate applicants, please contact board office or see meeting dates posted on website.

The Board requires that you are present on one of these dates to sign an affidavit concerning South Dakota laws and regulations and attend an informational meeting. You may attend any of these meetings as long as they are up to 90 days before graduation. Licenses will be issued after Part IV results are submitted to the executive director by the National Board of Chiropractic Examiners.

**Scope of Practice:** Practice of Chiropractic. Chiropractic is the science of locating and removing the cause of any abnormal transmission of nerve energy including diagnostic and applied mechanical measures incident thereto. Integral to chiropractic is the treating of specific joints and articulations of the body and adjacent tissues, to influence joints or neurophysiological functions of the body, or both, including the use of examination and treatment by manipulation, adjustment, and mobilization of a joint. No chiropractor may practice obstetrics or treat communicable diseases. The requirements of this section do not apply to those licensed pursuant to chapter 36-4.

**Board Members:**

Dr. Robin R. Lecy, President,  
Dr. Donn J. Fahrendorf, Vice President  
Dr. Mark Bledsoe, Secretary/Treasurer  
Dr. Mark Steiner  
James Lawler

**SOUTH DAKOTA STATE**  
**BOARD OF CHIROPRACTIC EXAMINERS**  
**NEW DOCTOR LICENSE APPLICATION**

**Important Notice:**

Completion of this application form is necessary for consideration for licensure under South Dakota Codified Law Chapter 36-5. Disclosure of this information is voluntary. However, failure to disclose all requested information may result in this form not being processed and may subsequently result in denial of this application. ***All candidates for licensure and/or examination have an obligation to update and supplement the information and responses on this application if they change.*** Failure to supplement the information and responses provided on this application may result in denial or other appropriate action. All information provided must be accurate.

**Carefully follow the directions on this application form. In addition, note the following:**

1. Type or print legibly with black or blue ink only.
2. The licensure and application fees are NOT refundable.
3. If the name shown on your supporting documents is different from that shown on your application, you must submit proof of legal name change – a certified copy of your marriage license, divorce decree, affidavit or court order.

**Supporting Documentation and Fees:**

If you are applying for licensure as a chiropractor, submit the following documents and fees:

1. Application for license accompanied by the application fee of \$100.00, payable to "SOUTH DAKOTA BOARD OF CHIROPRACTIC EXAMINERS", must be on file with the executive secretary of the Board at least **fifteen (15) days before the date of the exam.**
2. A certified true copy of the diploma from the chiropractic college attended. Transcripts of credits - Chiropractic and Liberal Arts must be mailed direct from the Registrar of the College to the executive secretary of the Board **fifteen (15) days before the date of the exam.**
3. A copy of the National Board of Chiropractic Examiners Part I-IV with the appropriate seal, sent by the National Board Secretary to the executive secretary of the Board.
4. Verification of license status if you hold a license to practice in another state of the U.S., and a letter of good standing from such State board secretary must be on file with the executive secretary of the Board at least **fifteen (15) days before the date of the exam.**
5. Letters of recommendation from two chiropractic physicians must be on file with the executive secretary of the Board at least **fifteen (15) days before the date of the exam.** These doctors will also sign the last page of the application.
6. Copy of malpractice declaration page indicating current malpractice insurance.
7. Attach to the application, an original unretouched photograph taken within the past six (6) months showing head and shoulders, front view, size 2"x2".
8. All candidates must appear in person at a scheduled date of the State Board of Chiropractic Examiners.
9. All candidates must submit to a background check. Contact board office for fingerprint cards.

Your application is **NOT** considered complete until all supporting documents and fees have been received by the SOUTH DAKOTA BOARD OF CHIROPRACTIC EXAMINERS.

**PART I: Applicant Identifying Information**

Complete this section of the form by providing all of the requested information. You must notify the South Dakota Board of Chiropractic Examiners of any address changes after you file this application in order to receive any further information.

