



Application for Certificate to Practice Acupuncture In The State of Ohio

Ohio State Chiropractic Board
77 S. High Street, 16th Floor ♦ Columbus, OH 43215-6108
Phone: (614) 644-7032 ♦ Fax: (614) 752-2539
Website: www.chirobd.ohio.gov

APPLICANT INFORMATION (please print)

Date:	Name:	D.C. License No:
Identify the DBA (business name), legal name, and address of all facilities that provide or administrate health related services in which you are employed, own, operate, manage, or otherwise have any ownership or fiduciary interest within the state of Ohio. *Failure to provide this information for all facilities may constitute making a false, fraudulent or deceitful statement to the Board.		
Clinic Name:		If your mailing address is a Post Office Box you must include the physical address.
Clinic Street Address:		
City:	State:	Zip:
County:	Phone:	Fax:
If you have additional addresses to report, provide the requested information for each location under Additional Information.		<input type="checkbox"/> Check if you have no second address.
Website:		Email:
Home Address:		If your home and clinic address are the same do you practice out of your home? <input type="checkbox"/> Yes <input type="checkbox"/> No
City:	State:	Zip:
Have you ever been found guilty of a criminal offense* that you have not reported to this Board in writing? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain under Additional Information. Include court, case number, charge, dates and disposition. *You do not need to report minor misdemeanor traffic offenses. DUI Convictions are not minor misdemeanors and must be reported.		

LICENSE INFORMATION

List all states in which you have ever held a chiropractic license, regardless of current status. Indicate any additional licenses under Additional Information.		
State:	State:	State:
List all states in which you have ever held licensure to perform acupuncture, regardless of current status. Indicate any additional under Additional Information.		
State:	State:	State:
Have you ever had a professional license or certification that has ever been limited, censured, forfeited, surrendered, put on probation, reprimanded, revoked, fined, suspended or disciplined for any reason which you have not reported to this Board in writing? If yes, provide detailed information under Additional Information. <input type="checkbox"/> Yes <input type="checkbox"/> No		

ACUPUNCTURE TRAINING

List the provider from which you obtained 300 hours of Board-approved acupuncture education. *An official transcript must be sent to the Board office directly from the educational institution.	
Sponsor/Provider:	Hours Earned:

NBCE EXAMINATION

Have you passed the NBCE Acupuncture Exam? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date Taken:	Score:
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*An official transcript must be sent to the Board office directly from the NBCE.

ADDITIONAL INFORMATION

PAYMENT

Make check or money order in the amount of \$100 payable to Ohio Treasurer, Richard Cordray. If paying by credit card, you must sign in the cardholder signature box. The application fee is non-refundable.

<input type="checkbox"/> Check <input type="checkbox"/> Visa <input type="checkbox"/> Mastercard Amount: \$ _____	Credit Card No. _____ Expires ____ / ____
Name of cardholder as shown on credit card: _____	Cardholder Signature: _____

SIGNATURE & AFFIRMATION

I attest that the information provided on this application and any attachment(s) is true, correct and complete. I understand that making a false, fraudulent or deceitful statement on this application may result in disciplinary action and/or the Board's refusal to issue a certificate to practice acupuncture.

I further understand and authorize the Board and its agents to investigate this application and verify the statements contained herein. I hereby authorize any government agency, law enforcement agency, licensing board, school, corporation, organization, association or any person to provide the Board with any information necessary to investigate information I have provided and disclosed on this application.

Signature: _____	Date: _____
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NOTARY

State of _____ County of _____

Subscribed and sworn to before me this _____ day of _____ 20 ____

My commission expires: _____

Dated _____ Signed _____

Notary Seal

**Mail application with payment to: Ohio State Chiropractic Board
77 S. High Street, 16th Floor
Columbus, OH 43215**