State of Tennessee
Department of Health

TENNESSEE BOARD OF CHIROPRACTIC EXAMINERS

665 Mainstream Drive, 2nd Floor
Nashville, TN 37243

(Toll Free In State) 1-800-778-4123
Local Nashville Area 615-741-3807
http://tennessee.gov/health/topic/Chiro-board

Application and Procedures for Licensure

Chiropractic X-Ray Technologist

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
DIVISION OF HEALTH LICENSURE AND REGULATION
665 Mainstream Drive, 2nd Floor
NASHVILLE, TENNESSEE 37243

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APPLICATION INSTRUCTIONS FOR EXAMINATION/CERTIFICATION AS A CHIROPRACTIC X-RAY/TECHNOLOGIST

Provided below is a checklist for your personal use and convenience containing all the things you must do to receive consideration for issuance of a Tennessee license to practice. **NOTE: All submissions must be executed and dated less than one (1) year before receipt or they will be rejected by the Board. If the application is not complete upon receipt by the Board's Administrative Office, a deficiency letter will be sent to you by certified mail or by email. The supporting documentation requested in the letter must be received in the Board's Administrative Office within thirty (30) days from the date of the initial deficiency letter. Files not completed within thirty (30) days will be closed.**

1. Complete all pages of this application and return to the above address.

2. Attach proof of having graduated from a high school (diploma) or successfully completing a general education development (G.E.D.) program (G.E.D. certificate).

3. If you are or have ever been licensed, certified, registered, or permitted by any state to practice as a chiropractic x-ray technologist (or any other health care professional), you must request a verification from each and every state. The verification must be mailed directly to the Board's Office from the other state(s).

4. Attach a recent (within 12 months) signed passport-size photograph of yourself.

5 Attach one (1) recent letter of recommendation from licensed chiropractic professionals who can attest to your good moral character. The letter must identify the individual(s) as a licensed chiropractic professional, be submitted on letterhead, and bear the signature of the author.

6. Submit a copy of your certificate of completion of a minimum combined total of 48 classroom hours approved by the board, including such subject material as radiation protection, radiation physics, radiographic techniques, patient care and positioning, equipment maintenance, radiographic anatomy and physiology, x-ray quality control, and instruction on Tennessee Law and Rules pertaining to the Chiropractic X-Ray Technologist..

7. Submit proof of successful completion of one thousand and forty (1,040) hours of clinical internship under direct supervision.

8. Submit verification of a completed state board examination with a minimum score of 70.

9. Attach proof of U.S. or Canadian citizenship or evidence of being legally entitled to live and work in the U.S. (e.g. copy of birth certificate, naturalization papers, or current visa status.) If not a U.S. or Canadian citizen, the front and back of the passport, valid visa, I-94 and Form I-766 must be submitted.

10. All applicants must complete, sign and have notarized the Declaration of Citizenship form and attach the documents required by the Declaration of Citizenship. The Declaration is online at http://tn.gov/assets/entities/health/attachments/PH-4183.pdf and must be attached to this application before submission.

11. A criminal background check is required. For instructions to obtain a criminal background check, go to http://tn.gov/health/article/CBC-instructions .

12. Submit with your application a check or money order in the amount of $150.00 application fee and $10.00 State Regulatory Fee for a total of $160.00 made payable to the Board of Chiropractic Examiners. This is a non-refundable fee.

APPLICATION BY CRITERIA (RECIPROCITY)

If you are applying by CRITERIA RECIPROCITY/ENDORSEMENT, in addition to items 1 through 12 on page one of the instructions, the following items are required:

1. An applicant requesting certification by criteria (reciprocity) must be currently licensed or certified in another state as a Chiropractic X-Ray Technologist **OR** be certified from either the American Chiropractic Registry of Radiological Technologists or the American Registry of Radiological Technologists. If the application is not complete upon receipt by the Board's Administrative Office, a deficiency letter will be sent to you by certified mail or by email. The supporting documentation requested in the letter must be received in the Board's Administrative Office within sixty (60) days from the date of the initial deficiency letter. Files not completed within sixty 60) days will be closed.

