

**State of Tennessee  
Department of Health**

**TENNESSEE BOARD OF CHIROPRACTIC EXAMINERS  
665 Mainstream Drive, 2<sup>ND</sup> Floor  
Nashville, TN 37243**

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

**[www.tn.gov/health](http://www.tn.gov/health)**



**Application and Procedures for Licensure**

**Chiropractic X-Ray Technologist**



## TENNESSEE BOARD OF CHIROPRACTIC EXAMINERS

665 Mainstream Drive

Nashville TN 37243

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

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

#### INSTRUCTIONS

1. Complete, sign, have notarized and mail the application pages 1 through 5.
2. Attach to your application in the space provided a clear, recognizable, recent photograph of yourself. You must sign the back of the photograph.
3. Submit with the application a certified birth certificate or other equivalent document.
4. All applicants must complete the attached Declaration of Citizenship form.
5. Submit with your application a notarized copy of your high school diploma or notarized copy of your GED certificate.
6. Submit one (1) original letter of recommendation from a health care professional on the signator's letterhead, attesting to your good moral character.
7. 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.
8. Provide proof of successful completion of one thousand and forty (1,040) hours of clinical internship.
9. Submit verification of a completed state board examination with a minimum score of 70.
10. If you hold or have ever held a license/certificate as a chiropractic therapy assistant in another state complete and mail **Attachment 1** to each state. Please follow directions on Attachment 1.
11. 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.
12. All Applicants must complete a criminal background check. Please [click here](#) for instructions.

If you are applying by RECIPROCITY/ENDORSEMENT in additions to items 1 through 9 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. Complete and mail Attachment 1 to the State in which you are currently licensed.

DONE

OR

Be certified from either the American Chiropractic Registry of Radiological Technologists or the American Registry of Radiological Technologists.

\* If license is not current, applicant must conform to Rule 0260-3-.04(2)(b)

2. If you hold or have ever held a license/certificate as an X-Ray Operator in another State (other than above) complete and mail Attachment 1 to each State.
3. Submit with your application a check or money order in the amount of \$150.00 application fee and a \$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.

PLACE  
FULL FACE,  
PASSPORT SIZE  
PHOTOGRAPH  
HERE

**Examination:**

Application	\$ 150.00
State Reg	\$ 10.00
Total	\$ 160.00

**Reciprocity:**

Application	\$ 150.00
State Reg	\$ 10.00
Total	\$ 160.00

STATE OF TENNESSEE  
DEPARTMENT OF HEALTH  
DIVISION OF HEALTH LICENSURE AND REGULATION  
665 MAINSTREAM DRIVE, 2<sup>ND</sup> FLOOR  
NASHVILLE, TENNESSEE 37243  
TENNESSEE BOARD OF CHIROPRACTIC EXAMINERS  
Local Nashville Area (615) 741-3807 or (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 (copy of certification must be attached)
- \_\_\_\_\_ (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.

Name: \_\_\_\_\_  
Last First Middle/Maiden

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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 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.

U.S. Citizen: ☐ YES ☐ NO All applicants **must** complete the Declaration of Citizenship attachment.

Do you wish to receive notification, including renewal notification, from the Department of Health via email?

☐ YES ☐ NO Email Address: \_\_\_\_\_

Current Mailing Address:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Current Practice Address:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_

Work Phone: (\_\_\_\_\_) \_\_\_\_\_

## **EDUCATION**

Have you received your high school diploma?

\_\_\_\_\_  
Yes

\_\_\_\_\_  
No

If "No", have you obtained your GED?

\_\_\_\_\_  
Yes

\_\_\_\_\_  
No

\_\_\_\_\_  
Date of Completion

\_\_\_\_\_  
Name of High School

\_\_\_\_\_  
City, State

\_\_\_\_\_  
Date of Graduation

## **LICENSURE AND CERTIFICATION INFORMATION**

List below all states, countries or provinces in which you have ever been or currently are licensed permitted or certified as a Chiropractic Therapy Assistant. Additional pages may be added if necessary. Submit a copy of **Attachment 1** to all such states, countries, or provinces regarding such licensure, certification or permit.