2 x 2 picture  
(please tape on back of picture)

1. Last Name	2. First Name	3. MI	4. Suffix (JR. )
5. Social Security Number			
6. Current Address (If PO Box, Must provide street address as well)			
7. Permanent Mailing Address including postal code (if different from Current address listed above)			
8. Business Mailing Address			
9. Identify Preferred mailing address. <input type="checkbox"/> Current <input type="checkbox"/> Permanent <input type="checkbox"/> Business			
Note: The preferred mailing address shall be available to the public.			
10. Identify any maiden name, surname, or any other names or aliases you have been known by or used and identify the reason for your name change.			
11. Place of Birth (List City, County, State or other Jurisdiction, Country)	12. Date of Birth MM/DD/YYYY	13. <input type="checkbox"/> Male <input type="checkbox"/> Female	
14. Contact Information			
(a) Telephone Numbers:			
Daytime:			
Evening:			
(b) E-mail address :			
(c) Fax number:			
15. Print Name as you wish it to appear on license			

**16. Citizenship**

- (a) Are you a United States Citizen? YES  NO
- (b) If you answered NO to question 16(a) above, are you:  
(Please check one of the following.)
- A qualified alien (as defined in 8 U.S.C.A. § 1641).
  - A nonimmigrant under the Immigration and Nationality Act (8 U.S.C.A. § 1101 *et seq.*).
  - An alien who is paroled into the United States under 8 U.S.C.A. § 1182(d)(5) for less than one year.
  - A foreign national not physically present in the United States.
  - Other – Please provide detailed explanation.
- (c) Do you intend to seek entry into the United States for the purpose of performing labor as a healthcare worker, other than a physician? YES  NO

**PART II: Education Information**

<b>1. Name of Last Secondary School Attended:</b>	<b>2. Last Secondary School Location</b> (City and State/Jurisdiction):	<b>3. Date of Graduation</b> ____ or <b>Date G.E.D. Earned</b> ____ (Check One) <b>Jurisdiction where earned:</b> _____  ____/____/____ Month      Year
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**4. Post Secondary Education History:**  
 Starting with your undergraduate education, list all schools, colleges, and universities attended, whether completed or not, in chronological order.

COLLEGE OR UNIVERSITY NAME (Undergraduate and Graduate)	LOCATION (City and State or Country)	DATES OF ATTENDANCE		GRADUATED? Yes/No  If no, number of credit hours earned?	DEGREE EARNED/ MAJOR
		FROM	TO		
		Month/Year	Month/Year		

**5. SPECIALIZED TRAINING**  
 List in chronological order from date of graduation from any professional school or program to the present all professional post-graduate training not including continuing education coursework (i.e., residency, vocational training, practical or clinical training).

INSTITUTION NAME	LOCATION (City and State or Country)	DATES OF ATTENDANCE		DID YOU COMPLETE TRAINING?
		FROM	TO	
		Month/Year	Month/Year	YES <input type="checkbox"/> NO <input type="checkbox"/>
				YES <input type="checkbox"/> NO <input type="checkbox"/>
				YES <input type="checkbox"/> NO <input type="checkbox"/>
				YES <input type="checkbox"/> NO <input type="checkbox"/>
				YES <input type="checkbox"/> NO <input type="checkbox"/>
				YES <input type="checkbox"/> NO <input type="checkbox"/>

**6. SPECIALIZED CERTIFICATION**  
 Have you earned certification by any recognized specialty in the chiropractic profession?      YES  NO

If Yes, INSERT REQUEST FOR PERTIENT INFORMATION (e.g. please enter your Certificate # \_\_\_\_\_).

**PART III: Record of Licensure Information**

If you have ever been licensed, certified or registered to practice in the profession for which you are now making application, or held *any other* professional license, certification or registration complete the information requested below. You must identify the method by which you obtained your professional license(s) – i.e. 1. licensure by examination, 2. score transfer, 3. endorsement, 4. grandparent/waiver provision, or 5. reciprocity – in the appropriate column. If you have ever held a temporary, trainee or apprenticeship license, or a permit, it must be listed here also. You must include jurisdictions both within and outside the United States. Failure to disclose all licenses, certifications or registrations held may result in denial of your application or other appropriate action.

