PUERTO RICO BOARD OF CHIROPRACTIC EXAMINERS
APPLICATION FOR EXAMINATION

FULL NAME: _____

PHYSICAL ADDRESS: _____

_____

POSTAL ADDRESS:

_____

TELEPHONE: _____ EMAIL: _____

SOCIAL SECURITY #: _____ DATE OF BIRTH: _____
(dd/mm/yyyy)

SECURELY PASTE A PASSPORT-TYPE PHOTOGRAPH IN THIS SPACE

RIGHT THUMB PRINT
(MAY BE SELF- APPLIED)

If right thumb is missing, use left.

AFFIDAVIT

State or of (territory) _____ country of (or city) _____,
Being duly sworn, says that _____ he (she) is the person referred to in this application and that the statements herein contained are true in every respect, and that the attached photograph is a true likeness of her (his) self-taken within the last six months.

I hereby authorize the Puerto Rico Board of Chiropractic Examiners to verify my **Chiropractic Information Network-Board Advisors and Decisions Status (CIN-BAD).**

I hereby expressly waive all provisions of Law forbidding any physician or hospitals, institutions, or organizations, who has attended or examined me or who hereafter attends or examined me from disclosing any knowledge or information which he thereby acquired, and I hereby consent that he may disclose such knowledge or information to the Puerto Rico Board of Chiropractic Examiners regarding with this application.

I have carefully read the foregoing application and have answered them completely, without reservation of any kind, I declare penalty of perjury that my answer and all statements made by me herein are true and correct. Should I furnish any false information in this application I hereby agree that such an act shall constitute cause for the denial, suspension, or revocation of my license to practice Chiropractic in Puerto Rico.

Sworn and signed before me by _____ of the personal circumstances indicated above and whom I CERTIFY that I personally know or have identified as provided by law, _____ today _____ of _____ of _____ in _____, Puerto Rico.

AFFIDAVIT NUM: _____

Notarial Seal

_____
Signature of Applicant

_____
Signature of Public Notary

PO Box 10200, San Juan, PR 00908-0200 | 787-999-8989 ext. 6607 | myrnet.gonzalez@salud.pr.gov

PERSONAL INFORMATION OF THE APPLICANT

1. Has your name ever been changed? YES _____ NO _____.
If so, give date place of such change: _____

Original name: _____

2. Date of birth: _____ Age: _____ Place of birth: _____

3. Are you a citizen of the United States? YES _____ NO _____. If naturalized, give date and place of naturalization: _____.

4. Residential address: _____

Since when: _____

5. Name the educational institution where you obtained the bachelor's degree: _____

Starting date: _____ Date of bachelor's degree obtained: _____

6. Name the educational institution where you obtained the doctor's degree: _____

Starting date: _____ Date of doctor's degree obtained: _____

Grade point average at the time of graduation: _____

7. Have you ever been examined by any other Licensing Board? YES _____ NO _____. If yes, give location: _____, _____, _____.

8. List all jurisdictions in which you have been issued a license to practice Chiropractic: active, inactive or expired. Indicate number and date issued:

a) State: _____ License #: _____ Date issued: _____
b) State: _____ License #: _____ Date issued: _____
c) State: _____ License #: _____ Date issued: _____

9. Have you ever been denied the privilege of taking an examination before in any state, territory, or country licensing? YES _____ NO _____. If yes, explain which state and why? _____

10. Have you been convicted of a violation of/or pledged Nolo Contendere on any federal, state of local statute, regulation or ordinance, or entered any plea bargaining relating to a felony or misdemeanor? (Excluding traffic violations, except convictions for driving under the influence). YES _____ NO _____.
If yes, explain: _____

11.Have you ever been denied or voluntarily surrendered your clinical privileges while under investigation, been censured or warned, or requested to withdraw from the staff of any professional school, internship, hospital nursing home, or other health care facility or health care provider? YES _____ NO _____.
If yes, explain: _____

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12. Have you ever had any of the following disciplinary actions taken against your license to practice Chiropractic (DEA permit, state-controlled substances registration if applicable), Medicaid, or any such actions pending (a) suspension revocation (b) probation (c) reprimand/cease and desist (d) had your practice monitored? YES _____ NO _____.
If yes, explain: _____

13. Have you ever had any membership in a state or local professional society revoked, suspended, or sanctioned? YES _____ NO _____. If yes, explain: _____

14. Have you voluntarily withdrawn from any professional society while under investigation? YES _____ NO _____. If yes, explain: _____

15. Have you been physically or emotionally dependent upon the use of alcohol/drugs or treated by, consulted with, or been under the care of professional for any substance abuse within the last two year? If so, please provide a letter from the treating professional. YES _____ NO _____.

16. Do you have a physical disease, mental disorder, or any condition which could affect your performance of professional duties? If so, provide a letter from your treating professional to include diagnosis, treatment, prognosis, and fitness to practice. YES _____ NO _____.

List in chronological order all professional practice since graduation, including internships and absences from work. Also list all periods of non-professional activity or employment for more than three months, please account for all time.

