

FORM A

To be used for questions requiring additional answer space. This form may be duplicated as necessary.

Question # _____

Question # _____

Question # _____

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Applicant Signature: _____

Date: _____

FORM 1
RECORD OF CRIMINAL CASES
This form may be duplicated as necessary

Name _____
First Middle Last

Date of incident (or time period involved) _____

Location incident occurred _____
City County State

Case Number _____

Name and location of court involved:

Name of court _____

City _____ State _____ Zip _____

Names and location of law enforcement agency involved:

Name of law enforcement agency _____

City _____ State _____ Zip _____

Charge(s) at time of arrest _____

Charge(s) convicted of _____

Conviction Date _____

Description of incident _____

You must disclose all information requested pertaining to your criminal history. You may not rely on the results of your fingerprint background check as disclosure of your criminal history.

If you have more than one criminal incident to disclose, you must copy this form and provide a completed form for each incident. You may not provide information pertaining to multiple incidents on one form.

The Board may verify the above information and charge you for any fees associated with this process. Your approval to sit for the Jurisprudence Examination may be delayed until all pertinent information is collected and reviewed by the Board.

Applicant Signature: _____

Date: _____

FORM 3
AUTHORIZATION TO RELEASE MEDICAL RECORDS
This form may be duplicated as necessary

Upon presentation of the original or a photocopy of this signed authorization, I (name of applicant) _____ hereby authorize:

Name of Institution or Doctor _____

Address _____

City _____ State _____ Zip _____

To provide information, including copies of records, concerning advice, care, or treatment provided to me without limitation relating to mental illness, use of drugs or alcohol, to representatives of the Ohio State Chiropractic Board who are involved in conducting an investigation into my moral character, professional reputation, and fitness for the practice of chiropractic.

I hereby release, discharge and exonerate the Ohio State Chiropractic Board, its agents and representatives and its agents and representatives so furnishing information from any and all liability of every nature and kind arising out of the furnishing or inspection of such documents, records and other information or the investigation made by the Ohio State Chiropractic Board.

Signature of Applicant

Subscribed and sworn to or affirmed before me

This _____ day of _____, 20_____,

Notary Public

My commission expires _____

Seal or stamp must be affixed to this page.

Applicant Signature: _____

Date: _____

FORM 4
DESCRIPTION OF MENTAL HEALTH OR
SUBSTANCE ABUSE CONDITION OR IMPAIRMENT
This form may be duplicated as necessary

Name _____
First *Middle* *Last*

Date of treatment: From Mo/Yr _____ to Mo/Yr _____

Name of attending physician _____

Physician's current address _____

City _____ State _____ Zip _____

Telephone _____

Name of hospital or institution _____

Address _____

City _____ State _____ Zip _____

Telephone _____

Describe the condition or problem _____

Describe any treatment and/or monitoring program _____

Applicant Signature: _____

Date: _____

