



STATE OF ALASKA  
DEPARTMENT OF COMMERCE, COMMUNITY, AND ECONOMIC DEVELOPMENT  
DIVISION OF CORPORATIONS, BUSINESS, AND PROFESSIONAL LICENSING  
**BOARD OF CHIROPRACTIC EXAMINERS**  
P.O. BOX 110806, JUNEAU, ALASKA 99811-0806  
(907) 465-3811  
E-mail: [license@alaska.gov](mailto:license@alaska.gov)  
Website: [www.commerce.alaska.gov/occ/pchi.htm](http://www.commerce.alaska.gov/occ/pchi.htm)

## **CHIROPRACTOR LOCUM TENENS PERMIT APPLICATION**

**In accordance with AS 08.20.100(a), a person may not practice chiropractic or use chiropractic core methodology in the State of Alaska without a license. Please be advised licensure in another state does not automatically qualify an applicant for an Alaska license. All Chiropractic applicants are required to take and pass the state chiropractic examination before licensure.**

**NOTE:** Please read the application, statutes, regulations, and all instructions carefully. It is your responsibility to be aware of licensing requirements and examination deadlines, and to provide all necessary documentation. The Board will not consider your application until your application file is complete.

### **INFORMATION ABOUT LOCUM TENENS PERMITS:**

A locum tenens permit may only be issued to a chiropractor for the purpose of substituting for an Alaska-licensed chiropractor practicing in the state. The permit is valid for 60 days and may be extended at the board's discretion.

### **APPLICATION INSTRUCTIONS:**

All applicants must complete the following before they will be considered for a locum tenens permit:

1. Fees payable to the State of Alaska as follows:
  - \$50 Application Fee (Nonrefundable)
  - \$100 Locum Tenens Permit Fee
  - \$100 State Chiropractic Examination Fee
2. Complete notarized application, including the sworn statement and "Authorization for Release of Records" form.
3. Notarized sworn statement by the Alaska licensed chiropractic physician for whom the applicant will substitute, including the dates of the substitute practice and the date that the Alaska licensed chiropractic physician will resume practice.
4. Pass the Alaska State Chiropractic examination.
5. A complete criminal history record issued within the past 90 days by the Alaska State Department of Public Safety sent directly to the Division of Corporations, business and Professional Licensing; and an equivalent report from all states or jurisdictions where the applicant holds or has ever held a chiropractic license sent directly to the Division of Corporations, business and Professional Licensing (see additional information on page 2).

### **FOR APPLICANTS QUALIFYING UNDER OPTION 'A' (similar to licensure by examination)**

**In addition to 1 – 5 above the following must be submitted before an applicant will be considered for a locum tenens permit under this option:**

1. Certified transcripts from a college of liberal arts or sciences verifying at least two academic years of study sent directly to the Division of Corporations, Business and Professional Licensing by the college.  
  
The board will accept in lieu of a liberal arts education, verification of active licensed practice of chiropractic for three of the four years preceding the date of application.
2. Certified transcripts showing degree granted from a school or college of chiropractic that is accredited by or a candidate for accreditation by the Council on Chiropractic Education sent directly to the Division of Corporations, Business and Professional Licensing by the college.
3. Official sealed copy of the National Board of Chiropractic Examiners (NBCE) scores indicating passage of Parts I, II, III, IV, and physiotherapy examinations (with a minimum score of 375), sent directly to the Division of Corporations, Business and Professional Licensing by NBCE.

An applicant who has been in the active practice of chiropractic for the past five continuous years may substitute passage of the Special Purposes Examination of Chiropractic (SPEC) for the Part III examination.

4. Verification of all licenses ever held in any other state or jurisdiction, sent directly to the Division of Corporations, Business and Professional Licensing by the issuing state or licensing agency.

All applicants will also be subject to a check of the national licensee database maintained by the Federation of Chiropractic Licensing Boards (FCLB) to verify any action(s) that may have been reported by other licensing agencies.

**FOR APPLICANTS QUALIFYING UNDER OPTION 'B' (similar to licensure by credentials)**

**In addition to 1 – 5 above the following must be submitted before an applicant will be considered for a locum tenens permit under this option:**

1. Verification of license in good standing to practice chiropractic in another jurisdiction for the five years preceding the date of application, sent directly to the Division of Corporations, Business, and Professional Licensing by the issuing state or licensing agency.
2. Verification of all licenses ever held in any other state or jurisdiction, sent directly to the Division of Corporations, Business and Professional Licensing, by the issuing state or licensing agency.

