



DEPARTAMENTO DE

SALUD

GOBIERNO DE PUERTO RICO

PUERTO RICO BOARD OF CHIROPRACTIC EXAMINERS

APPLICATION FOR EXAMINATION

FULL NAME: _____

PHYSICAL ADDRESS: _____

POSTAL ADDRESS: _____

TELEPHONE: _____ EMAIL: _____

SOCIAL SECURITY #: _____ DATE OF BIRTH: _____

AFFIDAVIT

State or of (territory) _____ country of (or city) _____,
Being duly sworn, says that _____ he (she) is the person referred to in this application
and that the statements herein contained are true in every respect, and that the attached photograph is a true
likeness of her (his) self-taken within the last six months.

I hereby authorize the Puerto Rico Board of Chiropractic Examiners to verify my **Chiropractic Information
Network-Board Advisors and Decisions Status (CIN-BAD)**.

I hereby expressly waive all provisions of Law forbidding any physician or hospitals, institutions, or
organizations, who has attended or examined me or who hereafter attends or examined me from disclosing any
knowledge or information which he thereby acquired, and I hereby consent that he may disclose such knowledge
or information to the Puerto Rico Board of Chiropractic Examiners regarding with this application.

I have carefully read the foregoing application and have answered them completely, without reservation of any
kind, I declare penalty of perjury that my answer and all statements made by me herein are true and correct.
Should I furnish any false information in this application I hereby agree that such an act shall constitute cause for
the denial, suspension, or revocation of my license to practice Chiropractic in Puerto Rico.

SWORN TO AND SUBSCRIBED BEFORE ME BY _____,
Personally known to me or whom I identified by men of: _____.
In _____, _____ **on this** _____ **day of** _____, _____.

AFFIDAVIT NUM: _____

SECURELY
PASTE A
PASSPORT-TYPE

PHOTOGRAPH IN
THIS SPACE

RIGHT THUMB PRINT
(MAY BE SELF- APPLIED)

If right thumb is missing,
use left.


Notarial Seal


Signature of Applicant

Signature of Public Notary

REV. MAY 2025

PO BOX 10200 SAN JUAN, PR 00908-0200

 (787)999-8989 Ext. 6607

 www.salud.pr.gov

PERSONAL INFORMATION OF THE APPLICANT

1. Has your name ever been changed? YES _____ NO _____.
If so, give date place of such change: _____
Give original name: _____
2. Date of birth: _____ Age: _____ Place of birth: _____
3. Are you a citizen of the United States? YES _____ NO _____. (If naturalized, give date and place of naturalization _____).
4. Residential address: _____
Since when: _____
5. Name the educational institution where you obtained the bachelor's degree: _____
Starting date: _____ Date of bachelor's degree obtained: _____
6. Name the educational institution where you obtained the doctor's degree: _____
Starting date: _____ Date of doctor's degree obtained: _____
Grade point average at the time of graduation: _____
7. List all jurisdictions in which you have been issued a license to practice Chiropractic: active, inactive or expired.
Indicate number and date issued: _____
8. Have you ever been examined by any other licensing Board? YES _____ NO _____. If yes, give location

9. Have you ever been denied the privilege of taking an examination before any state, territory, or country licensing?
YES _____ NO _____. If yes, explain which state and why? _____
10. Have you been convicted of a violation of/or pledged Nolo Contendere on any federal, state or local statute, regulation or ordinance, or entered any plea bargaining relating to a felony or misdemeanor? (Excluding traffic violations, except convictions for driving under the influence). YES _____ NO _____. If yes, explain _____

11. Have you ever been denied or voluntarily surrendered your clinical privileges while under investigation, been censured or warned, or requested to withdraw from the staff of any professional school, internship, hospital nursing home, or other health care facility or health care provider? YES _____ NO _____. If yes, explain _____

12. Have you ever had any of the following disciplinary actions taken against your license to practice Chiropractic (DEA permit, state-controlled substances registration if applicable), Medicaid, or any such actions pending (a) suspension revocation (b) probation (c) reprimand/cease and desist (d) had your practice monitored? YES _____ NO _____.
If yes, explain _____



- List in chronological order all professional practice since graduation, including internships and absences from work. Also list all periods of non-professional activity or employment for more than three months, please account for all time.**

NAME, LOCATION AND POSITION HELD

[illegible]



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CERTIFICATE OF GOOD MORAL CHARACTER

(To be filled and signed by a registered Chiropractor not related to applicant)

THIS CERTIFIES that I have been personally acquainted with _____
for _____ years, that I know him/her to be of good moral character, and that I hereby recommend him/her to the
Puerto Rico Board Chiropractic Examiners as entirely worthy of examination for a license to practice Chiropractic
pursuant to law.

