SOUTH DAKOTA STATE
BOARD OF CHIROPRACTIC EXAMINERS
RECIPROCITY 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. Please note that the information provided on this application is subject to the public information laws of this jurisdiction.

Criteria for Reciprocity Eligibility:
Applicants must meet the following four criteria to be eligible for reciprocity application under the statutory and regulatory requirements of SDCL 20:41:05:05, those being:

1. Has passed all parts of national boards required at the time of graduation;
2. Has actively practiced a minimum of five years immediately preceding the submission of the application;
3. Has no investigations pending; and
4. Has no adverse actions taken by another state board.
5. After review of an applicant's application and record, if the board has any remaining concerns about an applicant's clinical competency, the board may require the applicant to take and successfully pass the National Board of Chiropractic Examiners (NBCE) Special Purposes Examination for Chiropractic (SPEC) or the National Board of Chiropractic Examiners Part IV Examination. The board shall determine the score for successful passage and shall consider the NBCE recommended score to make that determination.

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. 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**.

3. A letter of recommendation from a chiropractic physician must be on file with the executive secretary of the Board at least **fifteen (15) days before the date of the exam.** This doctor will also sign the last page of the application.

4. Copy of malpractice declaration page indicating current malpractice insurance. Applicant should mail enclosed forms to appropriate insurance company. (If NCMIC is not current carrier, change address on certificate holder form and send to appropriate company) <u>This is needed only if you wish to obtain an active license</u>.

5. Request for reciprocity certification to be sent from each of the states you are licensed in. Applicant should mail form to appropriate states - unless the state has their own.

6. Attach to the application, an original unretouched photograph taken within the past six (6) months showing head and shoulders, front view, size 2"x2".

7. All candidates must appear in person at a scheduled date of the State Board of Chiropractic Examiners. Please contact board office for meeting dates or refer to website.

8. 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.***

Your application is **NOT** considered complete until all supporting documents and fees have been received by the SOUTH DAKOTA BOARD OF CHIROPRACTIC EXAMINERS, 407 BELMONT AVENUE, YANKTON, SD 57078.

SOUTH DAKOTA RECIPROCITY APPLICATION

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

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. ❑ Current ❑ Permanent ❑ 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. ❑ Male ❑ 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

1. Name of Last Secondary School Attended:	2. Last Secondary School Location (City and State/Jurisdiction):	3. Date of Graduation ___ or Date G.E.D. Earned ___ (Check One) Jurisdiction where earned: ____________________ ___ ___ / ___ ___ Month Year

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 FROM	TO	GRADUATED? Yes/No If no, number of credit hours earned?	DEGREE EARNED/ MAJOR
		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 FROM	TO	DID YOU COMPLETE TRAINING?
		Month/Year	Month/Year	YES ❑ NO ❑
				YES ❑ NO ❑
				YES ❑ NO ❑
				YES ❑ NO ❑
				YES ❑ NO ❑
				YES ❑ NO ❑

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

If Yes, *INSERT REQUEST FOR PERTINENT 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 (List applicable no. from above)	Date of ***Original (Initial)*** Issuance	If license is not current and in good standing, explain below or on separate sheet
Jurisdiction **of Original (Initial) Licensure:**					
Jurisdiction of Current Licensure where you most recently have been practicing:					
Other Jurisdictions of Licensure:					

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

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.

Question	Answer
1. Have you ever had any application for any professional license refused or denied by any licensing authority?	**YES ❑ NO ❑**
2. Have you ever been refused or denied the privilege of taking an examination required for any professional licensure?	**YES ❑ NO ❑**
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 ❑ NO ❑**
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 ❑ NO ❑**
5. Have you ever voluntarily surrendered your chiropractic license?	**YES ❑ NO ❑**
6. Have you ever allowed your chiropractic license to lapse, or had a limited license issued by any chiropractic licensing authority?	**YES ❑ NO ❑**
7. Have you ever voluntarily surrendered any other professional license?	**YES ❑ NO ❑**
8. Have you ever allowed any other professional license to lapse, or had a limited license issued by any other licensing authority?	**YES ❑ NO ❑**
9. Has your chiropractic license ever been revoked?	**YES ❑ NO ❑**
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 ❑ NO ❑**
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 ❑ NO ❑**
12. Have you ever had any other professional license revoked?	**YES ❑ NO ❑**
13. Have you ever been the subject of disciplinary action by any licensing agency with regard to any other professional license?	**YES ❑ NO ❑**
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 ❑ NO ❑**
15. Have you ever had a registration issued by a controlled substance authority revoked, suspended, surrendered, limited, or restricted?	**YES ❑ NO ❑**
16. Have you ever voluntarily surrendered a registration issued by a controlled substance authority?	**YES ❑ NO ❑**
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 ❑ NO ❑**
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 ❑ NO ❑**

Question	Answer
19. Have you ever been pardoned from a felony (or criminal) conviction?	YES ❑ NO ❑
20. Have you ever had a record expunged from a felony (or criminal) conviction?	YES ❑ NO ❑
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 ❑ NO ❑
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 ❑ NO ❑
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 ❑ NO ❑
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 ❑ NO ❑
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 ❑ NO ❑
26. Have you ever been named as a defendant to a civil suit related to your profession *(i.e. malpractice)*?	YES ❑ NO ❑
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 ❑ NO ❑
28. Do you work for a corporate practice? If YES, list all shareholders on attached sheet.	YES ❑ NO ❑ DO NOT KNOW ❑
29. IF YES, ARE ALL SHAREHOLDERS LICENSED IN THIS JURISDICTION?	YES ❑ NO ❑
30. Have you ever been court martialed or discharged other than honorably from the armed service?	YES ❑ NO ❑
31. Have you ever been terminated from a position with a city, county, state or federal position?	YES ❑ NO ❑

PART VI. Work History/Practical Experience

Complete each of the following items. List all employment chronologically since graduation from <u>chiropractic school</u> 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.