All applicants will also be subject to a check of the national licensee database maintained by the Federation of Chiropractic Licensing Boards (FCLB) to verify any action(s) that may have been reported by other licensing agencies.

**NOTE: Under AS 08.20.163(b)(2)(i) if any action has been reported to the national database of the Federation of Chiropractic Licensing Boards, you are not eligible for a Locum Tenens Permit under Option 'B'.**

3. Verification of active licensed clinical chiropractic practice for at least five years preceding the date of the application.
4. Certified transcripts showing degree granted from a school or college of chiropractic that is accredited by or a candidate for accreditation by the Council on Chiropractic Education sent directly to the Division of Corporations, Business and Professional Licensing by the college.
5. Official sealed copy of the National Board of Chiropractic Examiners (NBCE) scores indicating passage of the Parts I, II examinations, or the SPEC examination, (with a minimum score of 375), sent directly to the Division of Corporations, Business and Professional Licensing by NBCE.
6. Verification of completion of 120 hours of formal training in physiological therapeutics or passage of the National Board of Chiropractic Examiners (NBCE) Physiotherapy examination.

**CRIMINAL HISTORY RECORDS:**

The Alaska State Department of Public safety maintains records of criminal history. You must request that they send your record directly to the Division of Corporations, Business and Professional Licensing at the address on page one of this form. To find an office location or to download an application to request your records, visit their website at: [www.dps.state.ak.us/staewide/background/](http://www.dps.state.ak.us/staewide/background/) For other states or jurisdictions, you will need to contact their justice agency to request that an equivalent report be sent on your behalf.

**ALASKA STATE CHIROPRACTIC EXAMINATION:**

The Alaska State Chiropractic examination is administered by the Alaska Board of Chiropractic Examiners three times a year. Applications to sit for the examination must be received at least **45 days** before the scheduled examination date. Incomplete applications will be processed for the subsequent examination – no exceptions.

Information regarding exam dates and deadlines is available on the Division's website at: [www.commerce.alaska.gov/occ/pchi.htm](http://www.commerce.alaska.gov/occ/pchi.htm)

The Alaska State Chiropractic Examination consists of two parts:

1. A written exam covering information in the statutes and regulations booklet published by the Division of Corporations, Business and Professional Licensing and available on the Division's website at: [www.commerce.alaska.gov/occ/pchi.htm](http://www.commerce.alaska.gov/occ/pchi.htm).
2. An oral exam with questions of a general nature.

In addition, the exam may cover any other subjects that are deemed necessary to demonstrate knowledge of chiropractic as defined in AS 08.20.230. A score of 75 percent or higher is required to receive a passing score on the examination.

**GENERAL INFORMATION:**

Please be aware that all information on this form will be available to the public unless required to be kept confidential by state or federal law. In addition, current licensee information is available on the division's website at: [www.commerce.alaska.gov/occ](http://www.commerce.alaska.gov/occ) under "Professional License Search."

**SOCIAL SECURITY NUMBERS:** Alaska Statute 08.01.060(b) requires an applicant for a professional license to provide a United States Social Security Number. Applicants who do not have a social security number must complete the "Request from Social Security Number Requirement" (Form 08-4372) located on the division's website at: [www.commerce.alaska.gov/occ](http://www.commerce.alaska.gov/occ) or contact the division office for the form.

**RENEWAL:** Renewal notices are mailed at least 30 days before the license expiration. It is the licensee's responsibility to ensure renewal of the license. Failure to receive a renewal notice does not excuse nonrenewal. All licenses expire on December 31 of even-numbered years, regardless of when the license was renewed or issued.

**CHANGE OF ADDRESS:** The address provided on your application is the address where official correspondence will be sent. In accordance with 12 AAC 02.900, a person must notify the division in writing of any change in address. You can download the "Change of Address Form" (08-4291) from the division website at: [www.commerce.alaska.gov/occ](http://www.commerce.alaska.gov/occ).

