South Carolina Department of Labor, Licensing and Regulation
South Carolina Board of Chiropractic Examiners
110 Centerview Dr. • Columbia • SC 29210
P.O. Box 11329 • Columbia • SC 29211-1329
Phone: 803-896-4587 • Contact.chiro@llr.sc.gov • Fax: 803-896-4719
llr.sc.gov/chiro

APPLICATION FOR CHIROPRACTIC VOLUNTEER OR SPECIAL EVENT LICENSURE

No fee required.

Submit the following with your application to the above address:

- Copy of your valid driver's license, state issued ID, passport or military ID
- Copy of your Social Security card
- Notarized verification of lawful presence

Have submitted directly to the Board from the issuing agency or organization to the above address:

- Official copy of your chiropractic college transcript
- Official License Verification from another state (if applicable)

Applying for Doctorate of Chiropractic Licensure as/by (Check one only):

☐ State of Emergency ☐ Needy and Indigent Care ☐ Special Event

APPLICANT INFORMATION

Last Name:_____ First:_____ Middle:_____ Suffix:____

Have you ever legally changed your name? ☐ Yes ☐ No Prior Name/Alias: _____

If yes, please submit legal documentation supporting the change. (Marriage certificate, divorce decree, etc.)

Home Address: _____ City:_____ State:____ Zip:_____

Mailing Address: _____ City:_____ State:____ Zip:_____
(If different than above)

Telephone No.: _____ Email: _____

Date of Birth: _____ Social Security No.: _____

EDUCATION INFORMATION

List all professional education in chronological order until present date. Please have professional transcripts mailed directly to the Board from the college or program attended.

College/University	Date Degree Conferred	Degree

RECORD OF LICENSURE INFORMATION

List all states in which you hold a current and active license. You will need to contact one State Board and request a License Verification to be mailed directly to the SC Chiropractic Board.

State	License Type	License No.

PRACTICE HISTORY

List all related employment chronologically, most recent first, for the past five (5) years. If you have never been employed in the Chiropractic profession, please enter N/A. (Attach additional sheet, if needed.)

1. Company Name:	Company Address: (Street, City, State, Zip)	
Job Title:	Type of Employment: ☐ Full-time ☐ Part-time	Dates of Employment: From: _____ To: _____
Abbreviated description of duties performed:	Hours worked per week:	Reason for leaving:
2. Company Name:	Company Address: (Street, City, State, Zip)	
Job Title:	Type of Employment: ☐ Full-time ☐ Part-time	Dates of Employment: From: _____ To: _____
Abbreviated description of duties performed:	Hours worked per week:	Reason for leaving:

PERSONAL HISTORY

Any "Yes" answers to the following questions require a written explanation. If you answer "Yes" to an arrest or conviction; you will need to have the court mail to our office the disposition and you will need to have a Statewide Background check mailed in directly from the law enforcement agency.

1. Have you been convicted (including a nolo contendere plea or guilty plea) of a felony of any kind or a non-felony crime involving drugs, or of the unauthorized practice of chiropractic, whether or not sentence was imposed or suspended? ☐ Yes ☐ No

2. Have you had any investigation, formal complaint, disciplinary action or consent order filed against you by any person, employer, or licensing board in any jurisdiction? ☐ Yes ☐ No

3. Have you developed or been treated for any disease or condition, physical, mental, or emotional (including alcohol or other substance abuse) that may render further practice dangerous to the public? ☐ Yes ☐ No

4. Have you been addicted to or used in excess any drug or chemical substance including alcohol, or been treated for a drug or alcohol addiction or participated in a rehabilitation program? ☐ Yes ☐ No

5. Have you had an application for a professional license, examination, certification or registration denied or refused by any licensing board or other entity or have you ever surrendered a professional license? ☐ Yes ☐ No

6. Have you received disciplinary action by any employer for your job performance involving patient care or safety? ☐ Yes ☐ No

7. Have you had a malpractice claim, lawsuit, judgment or settlement filed against you? ☐ Yes ☐ No

ATTESTATION

I, _____ , am the person described and identified in this application. I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare that all statements made by me herein are true and correct. Should I furnish any false or incomplete information in this application, I hereby agree that such act shall constitute the cause for denial or revocation of my license to practice chiropractic medicine in South Carolina.

_____
Signature of Applicant

_____
Print Name of Applicant

Sworn to and subscribed before me this _____ day of _____ 20 _____ . *(Notary Seal)*

Notary Signature: _____

Print Name: _____

Notary for the State of: _____

My Commission expires: _____

PRIVACY DISCLOSURE

South Carolina Law requires that every individual who applies for an occupational or professional license provide a social security number for use in the establishment, enforcement and collection of child support obligations and for reporting to certain databanks established by law. Failure to provide your social security number for these mandatory purposes will result in the denial of your licensure application. Social security numbers may also be disclosed to other governmental regulatory agencies and for identification purposes to testing providers and organizations involved in professional regulation. Your social security number will not be released for any other purpose not provided for by law.

Other personal information collected by the Department for the licensing boards it administers is limited to such personal information as is necessary to fulfill a legitimate public purpose. The South Carolina Freedom of Information Act ensures that the public has a right to access appropriate records and information possessed by a government agency. Therefore, some personal information on the application may be subject to public scrutiny or release. The Department collects and disseminates personal information in compliance with The South Carolina Freedom of Information Act, the South Carolina Family Privacy Protection Act, and other applicable privacy laws and regulations. Additionally, the Department shares certain information on the application with other governmental agencies for various governmental purposes, including research and statistical services.

VOLUNTEER OR SPECIAL EVENT LICENSURE ADDENDUM

Submit this addendum along with this application if you are applying for one of these Specialty Licenses. Indicate the specialty license for which you are applying **(Check one only):**

Practice Purpose:

☐ **State of Emergency –** A chiropractor's practice must be exclusively and totally devoted to providing chiropractic care to citizens of the state in areas which have been declared by the Governor to be in a state of emergency. It will limit practice to a specific site(s) and practice setting(s). **For volunteer licenses, documentation and acknowledgment that the applicant has no expectation of payment or compensation and must not receive any payment or compensation, either direct or indirect or monetary or in-kind, for chiropractic care or any health services rendered.**

☐ **Needy and Indigent Care –** A chiropractor's practice must be exclusively and totally devoted to providing chiropractic care to the needy and indigent in South Carolina. **For volunteer licenses, documentation and acknowledgment that the applicant has no expectation of payment or compensation and must not receive any payment or compensation, either direct or indirect or monetary or in-kind, for chiropractic care or any health services rendered.**

Practice Location	Practice Setting	Dates of Care (From: _____ To: _____)

☐ **Special Event**

For chiropractors providing care only for members of the team or organization with which the chiropractor is associated during the period in which the team or organization is in this state.

Name of Team or Organization	Practice Location	Dates of Event (From: _____ To: _____)

_____ _____

Signature Date

_____

Print Name