<u>Explain any breaks in employment history of greater than 6 months.</u>

1. Name of Business/ Institution:		**Job Title:**
Address/Phone Number of Business/Institution:		**Description of Duties Performed:**
Name of Supervisor:		
Date of Employment: **FROM:** ___ ___ / ___ ___ **TO:** ___ ___ / ___ ___	**Hours Worked per Week:** **Type of Employment:** ❑ **Full-time** ❑ **Part-time**	**Reason for employment termination/resignation?**

2. Name of Business/ Institution:		**Job Title:**
Address/Phone Number of Business/Institution:		**Description of Duties Performed:**
Name of Supervisor:		
Date of Employment: **FROM:** ___ ___ / ___ ___ **TO:** ___ ___ / ___ ___	**Hours Worked per Week:** **Type of Employment:** ❑ **Full-time** ❑ **Part-time**	**Reason for employment termination/resignation?**

3. Name of Business/ Institution:		**Job Title:**
Address/Phone Number of Business/Institution:		**Description of Duties Performed:**
Name of Supervisor:		
Date of Employment: **FROM:** ___ ___ / ___ ___ **TO:** ___ ___ / ___ ___	**Hours Worked per Week:** **Type of Employment:** ❑ **Full-time** ❑ **Part-time**	**Reason for employment termination/resignation?**

4. Name of Business/ Institution:		**Job Title:**
Address/Phone Number of Business/Institution:		**Description of Duties Performed:**
Name of Supervisor:		
Date of Employment: **FROM:** ___ ___ / ___ ___ **TO:** ___ ___ / ___ ___	**Hours Worked per Week:** **Type of Employment:** ❑ **Full-time** ❑ **Part-time**	**Reason for employment termination/resignation?**

PART VII. Child Support Information

In accordance with 32-12-116, the Department of Commerce and Regulation/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 PHYSICIAN

Being personally acquainted with ____________________ for __________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 _________________________

Signature: _____________________________

Address: _________________________________

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

REQUEST FOR RECORDS

To: ______________________________________ (Malpractice Carrier)

____

____

____

I, ____ (Print name) hereby request a release of any and all records regarding claims made against me, whether settled or not, to include the name of the claimant, the alleged reasons for filing the claim, and the amount of any award if any or any other disposition of the case. I authorize such material to be made available only to:

South Dakota Board of Chiropractic Examiners
Marcia Walter, Executive Director
407 Belmont Avenue
Yankton, SD 57078

I hereby release ______________________________________ (Insurance Co.) and all of its agents, employees or other personnel from any and all civil or criminal liability for providing information pursuant to this request.

____
Print Name

____
Address

____
City, State, Zip

____
Signature

REQUEST TO ADD CERTIFICATE HOLDER

Dear Liability Insurance Company ____________________________________
(Name)

Please add the following company as Certificate Holder on my professional liability insurance policy.

South Dakota Board of Chiropractic Examiners
Marcia Walter, Executive Director
407 Belmont Avenue
Yankton, SD 57078

Phone: 605-668-9017 Fax: 605-668-9017 Email: sdbce@iw.net

Type of Business: State Licensing Board

I, Dr. _________________, authorize you to add the organization listed above as a Certificate Holder on my malpractice insurance policy. I understand that signing this document does not allow the Certificate Holder any coverage or rights under my policy. I understand that signing this release allows you to send my Certificate of Insurance to this Certificate Holder at my renewal, cancellation, or if a premium bearing change is made to my policy. I understand that this organization will remain a Certificate Holder on my policy indefinitely, or until I provide you, my insurance carrier, with a written request to have them removed from my policy.

Signature: ___________________________ Policy Number: ___________________

Date: _____________________

Please email a copy of my Certificate of Insurance listing this Certificate Holder to the following email address: sdbce@iw.net or via fax to: 605-668-9017

Doctor: Please mail or fax this completed form to your present liability insurance company immediately

REQUEST FOR RECIPROCITY CERTIFICATION

TO: Secretary/ State Board of Chiropractic Examiners
____
____
____

FROM: Marcia Walter, Executive Director
South Dakota Board of Chiropractic Examiners
407 Belmont Avenue
Yankton, SD 57078

RE: Name: ______________________________________ License #: ________________

Address:______________________________________

The above referenced doctor is applying to the South Dakota Board of Chiropractic Examiners for licensure by way of reciprocity.

Article 20:41:05:05. Reciprocity., of the Rules and Regulations further states; The fee for a license granted pursuant to SDCL 36-5-13 is $200. <u>An applicant seeking reciprocity shall include with a written application a certification from the secretary of the applicable state board of chiropractic examiners showing the date, license number, state and ratings or record of examination of the applicant in chiropractic subjects and basic science subjects, National Board of Chiropractic examiners diploma and grades, including the general average received, the status of the license issued</u>, and a recommendation concerning good moral character and worthiness of the applicant for reciprocal recognition.

Please provide for us the following information:
Date ______________________

Doctors Name _______________________________

License Number _____________________________

___________Your ratings or record of examination of the applicant in chiropractic subjects and basic science subjects:

___________National Board of Chiropractic examiners diploma and grades, including the general average received:

The state of the license issued. _______________

The status of the license issued. (Active, Inactive, Suspended, Other)

Has this applicant been under any current investigation? _________________

Has the applicant had any adverse actions by your board? ________________

Signed: ______________________________________
Secretary /Board of Chiropractic Examiners (Seal)