

**Board of Chiropractic**

P.O. Box 30670

Lansing, Michigan 48909

(517) 335-0918

[www.michigan.gov/healthlicense](http://www.michigan.gov/healthlicense)**CHIROPRACTIC EDUCATIONAL LIMITED LICENSURE 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. Please allow 6-8 weeks processing time. If an applicant fails to complete the requirements for licensure within two years from the date of filing the application, the application is no longer valid.

**CHIROPRACTIC EDUCATIONAL LIMITED LICENSE**

The Educational Limited License can be issued only for the purpose of supervised practice as a part of your chiropractic education. If you have already graduated from your chiropractic educational program, you are not eligible for this license.

1. Complete 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. An Educational Limited license is valid for 6 months, with no extensions available. Please be sure to indicate the beginning date for the Educational Limited License on the application where indicated.
2. **Effective October 1, 2008**, all applicants for a health profession license or registration in Michigan are required to submit fingerprints and undergo a criminal background check. Please see the attached instructions. The Michigan Board is not able to accept fingerprints that have been obtained for any other purpose. Your license or registration will not be issued until this process is complete.
3. Complete part I of the enclosed Certification of Chiropractic Education form. Forward the form to the Dean or Registrar of your chiropractic school for completion. The completed form must be submitted directly from the chiropractic school to the Board. You must have successfully completed at least two years, four semesters or six-quarter terms in an approved chiropractic school to be eligible for this license.
4. Complete part I of the enclosed Supervision Confirmation form. Forward the form to the supervisor of your education training completion. The completed Supervision Confirmation Form must be submitted directly to the Board.

## **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](http://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 333.16174 (2). 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.
4. The limited license is valid for six months from the date it is issued and is **not** renewable.



RICK SNYDER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

STEVEN H HILFINGER  
DIRECTOR

**CRIMINAL BACKGROUND CHECK  
FINGERPRINT REQUEST FORM INSTRUCTIONS- (Michigan locations only)  
AGENCY ID NUMBER IS 71734k**

Applicants for a Michigan health professional license may have their fingerprints taken by either L-1 Identity Solutions or Cogent Systems. Whether you use L-1 Identity Solutions or Cogent Systems, the Agency ID Number for health professional licensing is 71734k. This ID number MUST be used in order to have your fingerprint report sent to the Bureau of Health Professions. Keep the receipt you receive once your fingerprints are taken.

You must bring the Livescan Fingerprint Request Form (attached) and a driver's license or other state or federal-issued picture identification to your fingerprint appointment. You will also be required to pay a separate fee to the fingerprinting agency when registering for or scheduling your appointment.

When your fingerprints are taken, a technician will perform a scan of your fingerprints and submit the data electronically to the Michigan State Police. If no criminal history is found, the Bureau of Health Professions will be notified. If criminal history information is found, the Michigan State Police will send the record directly to the Bureau of Health Professions for review.

Information about fees and scheduling your fingerprint appointment with L-1 Identity Solutions can be found at [www.L1enrollment.com](http://www.L1enrollment.com) or by calling 1-866-226-2952.

Information about fees and registering to have your fingerprints taken by Cogent Systems can be found at [www.cogentid.com/index.htm](http://www.cogentid.com/index.htm). Click on Michigan and then select the Cogent MAPS (Michigan Applicant Processing Service) option. If you are using Cogent Systems, the MAPS option must be used for health professional licensing purposes. Cogent Systems can be reached by phone at 1-877-838-4903. E-mail inquiries about using Cogent Systems may be sent to [mihelp@cogentsystems.com](mailto:mihelp@cogentsystems.com).



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**CRIMINAL BACKGROUND CHECK  
FINGERPRINT REQUEST FORM INSTRUCTIONS  
(For applicants out of state or out of country)**

1. Contact a local law enforcement , governmental, or private fingerprinting agency to see if they can perform an ink fingerprint on an FBI (FD-258) card or on another state's official fingerprint card. The ink fingerprint must be completed on card stock.
2. Submit the card with your fingerprints, the completed Livescan Fingerprint Request Form (attached) and a business check or money order for \$62.75 made payable in U.S. Funds to L-1 Identity Solutions to the following address:

L-1 Enrollment Services/LiveScan Processing Unit  
1650 Wabash Ave. Ste. D  
Springfield, IL 62704

3. Please include a daytime telephone number or e-mail address where you can be reached if there are any questions.
4. L-1 Identity Solutions will submit your fingerprints to the Michigan State Police for analysis.
5. If no criminal history information is found, the Bureau of Health Professions will be notified.
6. If criminal history information is found, the Michigan State Police will send the record directly to the Bureau of Health Professions for review.
7. Call L-1 Identity Solutions toll-free at 1-866-226-2952 (8 am - 5 pm EST) if you have any questions.
8. L-1 Identity Solutions is under contract with the Michigan State Police (MSP) to provide fingerprint services. For questions, call MSP at (517) 241-0606.

