



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 convicted of, found guilty of, pled guilty to, pled no contest to, pled not guilty by reason of insanity to, entered an Alford plea, received treatment or intervention in lieu of conviction, or been found eligible for pretrial diversion or a similar program for any violation of any law (except minor traffic laws) in any jurisdiction, other than a violation that was resolved in juvenile court? Yes* No		
*If yes, explain under Additional Information. Include court, case number, charge, dates and disposition. If you are unsure what does and does not constitute a minor traffic violation, consult with legal counsel. Driving under the influence violations are not minor traffic violations 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?

Yes No

Date Taken:

Score:

*An official transcript must be sent to the Board office directly from the NBCE.

ADDITIONAL INFORMATION

PAYMENT

Non-refundable \$100 application fee (Visa or MasterCard). Cardholder must sign his or her name in signature box.

Visa 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:

NOTARY

State of _____ County of _____

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

My commission expires: _____

Dated _____ Signed _____

Notary Seal

Mail Application & Payment To:
Ohio State Chiropractic Board
77 S. High Street, 16th Floor
Columbus OH 43215