Jurisdiction	Title of License	License Number/ Name on License	How License Obtained <small>(List applicable no. from above)</small>	Date of <u>Original</u> <u>(Initial)</u> Issuance	If license is not current and in good standing, explain below or on separate sheet
<i>Jurisdiction of Original (Initial) Licensure:</i>					
<i>Jurisdiction of Current Licensure where you most recently have been practicing:</i>					
<i>Other Jurisdictions of Licensure:</i>					

**PART IV: Record of Licensure Examination/National Boards**

If you have ever taken a licensure examination, in this state or any other state, for the profession for which you are now making application, you must complete the information requested below. Each examination attempt must be shown. Failure to disclose an examination attempt may result in the denial of your application or other appropriate action.

Name of Examination <b>Note:</b> If an Examination is administered in parts, each part should be listed separately.	Jurisdiction	Date of Examination	Passed/Failed/Other <small>(If Other, please explain.)</small>

National Board Certificate Number \_\_\_\_\_ Issue Date \_\_\_\_\_

## PART V. Personal History Information

Please answer each of the following questions by putting a check (✓) in the appropriate box on the right. You must answer each question with a "Yes" or "No" response as no other response is acceptable. All "Yes" answers **MUST** be explained in detail in a separate **SIGNED** and **NOTARIZED** affidavit. The affidavit should include all relevant dates and identify the relevant jurisdiction and/or entity involved. Failure to disclose any of the requested information may result in the denial of your application or other appropriate action.

1. Have you ever had any application for any professional license refused or denied by any licensing authority?	YES <input type="checkbox"/> NO <input type="checkbox"/>
2. Have you ever been refused or denied the privilege of taking an examination required for any professional licensure?	YES <input type="checkbox"/> NO <input type="checkbox"/>
3. Have you ever been dropped, suspended, placed on probation, expelled, fined or requested to resign from any post secondary educational program in which you were enrolled?	YES <input type="checkbox"/> NO <input type="checkbox"/>
4. Have you ever been placed on probation, restrictions, suspension, revocation, modification, allowed to resign, requested to leave temporarily or permanently, or otherwise acted against by any professional training program prior to completing the training?	YES <input type="checkbox"/> NO <input type="checkbox"/>
5. Have you ever voluntarily surrendered your chiropractic license?	YES <input type="checkbox"/> NO <input type="checkbox"/>
6. Have you ever allowed your chiropractic license to lapse, or had a limited license issued by any chiropractic licensing authority?	YES <input type="checkbox"/> NO <input type="checkbox"/>
7. Have you ever voluntarily surrendered any other professional license?	YES <input type="checkbox"/> NO <input type="checkbox"/>
8. Have you ever allowed any other professional license to lapse, or had a limited license issued by any other licensing authority?	YES <input type="checkbox"/> NO <input type="checkbox"/>
9. Has your chiropractic license ever been revoked?	YES <input type="checkbox"/> NO <input type="checkbox"/>
10. Have you ever been the subject of disciplinary action with regard to your chiropractic license, been sanctioned by any chiropractic licensing authority, chiropractic association, licensed chiropractic facility, or chiropractic staff of such facility?	YES <input type="checkbox"/> NO <input type="checkbox"/>
11. Have your chiropractic privileges ever been restricted or terminated by any chiropractic licensing authority, chiropractic association, licensed chiropractic facility, or chiropractic staff of such facility; or have you ever voluntarily or involuntarily resigned or withdrawn from such association to avoid imposition of such measures?	YES <input type="checkbox"/> NO <input type="checkbox"/>
12. Have you ever had any other professional license revoked?	YES <input type="checkbox"/> NO <input type="checkbox"/>
13. Have you ever been the subject of disciplinary action by any licensing agency with regard to any other professional license?	YES <input type="checkbox"/> NO <input type="checkbox"/>
14. To your knowledge have any unresolved or pending complaints ever been filed against you with any chiropractic licensing agency, chiropractic association, licensed chiropractic hospital/clinic, or chiropractic staff of such hospital or clinic?	YES <input type="checkbox"/> NO <input type="checkbox"/>
15. Have you ever had a registration issued by a controlled substance authority revoked, suspended, surrendered, limited, or restricted?	YES <input type="checkbox"/> NO <input type="checkbox"/>
16. Have you ever voluntarily surrendered a registration issued by a controlled substance authority?	YES <input type="checkbox"/> NO <input type="checkbox"/>
17. Is there any disciplinary action pending against you by any licensing jurisdiction, the USDA, Drug Enforcement Agency, or any state drug enforcement authority? If YES, where and when?	YES <input type="checkbox"/> NO <input type="checkbox"/>
18. Have you ever been charged with or convicted (including a nolo contendere plea or guilty plea) of a felony (or criminal offense) in any state or in federal court (other than minor traffic violations) whether or not sentence was imposed or suspended? If YES, in addition to the affidavit, attach a certified copy of the court records regarding your conviction, the nature of the offense date of discharge, if applicable, as well as a statement from the probation or parole officer.	YES <input type="checkbox"/> NO <input type="checkbox"/>