## LIVESCAN FINGERPRINT REQUEST FORM

Fingerprint Date:	TCN:
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Type of I.D. Presented:	Type of Licensure/Registration:
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**Applicant Instructions:** Take this completed form along with your picture I.D. to your scheduled appointment. Please print clearly.

First Name:	Middle Name:	Last Name:	
Street Address:			
City:	State:	ZIP Code:	
Daytime Telephone Number w/ Area Code:		State or Country of Birth:	
Date of Birth (MM/DD/YYYY):	Race:	Sex:	
Height:	Weight:	Eye Color:	Hair Color:

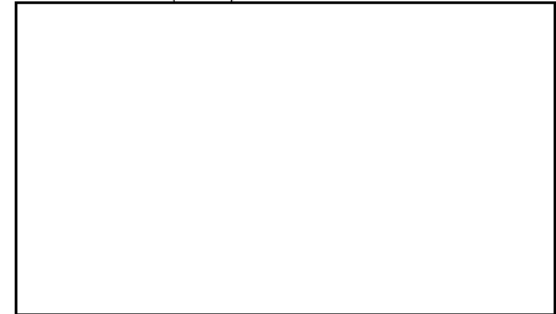
### REQUESTING AGENCY INFORMATION

Agency I.D. Number: <b>71734k</b>	Agency Name: <b>Department of Licensing and Regulatory Affairs, Bureau of Health Professions</b>
Reason Fingerprinted: <b>LHP - Licensed Health Care Professional (MCL333.16174)</b>	Cost:

**\*\*Disclaimer:** Any and all errors that result in dual fingerprinting (Duplicate transmission to MSP), multiple fingerprint codes, fingerprints processed with incorrect fingerprint codes/reasons, etc., are the responsibility of the **LIVESCAN AGENCY**. MSP will charge for dual fingerprinting (transmission), etc.

**APPLICATION FOR EDUCATIONAL LIMITED LICENSE**

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



Type or Print Only

Board Use Only

**I AM APPLYING FOR THE FOLLOWING:**

License Number: \_\_\_\_\_  
Date of Licensure: \_\_\_\_\_

Educational Limited License Fee: \$50.00 71-2301-05

**Start Date for Educational Limited License:** \_\_\_\_\_  
(Month/Day/Year)

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.

Legal First Name		Legal Middle Name		Legal 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
Have you ever held a health professional license in Michigan? <input type="checkbox"/> No <input type="checkbox"/> Yes			Michigan Health Professional Permanent I.D./License Number and Expiration Date		

**Check the appropriate answer to each of the following questions. NOTE: Submit a detailed explanation for any YES answer you check on a separate sheet with your application.**

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

Name
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- 5. Have you had 3 or more malpractice settlements, awards, or judgments in any consecutive 5 year period?  Yes  No
- 6. Have you had one or more malpractice settlements, awards, or judgments totaling \$200,000 or more in any consecutive 5 year period?  Yes  No
- 7. Have you ever had a federal or state health professional license or registration revoked, suspended, or otherwise disciplined; been denied a license; or currently have disciplinary action pending against you?  Yes  No
- 8. Have you ever been censured, or requested to withdraw from a health care facility's staff or had your health care facility staff privileges involuntarily modified?  Yes  No
- 9. Do you hold or have you ever held a chiropractic license in any state? If so, list each state, the license number, the date issued, and how the license was obtained (either endorsement or examination). **DO NOT LIST TEMPORARY LICENSES. You must have each state board verify licensure directly to this board office. (Attach additional sheets necessary.)**  Yes  No

State	License/Registration Number	Date of Issue	How obtained (Endorsement or examination)

**CERTIFICATION**

I understand that it is the policy of this agency to secure a criminal conviction history as part of the pre-licensure screening process. I authorize this agency to use the information provided in this application to obtain a criminal conviction history file search from the Central Records Division of the Michigan Department of State Police or other law enforcement or judicial record-keeping organization.

I further consent to the release of information to this agency regarding any disciplinary investigations conducted by a similar licensure, registration, or specialty certification board of this or any other state, of the United States military, of the federal government, or of another country.