**BUSINESS LICENSES:** Applications for business licenses are processed separately. For more information about business licenses, call (907) 465-2550 or use Internet address: <http://www.commerce.alaska.gov/occ>

**ABANDONMENT:** Under 12 AAC 02.190, an application is considered abandoned when 12 months have elapsed since correspondence was last received from or on behalf of the applicant. An abandoned application is denied without prejudice and the application fee is forfeited. Under 12 AAC 16.030(c), an applicant must satisfy all licensing requirements within 18 months of passing the Alaska State Chiropractic examination.



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 Website: www.commerce.alaska.gov/occ/pchi.htm

**CHIROPRACTIC LOCUM TENENS PERMIT APPLICATION**

**THIS APPLICATION MUST BE COMPLETED IN FULL. TYPE OR PRINT ALL INFORMATION IN INK.**

**Fees due with application:**

- \$50.00 Locum Tenens Permit Application Fee (nonrefundable)
- \$100.00 Locum Tenens Permit Fee
- \$100.00 Alaska State Chiropractic Examination Fee

***Make checks payable to the State of Alaska, or use the attached credit card payment form.***

**I HEREBY MAKE APPLICATION** for a Chiropractic Locum Tenens Permit in the State of Alaska.

I am applying under (refer to instructions for details)

**OPTION A**

**OPTION B** – If you have had any action reported to the Federation of Chiropractic Licensing Board national licensee database, you are not eligible for a locum tenens permit under option B.

Full Name \_\_\_\_\_  
 Last First M.I. Maiden or Other Names

Address \_\_\_\_\_  
 Street or P.O. Box City State (Country) Zip Code

Phone \_\_\_\_\_ Email Address: \_\_\_\_\_

Date of Birth \_\_\_\_\_ Sex  M  F Social Security Number \_\_\_\_\_  
 (Required by AS 08.01.060)

**GENERAL EDUCATION**

High School \_\_\_\_\_ City and State \_\_\_\_\_

Date of Graduation \_\_\_\_\_ OR Date GED Awarded \_\_\_\_\_

College or University \_\_\_\_\_ City and State \_\_\_\_\_

Dates Attended \_\_\_\_\_ Degree Awarded \_\_\_\_\_

**CHIROPRACTIC EDUCATION**

Name of School \_\_\_\_\_ City and State \_\_\_\_\_

Dates Attended \_\_\_\_\_ Degree Awarded \_\_\_\_\_

**NATIONAL BOARD EXAMINATION**

Part I passed \_\_\_\_\_ Year \_\_\_\_\_ Part II passed \_\_\_\_\_ Year \_\_\_\_\_

Part III (WCCE) passed \_\_\_\_\_ Year \_\_\_\_\_ Part IV passed \_\_\_\_\_ Year \_\_\_\_\_

Physiotherapy passed \_\_\_\_\_ Year \_\_\_\_\_ SPEC Passed \_\_\_\_\_ Year \_\_\_\_\_

**CHIROPRACTIC HISTORY**

Check which option you are applying under:

- Option A – Complete the “Practice Information” if you have ever actively practiced chiropractic.
- Option B – Document in “Practice Information” five years of active licensed **clinical** chiropractic practice.

**PRACTICE INFORMATION**

Include temporary or part-time work. State as to each employment or period of practice, the period during which you were employed as a chiropractor (or engaged in private practice) including dates, the address of the offices or places where you were so employed or engaged, and the names and addresses of all employers, partners, associates, or places where you practiced chiropractic, if any, and the reason for the termination of each employment or period of private practice.

INCLUSIVE DATES		ADDRESS, NAMES OF EMPLOYERS, ASSOCIATES, ETC.	STATUS, I.E., PART-TIME	REASON FOR LEAVING
Began	Ended			

Are you presently engaged in the (clinical – option “B”) practice of chiropractic?  Yes  No If “yes,” give location below:

Number of years at location below: \_\_\_\_\_

Location of Chiropractic Practice: \_\_\_\_\_  
Street City, State, Zip Code (Country)

**OTHER STATE, JURISDICTION, OR FOREIGN COUNTRY LICENSES**

Have you ever applied for or held a license, temporary permit, locum tenens permit, or courtesy license to practice chiropractic in the State of Alaska?  Yes  No

List all licenses for the practice of chiropractic that you now hold or ever have held.

JURISDICTION	LICENSED BY: (Exams, Reciprocal, or other)	LICENSE NO.	DATE OF ISSUANCE	EXPIRATION DATE

**CHARACTER REFERENCES**

List six character references, three of which are professional references.

