

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) Applicant has passed all parts of national boards required at the time of his/her graduation. If applicant graduated after January 1998, he/she must have passed all four parts of the National Boards;
- 2) Applicant has actively practiced a minimum of 5 years;
- 3) Applicant has no investigations pending; and
- 4) Applicant has no adverse actions taken by other state boards.

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:

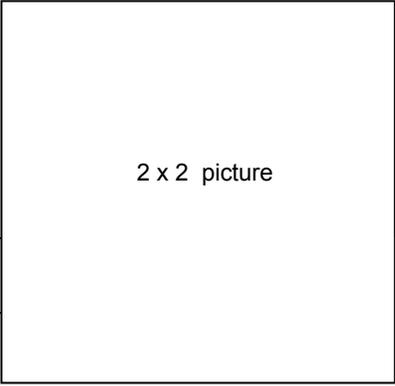
1. Application for license accompanied by the application fee of \$100.00, payable to "SOUTH DAKOTA BOARD OF CHIROPRACTIC EXAMINERS', must be on file with the executive secretary of the Board at least **fifteen (15) days before the date of the exam.**
2. Verification of license status if you hold a license 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)
This is needed only if you wish to obtain an active license.
5. Request for reciprocity certification to be sent from each of the states you are licensed in. Applicant should mail form to appropriate states.

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.

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.



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)		City	State Zip
7. Permanent Mailing Address (if different from Current address)		City	State Zip
8. Business Mailing Address		City	State Zip
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			12. Date of Birth MM/DD/YYYY
City	State	Zip or Jurisdiction	Country
13. Male Female			
14. Contact Information			
(a) Telephone Numbers:			
Daytime: _____			
Evening: _____			
(b) E-mail address : _____			
(c) Fax number: _____			
15. 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

<p>1. Name of Last Secondary School Attended:</p>	<p>2. Last Secondary School Location</p> <p>City _____</p> <p>State _____ Zip _____</p> <p>or Jurisdiction _____</p>	<p>3. Graduate Earned G.E.D.</p> <p>Jurisdiction where earned: _____</p> <p>_____</p> <p style="text-align: right;">Month Year</p>			
<p>4. Post Secondary Education History: Starting with your undergraduate education, list <u>all</u> schools, colleges, and universities attended, whether completed or not, in chronological order.</p>					
		DATES OF ATTENDANCE	GRADUATED? Yes/No		
COLLEGE OR UNIVERSITY NAME (Undergraduate and Graduate)	LOCATION (City and State or Country)	FROM	TO	If no, number of credit hours earned?	DEGREE EARNED/ MAJOR
		Month/Year	Month/Year		
<p>5. SPECIALIZED TRAINING List in chronological order from date of graduation from any professional school or program to the present <u>all</u> professional post-graduate training not including continuing education coursework (i.e., residency, vocational training, practical or clinical training).</p>					
		DATES OF ATTENDANCE		DID YOU COMPLETE TRAINING?	
INSTITUTION NAME	LOCATION (City and State or Country)	FROM	TO		
		Month/Year	Month/Year	YES	NO
				YES	NO
				YES	NO
				YES	NO
				YES	NO
				YES	NO
				YES	NO
<p>6. SPECIALIZED CERTIFICATION Have you earned certification by any recognized specialty in the chiropractic profession? YES NO</p> <p>If Yes, <u>INSERT REQUEST FOR PERTIENT INFORMATION</u> (e.g. please enter your Certificate # _____).</p>					

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 <u>Note: If an Examination is administered in parts, each part should be listed separately.</u>	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	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
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 martialled 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 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:
Business/Institution Address		Description of Duties Performed:
City	State Zip	
Phone Number		Reason for employment termination/resignation?
Name of Supervisor:		
Date of Employment:	Hours Worked per Week:	
FROM: _____	Type of Employment:	
TO: _____	Full-time Part-time	

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

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

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

REQUEST FOR RECORDS

To: _____ (Malpractice Carrier)

I, _____ (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 Secretary
407 Belmont Ave
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.

Name

Address

City, State Zip

Signature

To: NCMIC
Client Service Department
1452 29th Street, Suite 102
West Des Moines, Iowa 50266

RE: Request to add certificate holder

POLICY HOLDER _____

POLICY NUMBER _____

Dear Client Service Dept:

I am requesting that the South Dakota Board of Chiropractic Examiners be added as a certificate holder on my malpractice policy.

Please send this certificate information to:

South Dakota Board of Chiropractic Examiners
Marcia Walter, Executive Secretary
407 Belmont Ave
Yankton, SD 57078

Thank you.

_____, Policy Holder
Signature

Date

REQUEST FOR RECIPROCITY CERTIFICATION

TO: Secretary/ State Board of Chiropractic Examiners

FROM: Marcia Walter, Executive Secretary
South Dakota Board of Chiropractic Examiners
407 Belmont Ave
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. 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, 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? YES NO

Has the applicant had any adverse actions by your board? YES NO

Signed: _____
Secretary /Board of Chiropractic Examiners

(Seal)