

**IDAHO STATE BOARD OF CHIROPRACTIC PHYSICIANS
BUREAU OF OCCUPATIONAL LICENSES
700 West State Street, P.O. Box 83720
Boise, Idaho 83720-0063**

APPLICATION FOR IDAHO CHIROPRACTIC PHYSICIAN LICENSE

Instructions

Please complete this form by providing the requested information. Signatures must be notarized and the appropriate fees must be attached. Submit the completed form to the address noted below. An Application for Chiropractic License must be on file with all required supporting documentation before the Board will consider your application for licensure or a temporary permit. Failure to provide the requested information and required fees will result in the return of your application.

This application contains an affidavit that must be signed and notarized. The affidavit includes certification that the applicant has received and will comply with the Idaho laws and rules and scope of practice governing the practice of chiropractic in Idaho. The laws and rules are available online at the Board's website as noted below. Make checks payable to IBOL. All returned checks are subject to a \$20.00 fee.

APPLICATION FEE - \$250.00

TEMPORARY PERMIT FEE - \$50.00

Please mail your completed application and attachments to:

**IDAHO STATE BOARD OF CHIROPRACTIC PHYSICIANS
BUREAU OF OCCUPATIONAL LICENSES
700 West State Street, P.O. Box 83720
Boise, Idaho 83720-0063
E-MAIL chi@ibol.idaho.gov
WEB: www.ibol.idaho.gov**

APPLICATION FOR IDAHO CHIROPRACTIC PHYSICIAN LICENSE
(continued)

19. Please attach the names and current addresses of two persons willing to provide reference regarding your character.
(This office will contact the persons you list. We must receive their responses before your application will be processed.)

<hr/> name	<hr/> name
<hr/> position & license number	<hr/> position & license number
<hr/> current address	<hr/> current address
<hr/> city, state, zip	<hr/> city, state, zip

20. Attach a passport photograph of yourself taken within the last 12 months.

HEIGHT _____	WEIGHT _____	ATTACH
EYE COLOR _____	HAIR COLOR _____	PHOTOGRAPH
OTHER DISTINGUISHING FEATURES _____		HERE

21. Please attach a copy of your Chiropractic college diploma.

NOTE: If you wish a Temporary Permit to practice chiropractic in Idaho, please complete the Addendum for Temporary Practice and submit it with this application and attach an additional \$50.00 fee.

AFFIDAVIT

I hereby certify under penalty of perjury that the responses provided on and attached to this application are true and accurate to the best of my knowledge and belief. I further certify that I have reviewed and will comply with the Idaho Laws and Rules and the adopted Scope of Practice governing the practice of Chiropractic in Idaho.
I hereby authorize and direct any person, agency, firm, or other entity to release, upon the request of the Bureau of Occupational Licenses or it's authorized representative, any information, communication, report, record, statement, recommendation, or disclosure that may have bearing on my eligibility for or maintenance of the license for which I am applying.
I understand that by signing this form I am authorizing the release of information about me that may otherwise be protected or confidential.

Signature of applicant

State of _____, County of _____, ss.
Subscribed and sworn before me this _____ day of _____, 20 _____.

(seal)

Notary Public official signature
my commission expires _____

NOTE: IT IS UNLAWFUL TO PRACTICE CHIROPRACTIC, OR ADVERTISE AS A CHIROPRACTIC PHYSICIAN ,OR USE ANY WORD OR TITLE OR ABBREVIATION TO INDICATE CHIROPRACTIC LICENSURE OR PRACTICE IN IDAHO PRIOR TO OBTAINING A VALID LICENSE. ANY VIOLATION MAY RESULT IN CRIMINAL PROSECUTION AND DENIAL OF LICENSURE. (See §54-705. & 708., I.C.)

IDAHO STATE BOARD OF CHIROPRACTIC PHYSICIANS

BUREAU OF OCCUPATIONAL LICENSES

700 West State Street, P.O. Box 83720

Boise, Idaho 83720-0063

Phone: 208-334-3233; Fax: 208-334-3945

E-Mail: CHI@ibol.idaho.gov; Web: www.ibol.idaho.gov

PROFESSIONAL EXPERIENCE REFERENCE

APPLICANT: The Idaho Board of Chiropractic Physicians requires an application to include one (1) professional reference from an individual who has personal knowledge of your character and ability to practice chiropractic.

1. Applicant Name: _____

REFERENCE: Please complete this form and return it directly to the address noted above or to the applicant. Please provide all information requested. Incomplete information will delay the processing of the applicant's file. (Please type or print.)

1. Reference name _____

2. How long have you known the candidate? _____

3. Please describe your relationship with the candidate: (check all appropriate boxes)

Colleague Teacher Supervisor Personal acquaintance Other _____

4. If you are or were ever an employer, supervisor, or colleague of the candidate, please list the dates of that relationship: From _____ To _____, AND the candidate's title/position _____, AND
MM/DD/YY MM/DD/YY
the name of the organization _____

5. Please indicate your knowledge of the candidate's:

	Thorough Knowledge	General Knowledge	Little Knowledge
Training	_____	_____	_____
Work Experience	_____	_____	_____
Abilities	_____	_____	_____
Personality	_____	_____	_____

6. Do you believe, on the basis of ethical conduct, personal character, technical competence, and professional judgment, the candidate is a credit to the profession of chiropractic? Yes No
(If No, please explain on a separate sheet)

7. Do you have any reservations, not previously mentioned, about fully recommending this candidate for licensure as a Chiropractor Physician? Yes No
If Yes, please explain: _____

Signature of person completing reference form

Date

Phone Number

State of _____, County of _____, ss.

Subscribed and sworn before me this _____ day of _____, 20 _____.

SEAL

Notary Public Official Signature
My Commission Expires _____

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CERTIFICATE OF MORAL CHARACTER

APPLICANT: The Idaho Board of Chiropractic Physicians requires an application to include two (2) professional references from an individual who has personal knowledge of your character.

Applicant Name: _____

REFERENCE: Please complete this form and return it directly to the address noted above or to the applicant. Please provide all information requested. Incomplete information will delay the processing of the applicant's file. (Please type or print.)

Reference name _____

How long have you known the candidate? _____

Please describe your relationship with the candidate: (check all appropriate boxes)

Colleague Teacher Supervisor Personal acquaintance Other _____

If you are or were ever an employer, supervisor, or colleague of the candidate, please list the dates of that relationship: From _____ To _____, AND the candidate's title/position _____, AND the name of the organization _____

Please indicate your knowledge of the candidate's:

	Thorough Knowledge	General Knowledge	Little Knowledge
Training	_____	_____	_____
Work Experience	_____	_____	_____
Abilities	_____	_____	_____
Personality	_____	_____	_____

Do you believe, on the basis of ethical conduct, personal character, technical competence, and professional judgment, the candidate is a credit to the profession of chiropractic? Yes No

(If No, please explain on a separate sheet)

Do you have any reservations, not previously mentioned, about fully recommending this candidate for licensure as a Chiropractor Physician? Yes No

If Yes, please explain: _____

Signature of person completing reference form

Date

Phone