



Washington State Department of
Health
 Chiropractic Commission
 P.O. Box 47877
 Olympia, WA 98504-7877
 360.236.4700

Chiropractor License Application Packet

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Important Social Security Number Information:

Social Security Number: You are required by state and federal law to provide a social security number with your application. If you do not have a social security number at the time you send in this application, contact the Customer Service Center at 360.236.4700 for more information.

A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted.

In order to process your request:

Mail your application with Initial documentation and your check or money order payable to:

Department of Health
 PO Box 1099
 Olympia, WA 98507-1099

Send other documents not sent with initial application to:

Chiropractic Commission
 PO Box 47877
 Olympia, WA 98504-7877

Contact us:

360.236.4700

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Application Instructions Checklist

Important background check information: Washington State law authorizes the Department of Health to obtain fingerprint-based background checks for licensing purposes. This check may be through the Washington State Patrol and the Federal Bureau of Investigation (FBI). This may be required if you have lived in another state or if you have a criminal record in Washington State. This would be at your own expense.

All information should be typed or printed clearly. It is your responsibility to submit the correct required forms.

- Application Fee.** This fee is non-refundable. You can check the [fee page](#) for current fees. Select what you are applying for: Initial, Preceptorship or Endorsement.

- #1: Demographic Information:**
Social Security Number: You must list your social security number on your application. Please call the Customer Service Center at 360.236.4700 if you do not have one.

Legal Name: List your full name.

Definition of legal name: “Legal name” is the name appearing on your official certificate of birth or, if your name has changed since birth, on an official marriage certificate or an order by a court. The court must have the legal authority to change your name. We may ask you to prove your legal name. If you use any name other than your legal name on this form, your application may be denied.

Birth date: Provide the city, state and country where you were born.

Address: List the address we should use to send any information on your license. Be sure to include the city, state, zip code, county, and country. This will be your permanent address with Department of Health until we have been notified of a change.
See [WAC 246-12-310](#).

Phone, Fax, and Cell Numbers: Enter your phone, fax, and cell numbers, if you have them.

Email: Enter your email address, if you have one.

Other Name(s): Indicate whether you are known or have been known under any other names. If you have a name change, you must notify the Department of Health in writing. You must include proof of this change. See [WAC 246-12-300](#).

- #2: Personal Data Questions:**
All applicants must answer the same personal data questions. They are focused on your fitness to practice the essential skills of this profession.

If you answer “yes” to any questions in this section, you must provide an appropriate explanation. You must also provide the documentation listed in the note after the question. If you do not provide this, your application is incomplete and it will not be considered.

- Question 5 includes misdemeanors, gross misdemeanors and felonies. You do not have to answer yes if you have been cited for traffic infractions. You can get copies of court records through the county courthouse where the conviction, plea, deferred sentence, or suspended sentence was entered.
- Another jurisdiction means any other country, state, federal territory, or military authority.

- #3: Preceptorship:**
Complete name, date license was issued, preceptorship program, chiropractic college, date approved, and attach proof of malpractice insurance.

- #4: Training and Education:**
List in date order all colleges, universities, chiropractic school(s). Include all periods of time from pre-chiropractic school to present, whether or not engaged in activities related to chiropractic. (Attach more sheets if necessary).

For Example:

Bellevue Community College, 09/94 – 05/95.
Summer Break–traveled, 06/95 – 08/95.
Washington State University, 09/95 – 05/96.
Summer Break–food server, 06/96 – 08/96.
Chiropractic College, 09/96 – present.

An applicant must attach the following:

- An official transcript and diploma certified by the registrar from an approved chiropractic college.
- Official transcripts from pre-chiropractic schools showing successful completion of at least two years of liberal arts and sciences study.
- An official certificate of proficiency sent directly to the commission from the National Board of Chiropractic Examiners, parts I, II, III, & IV.

- #5: Professional Experience:**
List in chronological order all professional experience and practice from date of graduation from professional college. If you need more space, attach a piece of paper.

- #6: Other License(s), Certification, or Registration:**
List all states where licenses are or were held. Specifically list licenses granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if license is current. If you need more space, attach a piece of paper.

- #7: Letters of Recommendation:**
You must have two letters of recommendation. The person must read and fill out this section.