2. If you are or have ever been licensed, certified, registered, or permitted by any state to practice as a chiropractic x-ray technologist (or any other health care professional), you must request a verification from each and every state. The verification must be mailed directly to the Board's Office from the other state(s).

3. Submit with your application a check or money order in the amount of $130.00 application fee and a $10.00 State Regulatory fee and $100.00 Reciprocity/Endorsement Fee for a total of $240.00 made payable to the Board of Chiropractic Examiners. THIS IS A NON REFUNDABLE FEE.

UNDERSTANDING THE APPLICATION PROCESS

If an address change occurs at any time, you must notify the Board Office in writing immediately.

1. **ALL FEES ARE NON-REFUNDABLE.**

2. All documents and fees required to be submitted by you or which must be requested from the appropriate institutions in this application process, must be mailed directly to:

Board of Chiropractic Examiners **665 Mainstream Drive, 2nd Floor** **Nashville, TN 37243**	**For Federal Express or Special Courier:** **Board of Chiropractic Examiners** **665 Mainstream Drive, 2nd Floor** **Nashville, TN 37243**

3. Allow fourteen (14) working days for information mailed to our office to be received and placed in your file. Federal Express or special courier services will not appreciably reduce the processing time. Additionally, if Federal Express or special courier services are used you will be responsible for charges incurred. The Board asks that you please give the Board Office every consideration in this matter.

4. **We will discuss application status with the applicant or applicant's spouse only**. Please inform hospitals, employers, recruiters, referral companies or insurance companies that application status updates must be obtained from you.

5. If necessary documentation has not been received when your application has been received by the Board Office, an initial deficiency letter will be sent to you by certified mail. The supporting documentation requested in the letter must be received in the Board Office thirty (30) days from the date of the initial deficiency letter. Files not completed in a timely manner will be closed.

PLACE FULL FACE, PASSPORT SIZE PHOTOGRAPH HERE

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
DIVISION OF HEALTH LICENSURE AND REGULATION
665 Mainstream Drive, 2nd Floor
NASHVILLE, TENNESSEE 37243

For Office Use Only

Proficiency:		
Application	1145-001	$ 150.00
State Reg.	1145-006	$ 10.00
Total		$ 160.00
Criteria/Reciprocity:		
Application	1145-001	$150.00
Reciprocity	1145-001	$100.00
State Reg.	1145-006	$ 10.00
Total		$260.00

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Local Nashville Area (615) 741-3807 (Toll Free In State) 1-800-778-4123

APPLICATION FOR REGISTRATION AS A CHIROPRACTIC TECHNOLOGIST

Please indicate method of application.

_____(1) ARRT Examination for Limited Scope
(CRITERIA RECIPROCITY/ENDORSEMENT)

_____(1) Certification from the American Chiropractic Registry of Radiologic Technologists or the American Registry of Radiological Technologists

_____(2) Currently licensed/certified in another State as a Chiropractic X-Ray Technologist.

_____(3) Inactive license/certificate in another State as a Chiropractic X-Ray Technologist.

PERSONAL INFORMATION

Name: _____
Last First Middle Maiden (if not used as your middle name)

Social Security Number*:_____ U.S. Citizen: Yes ___ No____
All applicants must complete the Declaration of Citizenship form

Date of Birth: _____ Entitled to Live and Work in the U.S. Yes ___ No___

Mailing Address: _____

_____ Zip _____

Practice Address:_____

_____

_____ Zip _____

E-mail address: _____

Do you wish to receive notifications, including renewal notification, from Department of Health via email? Please note, by opting in, all correspondence from the Department of Health will be delivered to the email address on file for you. You will no longer receive physical mail from our office. ___Yes ___ No

Race: _____ Phone: Home: _____

Gender: Female_____ Male _____ Office: _____

Are you a member of the U.S. armed forces who has, within the preceding 180 days, retired from the armed forces, received any discharge other than a dishonorable discharge from the armed forces, or been released from active duty to a reserve component of the armed forces? (If yes, please provide proof of status.) Yes ____ No ____