FULL NAME	COMPLETE ADDRESS AND ZIP CODE	RELATIONSHIP
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

**DISCIPLINARY / INVESTIGATION / PRACTICE QUESTIONS**

- |   | <b>YES</b>               | <b>NO</b>                |
|---|--------------------------|--------------------------|
| 1. Do you have criminal charges pending against you? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are there any unsatisfied judgments against you resulting from the practice of chiropractic? .....     | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you aware of any investigations against you, in any state, jurisdiction, or foreign country? ..... | <input type="checkbox"/> | <input type="checkbox"/> |

**Have you ever:**

- |   |                          |                          |
|---|--------------------------|--------------------------|
| 4. practiced chiropractic illegally? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. secured or attempted to secure a license through deceit, fraud, or intentional misrepresentation? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. engaged in deceit, fraud, or intentional misrepresentation in the course of providing professional services or engaging in professional activities? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. advertised professional services in a false or misleading manner? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. been convicted, including a conviction based on a guilty plea or plea of nolo contendere, of a felony or misdemeanor (other than a minor traffic violation)? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. been convicted, including a conviction based on a guilty plea or plea of nolo contendere, of a crime involving the unlawful procurement, sale, prescription, or dispensing of drugs? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. intentionally or negligently engaged in or permitted the performance of patient care by persons under your supervision that does not conform to minimum professional standards (regardless of whether actual injury to the patient occurred)? ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. failed to comply with a board order? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. continued or attempted to practice after becoming unfit due to professional incompetence? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. engaged in lewd or immoral conduct in connection with the delivery of professional services to patients? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. failed to satisfy board-adopted continuing education requirements? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. had any malpractice settlements or judgments paid on your behalf? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. had your license denied, revoked, suspended, surrendered, recalled, cancelled, placed on probation, or been the subject of any restriction, censure, reprimanded, or other disciplinary action in any jurisdiction or foreign country? .....        | <input type="checkbox"/> | <input type="checkbox"/> |

**PERSONAL HISTORY QUESTIONS:**

- |   | <b>YES</b>               | <b>NO</b>                |
|---|--------------------------|--------------------------|
| 17. Are you now, or within the last five years have you been addicted to, or have you undergone treatment for the use of narcotics or drugs or excessive use of intoxicating liquors? ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Are you now experiencing, or have you within the last five years experienced a physical or mental disability? .....   | <input type="checkbox"/> | <input type="checkbox"/> |

**Within in the last five years have you:**

- |  |                          |                          |
|--|--------------------------|--------------------------|
| 19. been adjudicated an incompetent or an insane person by any court? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. been a patient in any sanitarium, hospital, or mental institution for mental illness? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. continued or attempted to practice after becoming unfit due to addiction or severe dependency on alcohol or a drug that impairs your ability to practice safely? ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. continued or attempted to practice after becoming unfit due to physical or mental disability? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. had any action reported to the Federation of Chiropractic Licensing Boards' national licensee database? .....  | <input type="checkbox"/> | <input type="checkbox"/> |

A "Yes" answer may not prejudice your application, failure to report honestly may.

**If you answered "Yes" to any of the above questions (1 – 24), please explain dates, locations and circumstances on a separate piece of paper. Also, submit any/all supporting documents that are applicable (court records, board actions, investigation notices etc.).**

**If you answered "yes" to questions 18 – 24 you must also submit a statement from your health care provider indicating your ability to practice the chiropractic profession.**

**Failure to fully disclose information pertaining to a "Yes" answer may cause a delay in the processing time of your application.**

\_\_\_\_\_, being first duly sworn upon his/her oath, deposes and says:  
(Applicant Name)

I make the following voluntary statement and no threats, promises, or any form of duress have been used to induce me to make this statement.

By my signature below, I declare that all facts, statements, and answers contained in this application are true and correct; I am not omitting any information that might be of value to this board in determining my qualifications and character, whether it is called for or not; and I agree that any falsification, omission, or withholding of information or facts concerning my qualifications as an applicant shall be sufficient to bar issuance of a license to me by the state board and such falsifications, omissions, or withholding shall serve as sufficient grounds for the suspension, cancellation, or revocation of my Alaska Chiropractic Locum Tenens Permit even though it is not discovered until after issuance.