### **STATE**

### **LICENSE NUMBER**

### **CURRENT STATUS**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PLEASE ANSWER THE FOLLOWING QUESTIONS.** If any answers to the questions in this part are in the **affirmative**, attach an explanation on a separate sheet. **In support of your explanation, the final documents or orders from the issuing states, courts, or agencies must be submitted along with this application.**

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 exercise reasoned professional judgments and to learn and keep abreast of developments in your profession; and
  - b. The ability to communicate those judgments and 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 or disorders, such as, but not limited to; orthopaedic, visual, speech and/or hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.
3. **"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.
4. **"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.
5. **"Illegal use of controlled substances"** means the use of controlled substances obtained illegally (e.g. heroin, or cocaine) as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

## COMPETENCY INFORMATION

### QUESTIONS:

**YES      NO**

- |   |  |  |
|---|--|--|
| <p>1. Do you currently have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety?</p> <p style="margin-left: 40px;">a. If yes, are they reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program?</p> <p style="margin-left: 40px;">b. If you have any limitations or impairments caused by an existing medical condition, are they reduced or ameliorated because of the field of practice, the setting or the manner in which you have chosen to practice?</p> <p><i>[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 so as to determine whether an unrestricted license should be issued, whether conditions should be imposed or whether you are not eligible for licensure.]</i></p> | <p>_____</p> <p>_____</p> <p>_____</p> | <p>_____</p> <p>_____</p> <p>_____</p> |
| <p>2. Do you currently use chemical substances?</p> <p style="margin-left: 40px;">If yes, do they in any way impair or limit your ability to practice your profession with reasonable skill and safety?</p> <p style="margin-left: 40px;">Please list the substances used _____</p> <p style="margin-left: 40px;">_____</p>   | <p>_____</p> <p>_____</p>              | <p>_____</p> <p>_____</p>              |
| <p>3. Are you currently engaged in the illegal use of controlled substances?</p> <p style="margin-left: 40px;">If yes, are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you in order to assure that you are not engaged in the illegal use of controlled substances?</p>   | <p>_____</p> <p>_____</p>              | <p>_____</p> <p>_____</p>              |
| <p>4. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?</p>  | <p>_____</p>                           | <p>_____</p>                           |
| <p>5. If you have held or applied for a license or certificate to practice as an chiropractic therapy assistant in any state, country or province, has or was it ever been denied, reprimand, suspended, restricted, revoked, or otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?</p>   | <p>_____</p>                           | <p>_____</p>                           |
| <p>6. Have you ever been convicted of a felony or a misdemeanor other than a minor traffic violation?</p>   | <p>_____</p>                           | <p>_____</p>                           |
| <p>7. In relation to the performance of your professional services in any profession:</p> <p style="margin-left: 40px;">a. Have you ever had final judgment rendered against you; or</p> <p style="margin-left: 40px;">b. Have you ever had settlement of any legal action rendered against you; or</p> <p style="margin-left: 40px;">c. Are there any legal actions pending against you or to which you are a party?</p>   | <p>_____</p> <p>_____</p> <p>_____</p> | <p>_____</p> <p>_____</p> <p>_____</p> |
| <p>8. If you have ever held a license or certificate in any health care profession, has it ever been reprimanded, suspended, restricted, revoked, or otherwise disciplined, curtailed or voluntarily surrendered under threat of investigation or disciplinary action?</p>  | <p>_____</p>                           | <p>_____</p>                           |

**APPLICANT: FILL OUT THE FOLLOWING AFFIDAVIT IN THE PRESENCE OF A NOTARY PUBLIC**

**AFFIDAVIT AND RELEASE**

I, \_\_\_\_\_, of \_\_\_\_\_,  
(Applicant's Name) (City) (State)

being duly sworn and identified as the person referred to in this application, attests 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 which were enclosed in the application packet and agree to abide by them in the practice of my profession 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 an 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 my profession.

**AUTHORIZE** release, use of 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.

**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 any 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 other qualifications for licensure.

**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.

**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**

Sworn to before me, this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

\_\_\_\_\_  
**NOTARY PUBLIC**

Affix Seal Here

My Commission expires \_\_\_\_\_



**STATE OF TENNESSEE**  
**DEPARTMENT OF HEALTH**  
**DIVISION OF HEALTH LICENSURE AND REGULATION**  
**665 MAINSTREAM DRIVE, 2<sup>ND</sup> FLOOR**  
**NASHVILLE, TENNESSEE 37243**  
**TENNESSEE CHIROPRACTIC THERAPY ASSISTANT**  
**Local Nashville Area (615) 741-3807 (Toll Free) 1-800-778-4123**  
[www.tn.gov/health](http://www.tn.gov/health)  
**CLEARANCE FROM OTHER STATE LICENSURE BOARDS**

**APPLICANT:** Please provide the information requested in the top box and then mail one form to the licensure board in each state where you hold or have ever held a license to practice any profession. (Copies of this form can be used.) **NOTE:** Some states require a fee for providing clearance information. To expedite your application, you may wish to contact the applicable state(s).