DATE (FROM TO) (dd/mm/yyyy) to (dd/mm/yyyy)	POSITION HELD	NAME OF PLACE	LOCATION

PO Box 10200, San Juan, PR 00908-0200 | 787-999-8989 ext.6607 | myrnet.gonzalez@salud.pr.gov

CLAIM HISTORY SHEET

If you answered YES to question #14 on page two (2) of the application, please either have your attorney submit a letter regarding malpractice suites and complete one of these sheets for each case you have been involved in. **(Make additional copies of this form as needed)**

Applicant name: _____

Claimant: _____

Date of Incident: _____ Date Claim Made: _____

Name of all defendants, persons, or entities against who claim was made: _____

_____

City, Country and State of Suit: _____

Name and address of defense attorney: _____

_____

Statement amount (If any): _____ Verdict Amount: _____ Date case closed: _____

Current status of claim (Indicate insurance company reserve if case is not closed): _____

_____

Name of involved Insurance Company: _____

Policy Number: _____ Detailed description of claim (use reverse side if necessary): _____

_____

AUTHORIZATION FOR RELEASE INFORMATION

(Must be completed by all applicants)

I hereby authorize any person, company, insurer, hospital, or other organization to release all information, privilege, or in their dominion, custody, or control, regarding insurance applicants by me, professional liability issued to me, as well as information abstained by any attorneys who are now representing me or have in the past represented me.

_____ _____ _____

DATE PRINT NAME SIGNATURE

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CERTIFICATE OF GOOD MORAL CHARACTER

(To be filled and signed by a registered Chiropractor not related to applicant)

THIS CERTIFIES that I have been personally acquainted with _____ for _____ years, that I know him/her to be of good moral character, and that I hereby recommend him/her to the Puerto Rico Board Chiropractic Examiners as entirely worthy of examination for a license to practice Chiropractic pursuant to law.

_____ _____

Name of Chiropractor **SIGNATURE OF AFFIANT**

ADDRESS: _____ **TELEPHONE:** _____

_____ **EMAIL:** _____

_____ **LICENSE NUMBER:** _____

TO BE COMPLETED BY THE PUERTO RICO BOARD OF CHIROPRACTIC EXAMINERS

(Please don't write in these spaces)

DATE APPLICATION RECEIVED: _____

_____ **APPLICANTION APPROVED** _____ **APPLICATION DENIED**

COMMENTS:

_____

_____

_____

APPLICATION EVALUATED BY:

_____ _____

President **Member**
Lic. Number: _____ **Lic. Number:** _____

_____ **Date:** _____

Vice President
Lic. Number: _____

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AUTORIZATION FOR RELEASE OF INFORMATION

☐ **I authorize** ☐ **I do not authorize**

...the Department of Health to offer information regarding my professional license status to employers, private or government agencies, educational institutions, professional institutions, health insurance companies, malpractice insurance companies and examining boards.

_____
NAME

_____
SIGNATURE

_____
DATE

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REQUIREMENTS TO PRESENT WITH THIS APPLICATION

Documents must be presented all at once. Official transcripts must be sent directly by educational or examining institutions by postal service to the postal address in this application.

1. **Official** application for examination duly fulfilled **(from page 1 to page 6)** with all requirements included.

2. **Official** transcript sealed and unopened from the university or college where you completed your bachelor's degree, as required prior to entering the Doctor of Chiropractic program, in accordance with the Chiropractic Law of Puerto Rico: "Law No. 493 of May 15, 1952, as amended" and Resolution 2025-59 of the Puerto Rico Board of Chiropractic Examiners: Exam Admission Requirements.

3. **Official** transcript sealed and unopened from the university where you complete your Chiropractic degree.

4. **Original and copy** of Doctor of Chiropractic diploma **(if original diploma isn't available, applicant must request the academic institution to send an official copy by postal service to the postal address in this application)**

5. **Original and copy** of Bachelor's diploma **(if original diploma isn't available, applicant must request the academic institution to send an official copy by postal service to the postal address in this application)**

6. **Official** sealed and unopened National Board of Chiropractic Examiners transcript of parts I, II, III and IV. (PT and Acupuncture, if taken).

7. Specialties. A certificate from any specialty, diplomat and/or fellowship from any recognized association and/or council like ACA, ICA or any other. **(if applicable).**

8. **Original and copy** of the Birth Certificate. **(PR Law NO. 191-2009)**

9. **Original and copy of valid unexpired identification** (driver's license or state identification card). Provide evidence of U.S. Citizenship, if applicable (Passport, Visa, or proof of Alien Status).

10. **Original** Certificate of Background Check from your State Police or State Law Enforcement Agency where you have been living during the last six (6) months.

11. **Original** Certificate of Child Support from your State Agency where you have been living during the last six (6) months.

12. **Three (3) original** letters of recommendation (with letterhead). One must be from an active licensed Doctor of Chiropractic with active practice in Puerto Rico. The other two recommendation letters can be from active Doctor of Chiropractic Practicing outside of Puerto Rico. **(Letters must have a headline with the doctor's information, the license number and must be hand signed).**

13. **Copy** of current Cardiopulmonary Resuscitation (CPR) card and/or certificate.

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14. Evidence of malpractice carrier coverage **(Applicable for applicants with a professional license in another state).**

15. Postal or Bank Money order, ATH, VISA, MASTERCARD, or certified check for the amount of **$100.00** (US Currency) payable to the Secretary of Treasury of Puerto Rico. **(Fee is non-refundable).**

16. Two envelopes with post stamps and your postal address.

17. Application **must** be submitted personally or by certified mail to the following address:

PUERTO RICO BOARD OF CHIROPRACTIC EXAMINERS
PO BOX 10200
SAN JUAN, P.R. 00908-0200

INCOMPLETE APPLICATIONS WILL NOT BE ACCEPTED.

Application must be received on or before the due date published in the official press announcement.