Name of Chiropractor

SIGNATURE OF AFFIANT

ADDRESS: _____

TELEPHONE: _____

EMAIL: _____

LICENSE NUMBER: _____

TO BE COMPLETED BY THE PUERTO RICO BOARD OF CHIROPRACTIC EXAMINERS

(Please don't write in these spaces)

DATE APPLICATION RECEIVED: _____

_____ **APPLICATION APPROVED**

_____ **APPLICATION DENIED**

REASON: _____

APPLICATION EVALUATED BY:

President

LICENSE NUM: _____

Vice President

DATE: _____

Member

CLAIM HISTORY SHEET

If you answered YES to question #14 on page two (2) of the application, please either have your attorney submit a letter regarding malpractice suites and complete one of these sheets for each case you have been involved in.

(Make additional copies of this form as needed)

Applicant name: _____

Claimant: _____

Date of Incident: _____ **Date Claim Made:** _____

Name of all defendants, persons, or entities against who claim was made: _____

City, Country and State of Suit: _____

Name and address of defense attorney: _____

Statement amount (If any): _____ **Verdict Amount:** _____ **Date case closed:** _____

Current status of claim (Indicate insurance company reserve if case is not closed): _____

Name of involved Insurance Company: _____

Policy Number: _____ **Detailed description of claim (use reverse side if necessary):** _____

AUTHORIZATION FOR RELEASE INFORMATION

I hereby authorize any person, company, insurer, hospital, or other organization to release all information, privilege, or in their dominion, custody, or control, regarding insurance applicants by me, professional liability issued to me, as well as information abstained by any attorneys who are now representing me or have in the past represented me.

DATE

PRINT NAME

SIGNATURE



DEPARTAMENTO DE

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AUTORIZATION FOR RELEASE OF INFORMATION

☐

I authorize

☐

I do not authorize

...the Department of Health to offer information regarding my professional license status to employers, private or government agencies, educational institutions, professional institutions, health insurance companies, malpractice insurance companies and examining boards.

NAME

DATE

SIGNATURE

REQUIREMENTS TO PRESENT WITH THIS APPLICATION

PLEASE SUBMIT THE FOLLOWING DOCUMENTATION

Documents must be presented *all at once*. Official transcripts must be sent directly by educational or examining institutions by postal service to the postal address in this application.

1. **Official** application for examination dully fulfilled and with all requirements included.
2. **Official** transcript sealed and unopened from the university or college where you completed your bachelor's degree, as required prior to entering the Doctor of Chiropractic program, in accordance with the Chiropractic Law of Puerto Rico: "Law No. 493 of May 15, 1952, as amended" and Resolution 2025-59 of the Puerto Rico Board of Chiropractic Examiners: Exam Admission Requirements.
3. **Official** transcript sealed and unopened from the university where you complete your Chiropractic degree.
4. **Original and copy** of Doctor of Chiropractic diploma (if original diploma isn't available, applicant must request the academic institution to send an official copy by postal service to the postal address in this application)
5. **Original and copy** of Bachelor's diploma (if original diploma isn't available, applicant must request the academic institution to send an official copy by postal service to the postal address in this application)
6. **Official** sealed and unopened National Board of Chiropractic Examiners transcript of parts I, II, III and IV. (PT and Acupuncture, if taken).
7. **Specialties**. A certificate from any specialty, diplomat and/or fellowship from any recognized association and/or council (ACA, ICA or any other) if applicable.
8. **Original and copy** of the Birth Certificate. (PR Law NO. 191-2009)
9. **Original and copy** of valid unexpired identification (driver's license or state identification card). Provide evidence of U.S. Citizenship, if applicable (Passport, Visa, or proof of Alien Status).
10. **Original** Certificate of Background Check from your State Police or State Law Enforcement Agency where you have been living during the last six (6) months.
11. **Original** Certificate of Child Support from your State Agency where you have been living during the last six (6) months.
12. Three (3) **original** letters of recommendation (with letterhead). One must be from an active licensed Doctor of Chiropractic with active practice in Puerto Rico. The other two recommendation letters can be from active Doctor of Chiropractic Practicing outside of Puerto Rico. (Letters must have a headline with the doctor's information, the license number and must be signed).
13. **Copy** of current Cardiopulmonary Resuscitation (CPR) card and/or certificate.
14. Evidence of malpractice carrier coverage (if applicable).
15. Postal or Bank Money order, ATH, VISA, MASTERCARD, or certified check for the amount of **\$100.00** (US Currency) payable to the Secretary of Treasury of Puerto Rico. (***Fee is non-refundable***).

16. Two envelopes with post stamps and your postal address.
17. The application **must** be submitted personally or by certified mail to the following address:

**PUERTO RICO BOARD OF CHIROPRACTIC EXAMINERS
PO BOX 10200
SAN JUAN, P.R. 00908-0200**

INCOMPLETE APPLICATIONS WILL NOT BE ACCEPTED

Application must be received on or before the due date published in the official press announcement.