- #8: Aids Education and Training Attestation:**
AIDS affidavit must be initialed and dated. AIDS training may include self-study, direct patient care, courses, or formal training required by [WAC 246-12-260](#). Course content can be found in [WAC 246-12-270](#).

- #9: Applicant's Attestation:**
You must sign and date this for us to process the application. Read to ensure you understand this section.

Additional Information

After all documents have been received and the application is complete, the jurisprudence examination will be mailed. You will have 30 days from the date of receipt to complete and return the following:

- Examination Booklet
- Answer Sheet
- Comment Sheet

Your chiropractic license will be issued after successfully passing the jurisprudence examination with a minimum score of 95 percent.

Notice to Spouses and Registered Domestic Partners of Military Personnel Transferring to Washington

Under a new state law, a spouse or registered domestic partner of military personnel transferring to Washington may receive his or her health professional license more quickly. In order for us to do this, please complete the additional form found at <http://www.doh.wa.gov/hsqa/professions/military/> and include supporting documentation with your application.



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Background
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Revenue: 0252020000

Chiropractor License Application

Initial License Preceptorship Endorsement

1. Demographic Information

Social Security Number (If you do not have a social security number, see instructions.)

— —

Male
 Female

Name First Middle Last

Birth date (mm/dd/yyyy)

Place of birth

City State Country

Address

City State Zip County

Country

Phone () Fax () Cell ()

Email address

Mailing address (if different from above)

City State Zip County

Country

NOTE: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information with the department.

Have you ever been known under any other name(s)? Yes No If yes, list name(s):

Will documents be received in another name? Yes No

If yes, list name(s): _____

For Office Use Only

License # _____ Issue Date _____

Validation _____ Received Date _____

2. Personal Data Questions

Yes No

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please attach explanation.....

“Medical Condition” includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, intellectual disabilities, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

If you answered yes to question 1, explain:

- 1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.
1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.

Note: If you answered “yes” to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.

The licensing authority may require you to undergo one or more mental, physical or psychological examination(s). This would be at your own expense. By submitting this application, you give consent to such an examination(s). You also agree the examination report(s) may be provided to the licensing authority. You waive all claims based on confidentiality or privileged communication. If you do not submit to a required examination(s) or provide the report(s) to the licensing authority, your application may be denied.

2. Do you currently use chemical substance(s) in any way which impair or limit your ability to practice your profession with reasonable skill and safety? If yes, please explain.

“Currently” means within the past two years.

“Chemical substances” include alcohol, drugs, or medications, whether taken legally or illegally.

3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism?.....

4. Are you currently engaged in the illegal use of controlled substances?.....

“Currently” means within the past two years.

Illegal use of controlled substances is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

Note: If you answer “yes” to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.

5. Have you **ever** been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction? ..

Note: If you answered “yes” to question 5, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and will not be considered.

To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.

2. Personal Data Questions (cont.)

Yes No

- a. Are you now subject to criminal prosecution or pending charges of a crime in any state or jurisdiction

Note: If you answered "yes" to question 5a, you must explain the nature of the prosecution and/or charge(s). You must include the jurisdiction that is investigating and/or prosecuting the charges. This includes any city, county, state, federal or tribal jurisdiction. If charging documents have been filed with a court, you must provide certified copies of those documents. If you do not provide the documents, your application is incomplete and will not be considered.

- b. If you answered "yes" to question 5a, do you wish to have decision on your application delayed until the prosecution and any appeals are complete?
6. Have you ever been found in any civil, administrative or criminal proceeding to have:
- a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes?
- b. Diverted controlled substances or legend drugs?
- c. Violated any drug law?
- d. Prescribed controlled substances for yourself?
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", please attach an explanation and provide copies of all judgments, decisions, and agreements?
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority?
9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority?
10. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession?

3. Preceptorship

Preceptor _____, D.C. _____

Washington License Issued _____ (5 year minimum)

Preceptorship Program _____ Chiropractic College _____

Date Approved _____ Proof of Malpractice Insurance (attach)

4. Training and Education

List in chronological order all colleges, universities, chiropractic school(s), and experience. Include all periods of time from pre chiropractic school to the present, whether or not engaged in activities related to chiropractic. If you need more space, attach a piece of paper.