The statements in this application are true and correct. I have not withheld information that might affect the decision to be made on this application. In signing this application, I am aware that a false statement or dishonest answer may be grounds for denial of my application or revocation of my license and that such misrepresentation is punishable by law.

Signature of Applicant	Date
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Michigan Department of Licensing and Regulatory Affairs  
**Board of Chiropractic**  
 P.O. Box 30192  
 Lansing, MI 48909  
 (517) 335-0918  
[www.michigan.gov/healthlicens](http://www.michigan.gov/healthlicens)

**CERTIFICATION OF CHIROPRACTIC EDUCATION**

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

**SECTION I - APPLICANT INFORMATION**

**Instructions: Applicant complete Section I. Type or print your legal name exactly as it appears on your application. For completion of Section II, send this form to the dean or registrar of the chiropractic school you attend. This certification must be submitted directly to the Michigan Board of Chiropractic by the chiropractic school.**

First Name	Middle Name	Last Name	
Social Security Number	Date of Birth		
Street Address			
City	State	ZIP Code	
Daytime Telephone Number	All Previous Names and/or Birth Name Used (if applicable)		

Signature of Applicant	Date
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**APPLICANT: UPON COMPLETION OF SECTION I, SEND THIS FORM TO THE DEAN OR REGISTRAR OF YOUR CHIROPRACTIC SCHOOL FOR COMPLETION OF SECTION II.**

The Department of Licensing and Regulatory Affairs 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.

Name
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**THIS SIDE TO BE COMPLETED BY THE DEAN OR REGISTRAR OF THE CHIROPRACTIC SCHOOL**

**SECTION II - CERTIFICATION OF CHIROPRACTIC EDUCATION**

Instructions: Please complete the following information. Return this completed certification directly to the Michigan Board of Chiropractic at the address shown on the reverse side of this form.

Name of Chiropractic School
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Street Address of Chiropractic School
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City, State and ZIP Code
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<p>I certify that _____ has successfully completed at least          (Applicant's Name)</p> <p><b>two years, four semesters, or six quarter terms in the chiropractic school named above.</b></p>	
<p>_____          Signature of Dean or Registrar</p>	<p>_____          Date of Signature</p>
<p>_____          Print or Type Name of Dean or Registrar</p>	<p><b>(SEAL)</b></p> <p>If school has no seal, please indicate</p>

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**SUPERVISION CONFIRMATION FORM FOR EDUCATIONAL LIMITED LICENSE**

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

**PART I - APPLICANT INFORMATION:**

Instructions: Complete Part I. Type or print your name exactly as it appears on your application. Send this form to your supervisor for completion of Parts II and III. This form must be submitted directly to the Board of Chiropractic from your supervisor.

First Name	Middle Name	Last Name	
Street Address			
City		State	Zip Code
U.S. Social Security Number		Birth Date	

**PART II - SUPERVISOR INFORMATION**

Instructions: Please complete Part II and III of this form and then mail it directly to the Board at the address given above.

Name	Michigan Permanent I.D. Number and Expiration Date
Current Business Address	
Current Position	

**PART III- CERTIFICATION OF SUPERVISION**

<p>I hereby certify that I am a licensed chiropractor in the state of Michigan and will supervise</p> <p>_____ during the practice portion of</p> <p style="text-align: center;">Applicant's Full Name</p> <p>his or her chiropractic education. My direct supervision will conform with all existing laws and rules governing such supervision.</p>	
<p>_____ Signature of Supervisor</p>	<p>_____ Date</p>
<p>_____ Print Name and Title of Supervisor</p>	

**Michigan Department of Licensing and Regulatory Affairs**  
**Bureau of Health Professions**  
 P.O. Box 30670  
 Lansing, MI 48909  
 www.michigan.gov/healthlicense

**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"/> Acupuncture <input type="checkbox"/> Audiology <input type="checkbox"/> Chiropractic <input type="checkbox"/> Counseling <input type="checkbox"/> Dentistry <input type="checkbox"/> Marriage & Family Therapy	<input type="checkbox"/> Medicine <input type="checkbox"/> Nursing <input type="checkbox"/> Nursing Home Admin. <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Optometry <input type="checkbox"/> Osteopathy	<input type="checkbox"/> Pharmacy <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Physician's Assistants <input type="checkbox"/> Podiatry <input type="checkbox"/> Psychology <input type="checkbox"/> Respiratory Therapy  <input type="checkbox"/> Sanitarian <input type="checkbox"/> Social Work <input type="checkbox"/> Veterinary Medicine
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