Are you the spouse of a member of the armed forces who has been transferred by the military to Tennessee or who has, within the preceding 180 days, retired from the armed forces, received a discharge other than a dishonorable discharge from the armed forces or been released from active duty to a reserve component? (If yes, please provide proof of same.) Yes ___ No__

Have you ever been known by any other names besides what is listed above? Yes ____ No _____

If yes, please state in full every other name by which you have been known, the reason therefore, and inclusive dates so known: _____

***You must put your social security number on this form for the application to be complete. State and federal law require social security numbers on this application. Tenn. Code Ann. §36-5-1301(a), as authorized by 42 U.S.C. §405 (c) (2)(C)(i). The number will be used to verify your identity, to ask questions about your financial responsibility, and for any other purpose allowed by state or federal law. When you provide your social security number on this application and sign the form, you are agreeing that the Department of Health may use your social security number in furtherance of federal and state law, for example, to collect delinquent fees.**

EDUCATIONAL AND EMPLOYMENT INFORMATION

Please provide the following information for your school attendance. Please include your post-secondary school training. Use the back of this page if you need additional space. Request that transcripts be sent directly to the Board's Office from your school.

From: _____ _____ _____ _____ _____ _____
MM/DD/YY MM/DD/YY Educational Institution City, State Degree Graduated

From: _____ _____ _____ _____ _____ _____
MM/DD/YY MM/DD/YY Educational Institution City, State Degree Graduated

How many hours of supervised clinical experience have you obtained? _____

Please complete your entire healthcare employment history starting with the most current position first. Use the back of this page, if you need additional space. Dates of employment must be included.

Company/ Employer:	**Supervisor**	**Address: (City, and State)**	**Position:**	**Duties:**	**Dates From: Mo./Yr.**	**To: Mo./Yr.**

CERTIFICATION INFORMATION

	YES	**NO**
Are you or have you ever been licensed in this profession in another state?	____	____
Are you or have you ever been licensed in any other profession in Tennessee or another state?	____	____

List below **ALL STATES, COUNTRIES, OR PROVINCES IN WHICH YOU HAVE EVER BEEN OR ARE CURRENTLY LICENSED, PERMITTED, OR CERTIFIED**. Additional pages may be added if necessary. Request that verification of licensure be submitted directly to the Board's Office from each state.

STATE	**PROFESSION**	**LICENSE NUMBER**	**CURRENT STATUS**

	YES	**NO**
Have you taken and passed the state board examination with a minimum passing score of 70	____	____
Have you received your high school diploma?	____	____
If No, have you obtained your GED?	____	____
Have you ever previously applied for a chiropractic, chiropractic assistant or a chiropractic x-ray license in Tennessee?	____	____

COMPETENCY INFORMATION

PLEASE ANSWER THE FOLLOWING QUESTIONS. If you answer "yes" to any of the questions in this part, you must supplement your affirmative response with a thorough explanation on a separate page. IN SUPPORT OF YOUR EXPLANATION, THE FINAL DOCUMENTS OR ORDERS FROM THE ISSUING STATES, COURTS, AND/OR AGENCIES MUST BE SUBMITTED ALONG WITH THIS APPLICATION. Additional information may be requested and/or required before a licensure decision may be made. For the purposes of these questions, the following phrases or words have the following meanings:

1. "**Ability to practice your profession**" is to be construed to include all of the following:

   a. The cognitive capacity to make appropriate clinical diagnoses, exercise reasoned medical judgments, to learn, and keep abreast of medical developments in your profession;

   b. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and

   c. The physical capability to perform tasks and procedures required of your profession, with or without the use of aids or devices, such as corrective lenses or hearing aids.

2. "**Medical Condition**" includes physiological, mental or psychological conditions including, but not limited to: orthopedic, visual, speech and/or hearing impairments, emotional or mental illness, specific learning disabilities, drug addiction, and alcoholism.

3. "**Minor Traffic Offense**" generally means moving and non-moving violations punishable by fines only and does not include offenses such as driving under the influence or while intoxicated or reckless driving.

4. "**Chemical substances**" is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

5. "**Currently**" does not mean on the day of or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs or alcohol may have an ongoing impact on one's functioning as a licensee or within the past two (2) years.