19. Have you ever been pardoned from a felony (or criminal) conviction?	YES <input type="checkbox"/> NO <input type="checkbox"/>
20. Have you ever had a record expunged from a felony (or criminal) conviction?	YES <input type="checkbox"/> NO <input type="checkbox"/>
21. Have you ever been charged with or convicted (including a nolo contendere plea or guilty plea) of a DUI whether or not sentence was imposed or suspended?	YES <input type="checkbox"/> NO <input type="checkbox"/>
22. Have you ever been charged with or convicted (including a nolo contendere plea or guilty plea) of a violation of any federal or state drug law(s) or rule(s) whether or not sentence was imposed or suspended?	YES <input type="checkbox"/> NO <input type="checkbox"/>
23. Are you now or have you in the last 5 years been addicted to any chemical substance including alcohol (excluding tobacco and caffeine)?	YES <input type="checkbox"/> NO <input type="checkbox"/>
24. Are you now being treated or have you in the last 5 years been treated for a drug or alcohol addiction or participated in a rehabilitation program?	YES <input type="checkbox"/> NO <input type="checkbox"/>
25. Do you currently have any disease or condition that interferes with your ability to competently and safely perform the essential functions of your profession, including any disease or condition generally regarded as chronic by the medical community, i.e. (1) mental or emotional disease or condition; (2) alcohol or other substance abuse; and/or (3) physical disease or condition, that may presently interfere with your ability to competently and safely perform the essential functions involved in practice as a chiropractor?	YES <input type="checkbox"/> NO <input type="checkbox"/>
26. Have you ever been named as a defendant to a civil suit related to your profession (i.e. malpractice)?	YES <input type="checkbox"/> NO <input type="checkbox"/>
27. Do you operate your chiropractic practice under a general or limited partnership? If "yes," how long has the partnership been in existence? _____ List all the partners on attached sheet.	YES <input type="checkbox"/> NO <input type="checkbox"/>
28. Do you work for a corporate practice? If YES, list all shareholders on attached sheet.	YES <input type="checkbox"/> NO <input type="checkbox"/> DO NOT KNOW <input type="checkbox"/>
29. IF YES, ARE ALL SHAREHOLDERS LICENSED IN THIS JURISDICTION?	YES <input type="checkbox"/> NO <input type="checkbox"/>
30. Have you ever been court martialled or discharged other than honorably from the armed service?	YES <input type="checkbox"/> NO <input type="checkbox"/>
31. Have you ever been terminated from a position with a city, county, state or federal position?	YES <input type="checkbox"/> NO <input type="checkbox"/>

**PART VI. Work History/Practical Experience**

Complete each of the following items. List all employment chronologically since graduation from high school to the present, beginning with the date of graduation. If you have never been employed, insert "N/A" for Not Applicable in Box 1. You are authorized to photocopy this form if additional space is required.