I give permission to the Alaska Board of Chiropractic Examiners to secure additional information concerning me or any statement in this application from any person or any source the board may desire. I further agree to submit to questioning by the board or any member thereof, and to substantiate any statements if desired by the board.

I solemnly declare upon my honor that if granted a license to practice chiropractic in Alaska, I will respectfully comply with any law governing the practice of chiropractic in this state, and will do my best to uphold and maintain the ethics of the profession.

**CONFIDENTIALITY**

The contents of licensing files are generally considered public records. If you believe that the additional information you are attaching to explain a "yes" answer should be considered confidential, state that in the attachment. A request for confidentiality may or may not be granted.

**WARNING: Pursuant to AS 08.20.170, the board may refuse to issue a license to, or impose a disciplinary sanction on, a person who has obtained or attempted to obtain a license to practice as a chiropractor by fraud, deceit or intentional misrepresentation. The person may also be subject to criminal charges for perjury (AS 11.56.200).**

I certify that the above information is true and correct.

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

SUBSCRIBED AND SWORN to before me, a Notary Public, in and for the State of \_\_\_\_\_ this \_\_\_\_\_ day  
of \_\_\_\_\_, 20\_\_\_\_\_.

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

My Commission Expires: \_\_\_\_\_

NOTARY SEAL

or

(postmaster stamp if notary public is not available)

THIS FORM MUST BE COMPLETED AND RETURNED WITH THE APPLICATION

State of Alaska  
Department of Commerce, Community, and Economic Development  
Division of Corporations, Business, and Professional Licensing  
Board of Chiropractic Examiners  
P.O. Box 110806  
Juneau, Alaska 99811-0806  
(907) 465-3811  
E-mail: license@alaska.gov  
Website: www.commerce.alaska.gov/occ/pchi.htm

**AUTHORIZATION AND RELEASE**

TO WHOM IT MAY CONCERN:

I, \_\_\_\_\_, residing at  
(Please print full name)

\_\_\_\_\_, hereby authorize the  
(Please print full address)

Division of Occupational Licensing and its investigators to examine my medical and dental records, employment and education records including all training which pertains to my practice of chiropractic, and any records pertaining to litigation, judgments, suits, and/or settlements, and any law enforcement records pertaining to me and discuss them with persons having possession of them. I also expressly permit and authorize the release of any and all such records pertaining to me to the Division of Occupational Licensing and its investigators. This release also applies to all records that pertain to credentialing records at facilities at which I have applied for or held privileges to practice chiropractic.

I authorize the Division to discuss my records with persons or organizations that are considered appropriate by the Division in connection with an official investigation, and to provide copies of my records to those persons or organizations deemed appropriate by the Division.

This release also applies to any documents or records which contain information pertaining to psychiatric, psychological, drug, or alcohol evaluation, counseling, diagnosis or treatment received by me and which were prepared or made in conjunction with, or under the authority or guidance of any local, state, or federal law which relates to psychiatric, drug or alcohol evaluation, diagnosis or treatment, including all information previously identified, collected, or stored under the authority of any state or federal law.

I request that upon presentation of this release, or a Certified True Copy thereof, that you provide copies of those records to the Division and/or its investigators, and/or representatives of the Office of the Attorney General of the State of Alaska.

This authorization expires one (1) year from the date of my signature below.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Home Telephone Number

\_\_\_\_\_  
Work Telephone Number

SUBSCRIBED AND SWORN to before me, a Notary Public, in and for the State of \_\_\_\_\_

this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

NOTARY SEAL  
OR  
(postmaster stamp if notary  
not available)

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

My Commissioner Expires: \_\_\_\_\_

NOTE: A photocopy reproduction of this request shall be, for all intents and purposes, as valid as the original.

**ALASKA STATE BOARD OF CHIROPRACTIC EXAMINERS  
VERIFICATION OF CHIROPRACTIC EDUCATION**

This form is essential to the application you are filing with this board. Before your application can be considered for approval, the information requested below must be officially verified by the chiropractic college where your degree was earned. Please complete the information in Section A and forward it to the college and they, in turn, will complete the remainder of this form and return it to this agency. You are advised to check with that college before forwarding this form to determine if there are additional requirements to be met before the information will be released.

