

**FORM A**

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

Question # \_\_\_\_\_

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Question # \_\_\_\_\_

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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 \_\_\_\_\_

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Describe any treatment and/or monitoring program \_\_\_\_\_

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

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