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

CONTINUING EDUCATION UNIT COURSE APPROVAL APPLICATION

Companies, schools or contractors seeking course approval must submit this application at least sixty (60) days before the start date of the program or course. There is a $25 processing fee which is to be submitted with this application.

Course Title: ____

Course Sponsor's Name: ____

Address: ____

Phone: ________________________ Email: __________________________

Date(s) Course will be conducted: ____________________ Location(s): ______________________
(***Attach course syllabus***)

Course fee per licensee/registrant: ____________________ Additional fees: ___________________

Mode of delivery (check one) _____ Home Study ______ Online ______ Live Lecture ______ Hybrid

If online delivery, provide website address: ____

Exact hours for which course is scheduled: ______________________________

Total number of CE hours requested for approval: _________________________

Is there an examination required for course completion? _____________________

Name of Instructor(s): ____
*(***Instructor's professional resume(s)/CV(s) must be attached to the application***)

Name of certifying officer and method used to ensure attendance/completion:

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Name of Chiropractor (if requestor) ______________________________ License No.:__________

Email Address:____________________________________ Phone No.: __________________

Note: Chiropractic licensees may request waiver of the 60-day submission deadline. *To expedite review,* ***MD licensed chiropractor submissions*** *may be sent via email to the Executive Director or mdh.chiropractic@maryland.gov*, ***no later than 30-days before the course date.***

BOARD USE ONLY

Check Date: _______________ **Check #:** __________________ **Check Amount:** ______________

Date to Committee: ______________ **Date to Board:** ______________ **Approved** ☐ **Yes** ☐ **No**

Notification to CE Provider_______________ **Notification to Requestor**__________________

TOPICS AND HOURS REQUESTED FOR APPROVAL

TOPIC	NO. HOURS REQUESTED
Scope of Practice (Philosophy, General Practice, etc.)	______
Specific modalities/procedures (describe): ____ ____	______
Examination Procedures	______
Physical Therapy	______
Ethics/Boundaries	______
Patient relations/diversity/cultural competency	______
Risk Management/Jurisprudence	______
Insurance/Coding/Billing	______
General Practice Management including supervision	______
Disease Control including AIDS/HIV, infectious diseases	______
Radiography	______
Research	______
Wellness/Nutrition/Exercise	______
Other (describe): ____ ____	______
Total Hours Requested For Approval	______

I attest that all information listed above is correct to the best of my knowledge.

______________________________	______________________________	________
Type/Print Name of Course Provider/Requestor	*Signature*	*Date*
______________________________	______________________________	________
Type/Print Name of Licensee	*Signature of Licensee*	*Date*

***** *Did you remember to include the following with this application?*

- ☐ **$25.00 Application Fee *(Each course submission must be on a separate application form)***
- ☐ Instructor CV/Resume
- ☐ Course Syllabus
- ☐ Sample Completion Certificate
- ☐ Sponsor verification (if applicable)