

Board of Chiropractic

P.O. Box 30670

Lansing, Michigan 48909

(517) 335-0918

www.michigan.gov/healthlicense**CHIROPRACTOR RELICENSURE INSTRUCTIONS**Authority: P.A. 368 of 1978, as amended
This form is for information only.

NOTE: It is your responsibility to have all required documentation sent to the Board of Chiropractic. Questions regarding your application can be directed to the Michigan Board of Chiropractic at (517) 335-0918 three weeks after the date you sent the application. If an applicant fails to complete the requirements for licensure within two years from the date of filing the application, the application and fee are no longer valid. Please allow 6-8 weeks processing time.

CHIROPRACTOR BY RELICENSURE

1. Completed the application and return it to the Board of Chiropractic with the appropriate fee. A check or money order drawn on a U.S. financial institution and made payable to the **STATE OF MICHIGAN** must accompany the application. An application accompanied by the appropriate fee is valid for two years. Applications received without a fee will be returned.
2. Submit either evidence of completion of 42 hours of board-approved continuing education within the three years immediately preceding the date of this application with at least 24 of those hours in chiropractic adjusting techniques and at least one hour in sexual boundaries, one hour in ethics and one hour in pain and symptom management; **OR**

Submit evidence of having been continuously licensed in another state during the three-year period immediately preceding the date of this application.
3. Send the enclosed Verification of Licensure or Registration form to any other state where you are currently or have ever held a permanent chiropractic license, the form may be duplicated as needed. As most states charge a fee for this service, you should contact each state board to determine if a fee is required before sending them the form for completion. The verification form must be sent to the Michigan Board directly from the states(s) where you have been licensed.

GENERAL INFORMATION

1. **NAME AND/OR ADDRESS CHANGES:** If your name and/or address changes please notify the Board of Chiropractic in writing. To change a name or address, you can download the [Data Change/Duplicate License Request Form](#) from our website www.michigan.gov/healthlicense and fax it to (517) 373-2179 or mail the form to Bureau of Health Professions, PO Box 30670, Lansing, MI 48909. Telephone calls are NOT accepted for these changes.
2. **REFUND POLICY:** If you wish to withdraw your application, you may be eligible for a partial refund. You must notify the Board of Chiropractic in writing to request a refund.
3. **NOTE:** If you have ever been licensed in another state and you have a current disciplinary sanction on that license, (even if the license is inactive), you are **not** eligible for licensure in Michigan according to the Public Health Code, PA 368, as amended, Section 222.16174 (3). Sanctions include probation, limitation, suspension, revocation or fine. Upon resolution of the sanction and verification that the license is active with no disciplinary action in effect, you can proceed with the filing of an application for a Michigan license or registration.

ORIGINAL LICENSES AND RELICENSURES ARE VALID FOR ONE YEAR OR LESS; SUBSEQUENT RENEWALS ARE GOOD FOR A TWO-YEAR PERIOD.

Michigan Department of Community Health
Board of Chiropractic
 P.O. Box 30670
 Lansing, MI 48909
 (517) 335-0918
 www.michigan.gov/healthlicense

APPLICATION FOR RELICENSURE

Authority: Public Act 368 of 1978, as amended
 If this form is not completed, a license will not be issued.

Type or Print Only

I AM APPLYING FOR THE FOLLOWING: <input type="checkbox"/> Relicensure Fee: \$140.00 71-2301-06 Your check or money order drawn on a U.S. financial institution and made payable to the STATE OF MICHIGAN must accompany this application. DO NOT SEND CASH. Fees are deposited upon receipt and can only be refunded under refund rules promulgated by the Department.			Board Use Only		
			License Number		
			Date of Relicensure		
First Name		Middle Name		Last Name	
U.S. Social Security Number		Date of Birth		Daytime Telephone Number ()	
Street Address					
City		State		ZIP Code	
All Previous Names and/or Birth Name Used (if applicable)				E-Mail Address	
Has your Michigan chiropractic license been lapsed more than three years? <input type="checkbox"/> No <input type="checkbox"/> Yes				Michigan Permanent I.D. Number/License and Expiration Date	

Check the appropriate answer to each of the following questions. NOTE: Attach a detailed explanation for any Yes answer you check.

1. Have you ever been convicted of a felony?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Have you ever been convicted of a misdemeanor punishable by imprisonment for a maximum term of 2 years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Have you ever been convicted of a misdemeanor involving the illegal delivery, possession, or use of alcohol or a controlled substance (including motor vehicle violations)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Have you been treated for substance abuse in the past 2 years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Have you had 3 or more malpractice settlements, awards, or judgments in any consecutive 5 year period?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Have you had one or more malpractice settlements, awards, or judgments totaling \$200,000 or more in any consecutive 5 year period?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

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Bureau of Health Professions
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VERIFICATION OF LICENSURE OR REGISTRATION IN ANOTHER STATE

Authority: Public Act 368 of 1978, as amended.

PART I: To be completed by the applicant and forwarded to the appropriate State Licensing Board for completion.

Check the profession for which you are requesting verification.			
<input type="checkbox"/> Audiology	<input type="checkbox"/> Medicine	<input type="checkbox"/> Osteopathy	<input type="checkbox"/> Psychology
<input type="checkbox"/> Chiropractic	<input type="checkbox"/> Nursing	<input type="checkbox"/> Pharmacy	<input type="checkbox"/> Respiratory Therapy
<input type="checkbox"/> Counseling	<input type="checkbox"/> Nursing Home Adm.	<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Sanitarians
<input type="checkbox"/> Dentistry	<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Physician's Assistants	<input type="checkbox"/> Social Work
<input type="checkbox"/> Marriage & Family Therapy	<input type="checkbox"/> Optometry	<input type="checkbox"/> Podiatry	<input type="checkbox"/> Veterinary
First Name	Middle Name	Last Name	
Previous Names Used	Date of Birth	U. S. Social Security Number	
State Board	License Number	Date of Issue	

The applicant listed above has applied for licensure in Michigan and has indicated licensure in your State. Please complete Part II of this form and return it to the appropriate Michigan Board at the address shown above.

PART II: To be completed by the State Licensing Board.

Type of License:	Original Issue Date	Expiration Date
Basis for Issuance of License:		
<input type="checkbox"/> Examination - Please indicate type of exam (National, Regional, State, etc.) _____		
<input type="checkbox"/> Endorsement - Please indicate name of state _____		
License Status	Has the applicant incurred any formal or informal actions in your State?	
<input type="checkbox"/> Current <input type="checkbox"/> Lapsed <input type="checkbox"/> Inactive	<input type="checkbox"/> No <input type="checkbox"/> Yes - If Yes, Please attach certified copies of any actions.	
Are formal or informal actions pending?	Has the applicant's license ever been limited, denied, surrendered, reprimanded, suspended or revoked?	
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	

CERTIFICATION

I hereby verify, to the best of my knowledge, the information above is true to the records of this Board.

Signature

Date

Type or Print Name

(S E A L)

Title

Full Name of Licensing Board