***Explain any breaks in employment history of greater than 6 months.***

1. Name of Business/ Institution:		Job Title:	
Address/Phone Number of Business/Institution:		Description of Duties Performed:	
Name of Supervisor:		Reason for employment termination/resignation?	
Date of Employment:	Hours Worked per Week:		
FROM: ____ / ____	Type of Employment:		
TO: ____ / ____	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time		

2. Name of Business/ Institution:		Job Title:	
Address/Phone Number of Business/Institution:		Description of Duties Performed:	
Name of Supervisor:		Reason for employment termination/resignation?	
Date of Employment:	Hours Worked per Week:		
FROM: ____ / ____	Type of Employment:		
TO: ____ / ____	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time		

3. Name of Business/ Institution:		Job Title:	
Address/Phone Number of Business/Institution:		Description of Duties Performed:	
Name of Supervisor:		Reason for employment termination/resignation?	
Date of Employment:	Hours Worked per Week:		
FROM: ____ / ____	Type of Employment:		
TO: ____ / ____	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time		

4. Name of Business/ Institution:		Job Title:	
Address/Phone Number of Business/Institution:		Description of Duties Performed:	
Name of Supervisor:		Reason for employment termination/resignation?	
Date of Employment:	Hours Worked per Week:		
FROM: ____ / ____	Type of Employment:		
TO: ____ / ____	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time		

**PART VII. Child Support Information**

In accordance with 25-7A-56, the Board of Chiropractic Examiners may not issue or renew any license under this chapter to a person after receiving notice from the South Dakota Department of Social Services that the person has support arrearages in the sum of one thousand dollars or more unless the person has made satisfactory arrangements with the Department of Social Services for payment of any accumulated arrearages. Failure to certify may result in disciplinary action, and making a false statement may subject the licensee to contempt of court.

**You must check one of the following:**

- I am more than \$1,000 delinquent in complying with a child support order.**
- I am currently under a child support order, but a stipulation arrangement has been made with the Department of Social Services.**
- I am not currently under any child support order.**

**PART VIII. Certifying Statement**

“By virtue of filing this application, I do solemnly swear or affirm that I am of good moral character, and that I understand the instructions and terms as set forth in this application form. I declare and affirm under the penalties of perjury that this application has been examined by me, and to the best of my knowledge and belief, is in all things true and correct **and that the photograph attached hereto is a true likeness of myself.** I hereby authorize the South Dakota Board of Chiropractic Examiners to verify any and all information contained in this application, including information maintained in applicable data banks, and to transmit this information to the licensing authority of the state to which this application is made. I authorize the licensing authority of the state where application is submitted to review state files pertaining to my licensure and practice, and all law enforcement records, administrative records, motor vehicle records, and court documents to confirm the accuracy and completeness of the information provided herein. This application and signature shall act as authorization of entities in possession of applicable information to release such information to the licensing authority.”

\_\_\_\_\_  
Signature of Applicant (Do not print)

Subscribed and sworn to before me this \_\_\_\_\_  
day of \_\_\_\_\_, 20\_\_.

\_\_\_\_\_  
Printed Name of Applicant

\_\_\_\_\_  
Notary Public

\_\_\_\_\_  
Date

I authorize the SDBCE to provide a scanned copy of my application photo to the SDCA for use in their newsletter and directory. (please circle one) YES / NO

\_\_\_\_\_  
*Signature of Applicant*

**RECOMMENDATION BY CHIROPRACTIC PHYSICIANS**

Being personally acquainted with \_\_\_\_\_ for (A) \_\_\_\_\_ years,  
(B) \_\_\_\_\_ years and recognizing the photograph attached hereto as one of the applicant, I the undersigned, certify that \_\_\_\_\_ he/she is not addicted to intoxicants or drugs and I recommend H \_\_\_\_ to the South Dakota Board of Chiropractic Examiners as a person of high moral character and of worthy professional recognition and confidence.

(A) Name: Print \_\_\_\_\_ (B) Name: Print \_\_\_\_\_

Signature: \_\_\_\_\_ Signature: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

PLEASE HAVE THE ABOVE CHIROPRACTORS SEND A LETTER OF RECOMMENDATION TO THE BOARD AT  
407 BELMONT, SD 57078