Schools Attended Full Name, City and State	Degree Earned	Attendance Dates	
		Start (mm/yyyy)	End (mm/yyyy)

5. Professional Experience

List in chronological order all professional experience and practice from date of graduation from professional college. Include the month/day/year in chronological order. If you need more space, attach a piece of paper.

Name of Business	Total Number of Months	Dates	
		Start (mm/yyyy)	End (mm/yyyy)

6. Other License(s), Certification, or Registration

List all states where licenses are or were held. List all licenses granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if license is current. If you need more space, attach a piece of paper.

State Jurisdiction	License Number	License		Method of License
		Issue Date	Expiration Date	

7. Letters of Recommendation

You are not expected to sign this letter if you do not know the applicant personally, and are not willing to supply the Department of Health more information about his or her character and reputation.

To: Health Professions Quality Assurance
State of Washington

This is to certify I have known _____ for _____ years,
from _____ to _____. To the best of my knowledge he/she is of good character
and reputation.

Signature _____ Date _____

Address _____

To: Health Professions Quality Assurance
State of Washington

This is to certify I have known _____ for _____ years,
from _____ to _____. To the best of my knowledge he/she is of good character
and reputation.

Signature _____ Date _____

Address _____

8. AIDS Education and Training Attestation

I certify I have completed the minimum of four (4) hours of education in the prevention, transmission and treatment of AIDS. This includes the topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations. I understand I must maintain records documenting said education for two (2) years and be prepared to submit those records to the department if requested. **I understand if I provide any false information, my license may be denied, or if issued, suspended or revoked.**

Applicant's Initials	Date

9. Applicant's Attestation

I, _____, declare under penalty of perjury under the laws of
(Print applicant name clearly)
the state of Washington the following is true and correct:

- I am the person described and identified in this application.
- I have read [RCW 18.130.170](#) and [RCW 18.130.180](#) of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local or foreign government agencies.

I understand I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated _____ at _____ (city, state)
mm/dd/yyyy

By: _____
Signature of applicant



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Chiropractor Credential Verification

PART 1: Note to Applicant

Complete Part 1 and send it to the state(s) and/or jurisdiction(s) where you are or have been credentialed. Instruct them to send the form directly to the address listed above. Make a copy of this form if you are or have been credentialed in more than one state or jurisdiction. Credentialing agencies normally charge a fee to verify a credential, check in advance to help expedite this process.

Name _____ Other names used _____

Mailing address _____

Credential Number _____ Date Issued _____
mm/yyyy

PART 2

Please complete this form about the applicant listed above. Submit the completed form and any other requested material directly to this office at the address above. We will not accept the form if sent by the applicant. Thank you.

Name of credential holder: _____

Authority providing verification (state, name & title): _____

Applicant licensed by:

Written Exam Name of Exam _____ Date _____ Score _____
mm/yyyy

Other Exam Name of Exam _____ Date _____ Score _____
mm/yyyy

Status of License/Certification/Registration: Current Not Current Expiration Date _____

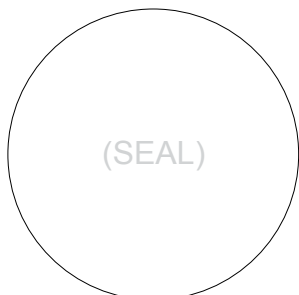
Is this individual considered to be in good standing in your state? Yes No If no, explain _____

Has this credential ever been denied? Yes No Suspended? Yes No

Revoked? Yes No Surrendered? Yes No Reinstated? Yes No

If "yes", please provide a copy of the final order or other documentation of action taken.

If this credential holder has been disciplined, has he/she successfully completed all requirements and is currently in good standing? Yes No



Signature _____

Name _____

Title _____

Date _____
mm/dd/yyyy

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Health Professions Reference Numbers and Links

RCW/WAC Links

- Uniform Disciplinary Act** [UDA RCW 18.130](#)
- Administrative Procedure Act** [APA RCW 34.05](#)
- Administrative procedures and requirements** [WAC 246-12](#)
- Chiropractic RCW** [RCW 18.25](#)
- Chiropractic WAC** [WAC 246-808](#)

AIDS Courses

- Health Impact** **1.800.783.2437 or 206.284.3865**
- W.F. Professional** **1.800.323.4305**
- AIDS Resources** **206.784.5655**

On-Line

- AIDS Training** [Reference Page](#)
- Chiropractic Quality Assurance Commission** [Web Page](#)