6. "**Illegal use of illicit or controlled substances**" means the use of substances obtained illegally (e.g., heroin or cocaine) as well as the use of controlled substances that are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

QUESTIONS: Please respond to ALL questions. If you answer "YES" to any question, please attach a written explanation.

		YES	NO
1.	Do you currently have any physical or psychological limitations or impairments caused by an existing medical condition which are reduced or ameliorated by ongoing treatment or monitoring, or the field of practice, the setting or the manner in which you have chosen to practice	___	___
2.	Do you currently use any chemical substances which in any way impair or limit your ability to practice your profession with reasonable skill and safety?	___	___

If so, please list: _____

[If you receive such ongoing treatment or participate in such a monitoring program, the Board will make an individual assessment of the nature, the severity, and the duration of the risks associated with an ongoing medical condition to determine whether an unrestricted license should be issued, conditions should be imposed, or you are not eligible for licensure.]

COMPETENCY INFORMATION CONTINUED

QUESTIONS: Please respond to ALL questions. If you answer "YES" to any question, please attach a written explanation.	**YES**	**NO**
3. At any time within the past two years, have you engaged in the illegal use of illicit or controlled substances?	___	___
4. Are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you to assure that you do not consume alcohol and/or do not engage in the illegal use of illicit or controlled substances?	___	___
5. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or other diagnosis of a predatory nature?	___	___
6. Have you ever held or applied for a license, privilege, registration or certificate to practice your profession in any state, country, or province, that has been or was ever denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	___	___
7. Have you ever had staff privileges at any hospital or health care facility that were ever revoked, suspended, curtailed, restricted, limited, otherwise disciplined, or voluntarily surrendered under threat of restriction or disciplinary action?	___	___
8. Have you ever applied for or held a state or federal controlled substance certificate that was ever denied, revoked, suspended, restricted, voluntarily surrendered or otherwise disciplined or surrendered under threat of restriction or disciplinary action?	___	___
9. Have you ever been convicted (including a nolo contendere plea or guilty plea) of a felony or misdemeanor (other than a minor traffic offense) whether or not sentence was imposed or suspended?	___	___
10. Have you ever been rejected or censured by a professional association or society?	___	___
11. In relation to the performance of your professional services in any profession:		
a. Have you ever had a final judgment rendered against you;	___	___
b. Have you ever entered into any settlement of any legal action; or	___	___
c. Are there any legal actions pending against you or to which you are a party?	___	___
12. Have you ever held a license, registration, privilege or certificate in any profession that has ever been reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action in any jurisdiction?	___	___
13. My name has been placed on the registry of persons who have abused, neglected or misappropriated the property of vulnerable individuals (Tennessee abuse registry or an abuse registry in another state)	___	___
14. Have you ever been dropped, suspended, expelled, or disciplined by any school or college for any cause?	___	___

APPLICANT: FILL OUT THE FOLLOWING AFFIDAVIT

AFFIDAVIT AND RELEASE

I, _____, of _____,
(Applicant's Name) *(City)* *(State)*

being duly sworn and identified as the person referred to in this application attest to the truth of each statement made in said application. I further swear that I have read and understand the law and the Rules and Regulations regarding the practice of my profession, which are posted on the Board's Internet site and/or were provided to me by the Board office, and agree to abide by them in the practice as a chiropractic x-ray technologist in the State of Tennessee.

I HEREBY:

SIGNIFY my willingness to appear to answer such questions as the Board may find necessary, which may include a full Board interview.

RELEASE to the Board, its staff, and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safely practice as a chiropractic x-ray technologist.

AUTHORIZE the Board, its staff, and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others, and other qualifications.

RELEASE from liability the Board, its staff, and all their representatives and any and all organizations which provide information for their acts performed and statements made in good faith and without malice concerning my competence, ethics, character, and/or other qualifications, for certification.

ACKNOWLEDGE that I, as an applicant for licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical, and other qualifications, and for resolving any doubts about such qualifications.

AUTHORIZE release, use and disclosure of otherwise HIPAA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary.

This certifies that the information submitted by me in this application is true and complete to the best of my knowledge and belief.

_____ _____
SIGNATURE **DATE**