**SECTION A**

TO BE COMPLETED BY THE APPLICANT (Please type or print legibly):

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(Please print Full Name) Maiden Name

Address \_\_\_\_\_  
Street or P.O. Box \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ (Country) \_\_\_\_\_ Zip \_\_\_\_\_

Code \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I hereby request and authorize \_\_\_\_\_ to provide any and all pertinent information requested in this form to the Alaska Board of Chiropractic Examiners to complete an application filed with that agency.

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Signature Date Signed

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**SECTION B - Complete for graduated students.**

I hereby certify that \_\_\_\_\_ matriculated in the \_\_\_\_\_  
\_\_\_\_\_ Chiropractic College on the \_\_\_\_\_ day of \_\_\_\_\_ and  
has attended \_\_\_\_\_ hours of instruction, graduating with a degree of chiropractic on the \_\_\_\_\_ day  
of \_\_\_\_\_.

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**SECTION C - Complete for pre-graduate students.**

I hereby certify that \_\_\_\_\_ matriculated in the \_\_\_\_\_  
\_\_\_\_\_ Chiropractic College on the \_\_\_\_\_ day of \_\_\_\_\_ and  
has attended \_\_\_\_\_ hours of instruction, (1) is currently enrolled in the chiropractic college; (2) is actively pursuing completion  
of a chiropractic curriculum; and (3) has obtained senior status and is working on the clinical portion of the curriculum.

Expected Graduation Date: \_\_\_\_\_

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**SECTION D – Complete for ALL students and submit with an official transcript.**

**CERTIFICATE OF REGISTRAR OF CHIROPRACTIC COLLEGE**

This applicant has completed \_\_\_\_\_ hours of formal training in physiological therapeutics. If courses are not clearly recognizable as a course containing physiological therapeutics please attach a separate letter indicating the course title and the number of hours dedicated to PT.

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Signature of Dean or Registrar SEAL OF COLLEGE OR UNIVERSITY

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Date

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**Please return this form directly to:**

Department of Commerce, Community and Economic Development  
Division of Corporations, Business and Professional Licensing  
Board of Chiropractic Examiners  
P.O. Box 110806  
Juneau, AK 99811-0806

**An official transcript must accompany this form.**

**ALASKA STATE BOARD OF CHIROPRACTIC EXAMINERS  
AUTHORIZATION FOR INTERSTATE EXCHANGE OF EXAMINATION AND LICENSURE INFORMATION**

This form is essential to the application you are filing with this board. Before your application can be considered for approval, the information requested below must be officially verified by the chiropractic board(s) in **all** states or jurisdictions where you hold or have ever held a license. Please complete the information requested and forward it to the state(s) or jurisdiction(s) where you hold or have ever held a license to practice. You are advised to check with that state or jurisdiction before forwarding this form to determine if there are additional requirements to be met or fees due before the information will be released.

**PART I**

TO BE COMPLETED BY THE APPLICANT (Please type or print legibly):

\_\_\_\_\_ Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Maiden Name \_\_\_\_\_

\_\_\_\_\_ Mailing Address \_\_\_\_\_

\_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Date of Birth: \_\_\_\_\_ License No.: \_\_\_\_\_

I hereby request and authorize \_\_\_\_\_ to provide any and all pertinent information requested in this form to the Alaska Board of Chiropractic Examiners to complete an application filed with that agency.

\_\_\_\_\_ Signature \_\_\_\_\_ Date Signed \_\_\_\_\_

**PART II – NOT TO BE COMPLETED BY THE APPLICANT**

The above applicant is applying for a locum tenens permit in this state. Please complete the following and **return directly to the Alaska State Board of Chiropractic Examiners.**

State/Agency \_\_\_\_\_

Name of Licensee \_\_\_\_\_

Graduate of \_\_\_\_\_

License No. \_\_\_\_\_ Issued Effective \_\_\_\_\_

By reciprocity/endorsement \_\_\_\_\_ By examination \_\_\_\_\_

License is current \_\_\_\_\_ lapsed \_\_\_\_\_ Expiration date \_\_\_\_\_

License in good standing?  Yes  No

If the applicant's license has lapsed or expired, please explain why (e.g., failure to pay licensing renewal fees, etc.): \_\_\_\_\_

Date of exam \_\_\_\_\_ . The examination consisted of the following subjects:

Written:	Principles and Practice	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Score: _____
Clinical:	Adjustive Technique	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Score: _____
	Ortho-Neuro	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Score: _____
	Physiotherapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Score: _____
	X-ray Interpretation and Technique	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Score: _____

**OTHER SUBJECT AREAS TESTED**

SUBJECTS	GRADES	PRACTICAL/ORAL/WRITTEN

Has the applicant's license ever been suspended or revoked?  Yes  No If "yes", for what reason?

