



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

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**GENERAL INFORMATION**

**CHIROPRACTIC ASSISTANT**

Effective September 8, 2008, the Chiropractic Board of Examiners has completed all the necessary legislation and obtained rule-making authority to require chiropractic assistants to be certified. Copies of the statutes and rules regarding chiropractic assistants can be found on our website at <http://chiropractic.sd.gov> and clicking on statute SDCL 36-5-23 through SDCL 36-5-29 and administrative rule ARSD 20:41:15. The Board of Examiners has set January 1, 2009 as the deadline to have all current chiropractic assistants certified.

**Application:** Please complete the following application and submit to the board office along with a copy of certification showing completion of 20 hours of approved chiropractic assistant training as well as certification of CPR training.

**Application fee:** The nonrefundable application/initial certification fee is **\$50.00** and should be made payable to the South Dakota Board of Chiropractic Examiners. The payment should be included with your application.

**Renewal Fee:** The yearly renewal fee of **\$25.00** per year will be required to keep your certificate active.

**Continuing Education:** 6 hours of continuing education every three years as approved by the board. The current education period starts January 1, 2010.

**Please submit application, certificates of completion and application fee to the address listed below:**

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

**SOUTH DAKOTA STATE  
BOARD OF CHIROPRACTIC EXAMINERS  
CHIROPRACTIC ASSISTANT 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. **APPLICATION MUST BE TYPED OR HANDWRITTEN LEGIBLY. SUBMISSION OF AN ILLEGIBLE APPLICATION MAY RESULT IN DENIAL OF CERTIFICATION.**

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.      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 certificate			

**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.

**PART II: Education Information**

COLLEGE OR UNIVERSITY NAME (If none, please indicate)	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		
<p><b>SPECIALIZED TRAINING</b>                  List in chronological order any chiropractic assistant coursework as well as CPR certification. <u>Include with application copies of certificates of completion for the assistant coursework as well as CPR certification.</u></p>					
INSTITUTION NAME & LOCATION (City and state or Country)	HOURS COMPLETED	DATES OF ATTENDANCE		DID YOU COMPLETE TRAINING?	
		FROM	TO		
		Month/Year	Month/Year	YES NO CURRENTLY COMPLETING	
				YES NO CURRENTLY COMPLETING	
				YES NO CURRENTLY COMPLETING	

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

Complete each of the following items. List all employment chronologically in the last five years. 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:			
Date of Employment: FROM: _____ / _____ TO: _____ / _____	Hours Worked per Week:  Type of Employment: Full-time     Part-time		
		Reason for employment termination/resignation?	

<b>2. Name of Business/ Institution:</b>		<b>Job Title:</b>
<b>Address/Phone Number of Business/Institution:</b>		<b>Description of Duties Performed:</b>
<b>Name of Supervisor:</b>		
<b>Date of Employment:</b> FROM: _____ / _____ TO: _____ / _____	<b>Hours Worked per Week:</b>	
<b>Type of Employment:</b> Full-time      Part-time		
		<b>Reason for employment termination/resignation?</b>
<b>3. Name of Business/ Institution:</b>		<b>Job Title:</b>
<b>Address/Phone Number of Business/Institution:</b>		<b>Description of Duties Performed:</b>
<b>Name of Supervisor:</b>		
<b>Date of Employment:</b> FROM: _____ / _____ TO: _____ / _____	<b>Hours Worked per Week:</b>	
<b>Type of Employment:</b> Full-time      Part-time		
		<b>Reason for employment termination/resignation?</b>
<b>4. Name of Business/ Institution:</b>		<b>Job Title:</b>
<b>Address/Phone Number of Business/Institution:</b>		<b>Description of Duties Performed:</b>
<b>Name of Supervisor:</b>		
<b>Date of Employment:</b> FROM: _____ / _____ TO: _____ / _____	<b>Hours Worked per Week:</b>	
<b>Type of Employment:</b> Full-time      Part-time		
		<b>Reason for employment termination/resignation?</b>

**PART IV. CERTIFYING STATEMENT - PLEASE READ ALL QUESTIONS AND SIGN AFFIDAVIT BELOW**

1. Have you ever had any occupational license or permit revoked, suspended, reprimanded, censured, or otherwise disciplined or disqualified from that occupation or profession?  
Yes \_\_\_\_\_ No \_\_\_\_\_
  
2. Have you been the subject of ANY administrative disciplinary or criminal action by ANY government, jurisdictional or licensing authority: federal, state or municipal other than speeding tickets?  
Yes \_\_\_\_\_ No \_\_\_\_\_  
(This includes any other professional license that has had action taken against it or been suspended and/or any criminal convictions or deferred sentences where a guilty or no contest has been given.)
  
3. Have you ever been convicted of, or pled guilty to, or no contest to any offense related to controlled dangerous substances, a DUI, DWI, etc?  
Yes \_\_\_\_\_ No \_\_\_\_\_

**\*If you answered yes to any of the questions 1 thru 3, please attach a letter with an explanation including any charges, dates, county/state, and the outcome.**

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 also agree to abide by the laws of the state of South Dakota concerning chiropractic assistants.

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

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

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

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

\_\_\_\_\_  
Date

**PLEASE SUBMIT APPLICATION, CERTIFICATES OF COMPLETION AND \$50 APPLICATION / INITIAL CERTIFICATION FEE TO THE SOUTH DAKOTA BOARD OF CHIROPRACTIC EXAMINERS OFFICE AT 407 BELMONT AVENUE, YANKTON, SD 57078**