



MARYLAND STATE BOARD OF CHIROPRACTIC EXAMINERS

4201 Patterson Avenue, Suite 301

Baltimore, MD 21215

Website: www.health.maryland.gov/chiropractic; Email: mdh.chiropractic@maryland.gov

(410) 764-4738 (Mainline)

APPLICATION FOR RECOGNITION OF OUT-OF-STATE CHIROPRACTIC LICENSURE PURSUANT TO THE VETERANS AUTO AND EDUCATION IMPROVEMENT ACT OF 2022 (PL 117-333)

THERE IS NO FEE ASSOCIATED WITH THIS APPLICATION

COMPLETE THIS APPLICATION ONLY IF:

1. You are a Chiropractor who is presently a Servicemember or the spouse of an active Servicemember;
2. You have a chiropractic license, in good standing, in one or more states other than Maryland, and you have actively used the license(s) during the two (2) years immediately preceding your military relocation to Maryland;
3. You or your spouse are under orders to provide military service outside of the state or states in which you hold a chiropractic license;
4. You reside in Maryland; and
5. You (the applicant) seek recognition to practice chiropractic that is effective only during (a) the pendency of you or your spouse's military service outside of the state(s) in which you hold a chiropractic license; and (b) during the period in which you reside in Maryland.

IF YOU SEEK A MARYLAND CHIROPRACTIC LICENSE THAT DOES NOT EXPIRE WHEN YOU OR YOUR SPOUSE'S MARYLAND MILITARY ORDERS EXPIRE, COMPLETE THE APPLICATION FOR INITIAL CHIROPRACTIC LICENSURE which is available on the Board's website at <https://health.maryland.gov/chiropractic/Pages/forms.aspx>.

Please note the following:

“Servicemember” is defined as a member of the “uniformed services.” “Uniformed services” means

- a) the armed forces;
- b) the commissioned corps of the National Oceanic and Atmospheric Administration; and
- c) the commissioned corps of the Public Health Service. "Armed forces" is defined as " Army, Navy, Air Force, Marine Corps, Space Force, and Coast Guard."

“Spouse” is defined as "husband or wife, as the case may be."

“Reside in the State of Maryland” is defined as Maryland being the site of your residency as a result of military orders.

DOCUMENTS TO BE INCLUDED WITH THIS APPLICATION

- Notarized Application
- One recent color passport size photograph
- Copy of military order of Servicemember
- Copy of Military ID with application
- Spouse of Servicemember - provide Military ID of spouse and Copy of Marriage Certificate
- Verification of Good Standing from out of state Board(s)
- Copy of unexpired CPR Card (Healthcare Provider Level)



APPLICATION FOR RECOGNITION AS A CHIROPRACTOR

MARYLAND STATE BOARD OF CHIROPRACTIC EXAMINERS

APPLICATION FOR RECOGNITION AS A CHIROPRACTOR Pursuant to the Veterans Auto and Education Improvement Act of 2022 (PL 117-333)

IMPORTANT

Are you an Servicemember of the U.S. military? Yes No

Are you the spouse of an active Servicemember of the U.S. military? Yes No

GENERAL INFORMATION (Please print or type all information)

Name: _____
(Last) _____ (First) _____ (Middle) _____

SSN/ITIN: _____ Date of Birth: _____

Maryland Home Address: _____
(Street) _____ (City) _____ (State) _____ (Zip) _____

Business/Employer Name and Address: _____

Home Phone: _____ Cell: _____ Work: _____

Personal Email: (Required): _____ Business Email: (Required): _____

The Board of Chiropractic Examiners requests applicants to **voluntarily** provide the following information.

ETHNICITY: Hispanic/Latino Not Hispanic or Latino

RACE (please check all that apply)

Asian White Black/African American Native Hawaiian/Pacific Islander

American Indian/Alaska Native Other _____ (please state)

GENDER: Male Female Other (please state) _____ Preferred Pronoun _____

LICENSURE IN OTHER STATES

List all states in which you currently hold an active chiropractic license in the last two years. Request a verification of "Good Standing" to be sent directly to the MD Board at mdh.chiropractic@maryland.gov.

State _____ License # _____ Date Issued _____ Expiration Date _____

State _____ License # _____ Date Issued _____ Expiration Date _____

(List additional states on a separate sheet and attach to the application)

BOARD USE ONLY

Date Application Received _____ Initials _____ Date Application Approved _____ Initials _____



APPLICATION FOR RECOGNITION AS A CHIROPRACTOR

Applicant's Last Name & Last 4 digits of Social Security No.

CHECKLIST OF REQUIRED DOCUMENTS

Please check all documents included with this application:

<input type="checkbox"/> Notarized Application	<input type="checkbox"/> Copy of military order of Servicemember
<input type="checkbox"/> One recent color passport size photograph	<input type="checkbox"/> Copy of Military ID with application.
<input type="checkbox"/> Copy of unexpired CPR Card (Healthcare Provider Level)	
<input type="checkbox"/> Spouse of Servicemember-provide Military ID of spouse and Copy of Marriage Certificate.	

REQUIRED DOCUMENTS I HAVE REQUESTED TO BE SENT DIRECTLY TO THE MD BOARD

Verification of Good Standing from out of state Board(s).

MAIL APPLICATION AND SUPPORTING DOCUMENTS TO:

Maryland State Board of Chiropractic Examiners
4201 Patterson Avenue, Suite 301
Baltimore, MD 21215

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APPLICATION FOR RECOGNITION AS A CHIROPRACTOR

RELEASE, CERTIFICATION AND ATTESTATION

The practice of chiropractic without a current recognition of out-of-state chiropractic licensure issued by the Maryland State Board of Chiropractic Examiners is a violation of the Maryland Chiropractic Act. I agree to abide by the laws and regulations governing the practice of chiropractic found in Maryland Code Annotated, Health Occupations Article §§3-101 *et seq.* and in the **Code of Maryland Regulations 10.43.01 et seq.**

I agree to hold the Maryland State Board of Chiropractic Examiners, its members, officers, staff, and agents free from any damage or claim for damage or complaints by reason of any action they or any one of them take in connection with this application, and/or failure of the Board to issue me a Recognition of Out-of-State Chiropractic license.

I hereby grant permission to the Board to seek any and all information or references it deems fit in securing my credentials pertinent to this application, from any person or agency, including but not limited to postgraduate program directors, individual chiropractors, government agencies, the National Practitioner Data Bank, the Healthcare Integrity and Protection Data Bank, hospitals and other licensing bodies, and I agree that any person or agency may release to the Board the information requested. I also agree to sign any subsequent release for information that may be requested by the Board.

The information provided in this application is truthful and correct to the best of my knowledge and belief. I understand that providing false information of any kind or omitting information known to me may result in the voiding of this application. I agree that all documents submitted with this application are the property of the Board and are not returnable.

Print Name

Applicant's Signature

Date

NOTARY CERTIFICATION:

State: _____ City/County: _____

The undersigned notary public attests that the above-signed individual/applicant has presented photo identification and has signed the above under oath/affirmation.

Signed and sworn before me this _____ day of _____, _____.

Name and Signature

Date My Commission Expires

NOTARY SEAL

Please provide one (1) passport type, color, head and shoulder photos on a solid background.

Photo must be 2"x2" or 2"x3". Full body photos are not acceptable.

Affix the photo to this box.