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Has the applicant been subject to any other disciplinary action(s) (e.g., letter of warning, stipulation)?  Yes  No  
If "yes", please provide a copy of the official action taken.

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Please provide any information you believe relevant to the applicant's qualifications and fitness to practice chiropractic.

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General Comments: \_\_\_\_\_

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STATE BOARD  
OR  
AGENCY  
SEAL

Signed: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Title: \_\_\_\_\_

State Board/Agency: \_\_\_\_\_

Date: \_\_\_\_\_

**Please return this form directly to:**

Department of Commerce, Community, and  
Economic Development  
Division of Corporations, Business, and  
Professional Licensing  
Alaska Board of Chiropractic Examiners  
P.O. Box 110806  
Juneau, AK 99811-0806

**ALASKA STATE BOARD OF CHIROPRACTIC EXAMINERS**

**SWORN STATEMENT FROM  
ALASKA LICENSED CHIROPRACTIC PHYSICIAN  
(FOR WHOM THE APPLICANT WILL BE SUBSTITUTING)**

\_\_\_\_\_, being first duly sworn upon his/her oath, deposes and says:  
(Name of licensed Alaska Chiropractic Physician requesting a substitute physician)

**I make the following voluntary statement and no threats, promises, or any form of duress have been used to induce me to make this statement.**

By my signature below, I declare that I am currently a licensed Chiropractic Physician ( \_\_\_\_\_ ) in the State of Alaska.  
(License Number)

I will stop practicing in the State of Alaska beginning \_\_\_\_\_ and will resume practicing \_\_\_\_\_.  
(Beginning Date) (Ending Date)

Dr. \_\_\_\_\_ will be providing chiropractic care during this time.

**WARNING: Pursuant to AS 08.20.170, the board may refuse to issue license to, or impose a disciplinary sanction on, a person who has obtained or attempted to obtain a license to practice as a chiropractor by fraud, deceit or intentional misrepresentation. The person may also be subject to criminal charges for perjury (AS 11.56.200).**

I certify that the above information is true and correct.

SIGN HERE 

\_\_\_\_\_  
Signature of Chiropractic Physician requiring a substitute physician

\_\_\_\_\_  
Printed Name

Date: \_\_\_\_\_

SUBSCRIBED AND SWORN TO before me, a Notary Public in and for the State of \_\_\_\_\_, this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

NOTARY SEAL

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

or

My Commission Expires: \_\_\_\_\_

(postmaster stamp if notary is not available)

**Please return this form directly to:**

Department of Commerce, Community, and  
Economic Development  
Division of Corporations, Business, and  
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**ALASKA STATE BOARD OF CHIROPRACTIC EXAMINERS  
CHIROPRACTIC PRACTICE VERIFICATION**

Please check the option for which you are applying under.

This form is essential to the application you are filing with this board. Before your application can be considered for approval, the information requested below must be completed by an employer, partner, or another chiropractic physician who can verify that you have engaged in:

Option A – Active licensed practice of chiropractic for three of the four years preceding the filing of this application. (In lieu of transcripts reflecting two academic years of study in a college of liberal arts or sciences – AS 08.20.120(a)(2).)

Option B – Active licensed **clinical** practice of chiropractic for five years (AS 08.20.163.(b)(2)(B).)

YOU MAY MAKE PHOTOCOPIES OF THIS FORM IF NECESSARY. PLEASE TYPE OR PRINT LEGIBLY IN INK ONLY.

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**SECTION I - To be completed by the applicant:**

I, \_\_\_\_\_, am applying for licensure as a Chiropractic Physician  
(Name of Applicant)

in the State of Alaska and hereby authorize you to release information as required on this form.

