Maryland State Board of Chiropractic Examiners
4201 Patterson Avenue, Suite 301
Baltimore, MD 21215
(410) 764-4726
www.health.maryland.gov/chiropractic

BOARD USE ONLY
Date Rec'd: _____
CHRC: _____
APVD: Yes ___No___
Dbase entry: _____

REINSTATEMENT AND REACTIVATION APPLICATION

A LICENSEE/REGISTRANT WHOSE LICENSE/REGISTRATION HAS BEEN NON-RENEWED FOR OVER 5 YEARS MUST REAPPLY AS A NEW LICENSEE/REGISTRANT, MEETING ALL CURRENT STANDARDS AND QUALIFICAIONS.

PLEASE PRINT OR TYPE ALL INFORMATION LEGIBLY. PAYMENT MUST BE MAILED BY CHECK OR MONEY ORDER, PAYABLE TO: *MD STATE BOARD OF CHIROPRACTIC EXAMINERS.*

NAME: _____ LICENSE/REGISTRATION # _____

REINSTATEMENT FEES DUE	**DC**	**CA**
REINSTATEMENT FEE	$300	$300
RENEWAL FEE **(ASSESSED FOR EVERY LICENSE RENEWAL PERIOD MISSED)**	$700	$250
LATE RENEWAL FEE (In addition to the Reinstatement or Renewal Fee)	$500	$200
STATUTORY HEALTHCARE USER FEE	$26	N/A
REACTIVATION FEES DUE	**DC**	**CA**
RENEWAL FEE	$700	$250
REACTIVATION FEE (In addition to the Reinstatement or Renewal Fee)	$200	$200
STATUTORY HEALTHCARE USER FEE	$26	N/A

FEES DUE IS REFLECTED BELOW FOR REINSTATEMENT AND REACTIVATION BASED ON YOUR CURRENT STATUS.

____ REINSTATEMENT FEE ____$_____

____ RENEWAL FEE (X _____ RENEWAL PERIODS MISSED) ____$_____

____ LATE FEE (In addition to the Reinstatement or Renewal Fee) ____$_____

____ REACTIVATION FEE (In addition to the Reinstatement or Renewal Fee) ____$_____

____ STATUTORY HEALTHCARE FEE ____$_____

TOTAL DUE ____$_____

REQUIREMENTS DUE FROM APPLICANTS:

- Continuing Education: Attach documented proof of satisfactory completion of at least ☐ **48 hours for DCs**; Mandatory-3 in risk management, 3 in communicable diseases – sanitary procedures, 1 in jurisprudence and,1 in cultural diversity ☐**10 hours for CAs**; of Board approved CEUs within the past 2 calendar years.
- CPR Certification: ☐ Attach documented proof of CPR certification at **Healthcare Provider Level** from a recognized accredited source.
- Verification of Good Standing: ☐ Request certified licensing verification status and disciplinary history from current and/or previous licensing Board sent directly to the MD Board.

CONTINUED ON REVERSE

BOARD USE ONLY
Check Date:_____ **Check #:**_____ **Check Amt.:**_____

REINSTATEMENT AND REACTIVATION APPLICATION

COMPLETE ALL REMAINING SECTIONS OF THIS APPLICATION
PRINT OR TYPE ALL INFORMATION LEGIBLY

NAME: _____

CURRENT MAILING ADDRESS: _____

BUSINESS PHONE: _____ HOME PHONE: _____CELL: _____

EMAIL: _____

PROFESSIONAL COMPETENCY & MORAL CHARACTER AND FITNESS QUESTIONS

Please write "yes" or "no" for each question. Affirmative response(s) requires a detailed explanation on a separate sheet and must be included with this application.

1. _____Are you or have you been addicted to drugs or alcohol?

2. _____Has any State Licensing or Disciplinary Board in **any** jurisdiction denied your application for licensure/certification/registration reinstatement or renewal, or taken **any** action against your license/certification/registration including but not limited to reprimand, suspension, or revocation?

3. _____Are there any current complaints, investigations, charges, or allegations pending against you in **any** State by **any** Licensing or Disciplinary Board or Federal, State or Local jurisdictions?

4. _____Have your surrendered or allowed your license/certificate/registration to expire while under investigation by a licensing or disciplinary board in **any** jurisdiction?

5. _____Have you had or do you have a physical or mental health condition, injury or disability that impaired or impairs your ability to practice?

6. _____Have you **ever** pled guilty, no contest, nolo contendere, or been arrested or convicted or received probation before judgment for **any** criminal act, including DWI or DUI?

7. _____Has any hospital or related health care institution, insurer or employer denied you privileges or employment, denied any application for privileges or employment, failed to renew your privileges or contract or limited, restricted, suspended, revoked, or terminated your privileges or contract for any reason related to your practice?

8. _____Has a malpractice suit ever been filed against you, or has a claim for damages been settled or awarded against you?

CONTINUING EDUCATION CERTIFICATION (Initial below):

_____I certify that I have earned the required _____hours of CEUs in the past 2 years and that copies of course completion certificates are attached. I understand the Board may verify this information with the provider.

_____I hold a current healthcare provider level CPR certification. A copy is attached.

ATTESTATION:

I affirm and attest that all information provided on this application is true and correct to the best of my knowledge and belief:

_____	_____	_____
PRINTED NAME	SIGNATURE	DATE

An incomplete application package will delay the processing of your application.