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**SECTION II – NOT TO BE COMPLETED BY THE APPLICANT - To be completed on the applicant’s behalf, by an employer, partner, or another chiropractic physician who can verify the active licensed practice of chiropractic (option “A”) or the active clinical licensed practice of chiropractic (option “B”).**

**Which are you documenting on behalf of the applicant?**

Active licensed practice of chiropractic

Active clinical licensed practice of chiropractic

1. Dates of Practice: From \_\_\_\_\_ to \_\_\_\_\_  
MM/DD/YYYY MM/DD/YYYY

2. Location of Practice: \_\_\_\_\_

3. Type of Practice: \_\_\_\_\_

Name of employer, partner, chiropractic physician or name of private practice: \_\_\_\_\_

---

**I certify that the above named applicant has engaged in the active licensed practice of chiropractic for the period indicated herein.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Physical Address

\_\_\_\_\_  
Chiropractic License Number

\_\_\_\_\_  
City, State, Zip, (Country)

\_\_\_\_\_  
State, Jurisdiction, Country where your  
license was issued

SUBSCRIBED AND SWORN TO BEFORE ME, a Notary Public, in and for the State of \_\_\_\_\_ this  
\_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

NOTARY SEAL  
OR  
(Postmaster stamp if  
notary public not available)

\_\_\_\_\_  
NOTARY PUBLIC SIGNATURE  
My Commission Expires: \_\_\_\_\_

---

**Please remit this form directly to:**

Department of Commerce, Community, and Economic Development  
Division of Corporations, Business, & Professional Licensing  
Board of Chiropractic Examiners  
P.O. Box 110806  
Juneau, AK 99811-0806  
084319f (Rev. 08/12/10)

**OPTION 'B' APPLICANTS**

**ALASKA STATE BOARD OF CHIROPRACTIC EXAMINERS**

**SWORN STATEMENT**

\_\_\_\_\_ being first duly sworn upon his/her oath, deposes and says:  
(Applicant Name)

**I make the following voluntary signed statement and no threats, promises, or any form of duress have been used to induce me to make this statement.**

By my signature below, I declare I have not been, within the five years preceding the date of application, the subject of an unresolved review or an adverse decision based upon a complaint, investigation, review procedure, or disciplinary proceeding undertaken by a state, territorial, local, or federal chiropractic licensing jurisdiction, chiropractic society, or law enforcement agency that relates to criminal or fraudulent activity, chiropractic malpractice, or negligent chiropractic care that adversely reflects on my ability or competence to engage in the practice of chiropractic or the safety or well-being of patients.

**WARNING: Pursuant to AS 08.20.170, the board may refuse to issued a license to, or impose a disciplinary sanction on, a person who has obtained or attempted to obtain a license to practice as a chiropractor by fraud, deceit or intentional misrepresentation. The person may also be subject to criminal charges for perjury (AS 11.56.200).**

**I certify that the above information is true and correct.**

SIGN HERE 

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Printed Name

Date: \_\_\_\_\_

SUBSCRIBED AND SWORN TO before me, a Notary Public, in and for the State of \_\_\_\_\_

this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_

NOTARY SEAL

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

My Commission Expires: \_\_\_\_\_

(or postmaster stamp if notary is not available)

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State of Alaska  
 Department of Commerce, Community, and Economic Development  
 Division of Corporations, Business and Professional Licensing  
 PO Box 110806, Juneau, Alaska 99811-0806  
 Phone: (907) 465-2550  
 Fax: (907) 465-2974

OFFICE USE ONLY

**CREDIT CARD PAYMENT**

For security purposes, please **do not email** credit card information. Fax or mail this form to the Division. Completion of this form is not proof of payment until the division processes the information contained herein. If any information on this form is illegible, the form will be rejected. Please print.

Name of Applicant or Licensee: \_\_\_\_\_  
*Corporate or Individual (first, middle, last)*

License Number (if applicable): \_\_\_\_\_

Type of License: \_\_\_\_\_

I wish to make payment by credit card for the following (check all that apply):

- |   |                     |
|---|---------------------|
| <input type="checkbox"/> Application fee          | Amount              |
| <input type="checkbox"/> License (or renewal) fee | _____               |
| <input type="checkbox"/> Fine                     | _____               |
| <input type="checkbox"/> Other (specify): _____   | _____               |
|   | <b>Total:</b> _____ |

Print Name on Credit Card: \_\_\_\_\_

Complete Mailing Address: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Email Address (optional): \_\_\_\_\_

Credit Card Type (check one):  VISA  MASTERCARD

**Signature of Credit Card Holder:** \_\_\_\_\_

**Card Number:** \_\_\_\_\_ **Expiration Date:** \_\_\_\_\_

*The bottom section of this form will be destroyed upon processing of the payment.*