**To Be Completed By Applicant (Please Print In Ink)**

I, the undersigned applicant, was granted a license/certificate to practice _____ with <b>(check one)</b>	
	(Profession)
License π / Certificate π / Registry π number _____	on _____ the State of _____
	(Date)
The Tennessee Board of Chiropractic Examiners requests that I submit evidence of the current status of that license/certification in your state. You are hereby authorized to release any information in your files, favorable or otherwise, directly to the Tennessee Board of Chiropractic Examiners.	
Date: _____	_____ Applicant's Signature
	_____ Applicant's typed or printed name

**To Be Completed By Administrative Office of State Licensure Board**

Name In Full As It Appears On License/Certificate or Permit.		
_____	_____	_____
(First)	(M.I.)	(Last)
License/Certificate/Permit Number: _____	Profession: _____	
Date Issued: _____		
Basis of issuance: _____	Endorsement/Reciprocity with _____	
(Check One)	(State)	
	Written Examination _____	
	(Name of Exam)	
The License is currently active and registered?	Yes _____	No _____
Is there any derogatory information on file?	Yes _____	No _____
_____ Authorized Signature	_____ Title	_____ Date

State Board: Please return this form to:

BM/G6010188/BCE

PH-3666  
(Rev 09-13)

**Tennessee Board of Chiropractic Examiners**  
**665 Mainstream Drive, 2<sup>nd</sup> Floor**  
**Nashville, TN 37243**



STATE OF TENNESSEE  
DEPARTMENT OF HEALTH  
DIVISION OF HEALTH LICENSURE AND REGULATION  
665 MAINSTREAM DRIVE  
NASHVILLE, TN 37243

DECLARATION OF CITIZENSHIP  
MUST ACCOMPANY ALL APPLICATIONS FOR INITIAL LICENSURE OR REINSTATEMENT OF LICENSURE

The "SAVE Act" requires Tennessee Department of Health (including all Boards, Commissions, and contractors), along with every local health department in the State, to verify that every adult applicant for a professional license is either a U.S. citizen, a "qualified alien," or a nonimmigrant who meets the requirements set out at 8 U.S.C. 1621.

I am a(n) \_\_\_\_\_  
Healthcare Profession (Please Print) License number if applicable

Please Print Legibly

1. Name: \_\_\_\_\_  
Last First Middle Maiden
2. Mailing Address: \_\_\_\_\_
3. Phone Number: Home: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Office: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_ - \_\_\_\_
4. I am a United States Citizen: \_\_\_\_ Yes \_\_\_\_ No
5. I am a foreign national not physically present in the United States \_\_\_\_ Yes \_\_\_\_ No. If you answered yes, to this question please sign this form in the presence of a notary and return it with your application. No further documentation is required.
6. Applicants Claiming United States Citizenship **MUST** provide one of the following:
  - a) Tennessee Driver's License, or photo ID issued by Department of Safety.
  - b) A valid driver license or ID issued by another state, provided its issuance requirements meet Department of Safety criteria.
  - c) An official birth certificate issued by a U.S. state, territory, or other jurisdiction. Puerto Rican birth certificates issued before July 1, 2010 do not count.
  - d) A federally issued birth certificate.
  - e) A valid, unexpired U.S. passport.
  - f) A report of birth abroad of a U.S. citizen.
  - g) A certificate of citizenship.
  - h) A certificate of naturalization.
  - i) A U.S. citizen ID card.
  - j) Any successor document to #'s a-i above.
  - k) SSN that the entity or local health department may verify with the Social Security Administration in accordance with federal law.
7. If you checked "No" in question 4 please indicate from the list below which category applies to you: (circle one)
  - a) Permanent Residents
  - b) A nonimmigrant applicant for a professional or commercial license whose visa for entry into the United States is related to such employment, or a nonimmigrant under the Immigration and Nationality Act (8 U.S.C. 1101 *et seq.*).
  - c) Asylees who meet the qualifications set out in 8 U.S.C. 1158
  - d) Refugees who meet the qualifications set out in 8 U.S.C. 1157



- e) Persons who have been “paroled into the United States,” under 8 U.S.C. 1182(d)(5) or whose deportation has been withheld under 8 U.S.C. 1253.
- f) Cuban or Haitian entrants as defined by section 501(e) of the Refugee Education Assistance Act of 1980
- g) Persons granted conditional entry into the U.S. under 8 U.S.C. 1153(a)(7) before April 1, 1980, because of persecution or fear of persecution on account of race, religion, or political opinion or because of being uprooted by catastrophic national calamity.
- h) An alien who has been “battered” or subjected to “extreme cruelty” by a parent or spouse as defined by 8 U.S.C. 1641(c), and also meets the qualifications set out 8 U.S.C. 1641(c)(1)(B). Under the circumstances set out in 8 U.S.C. 1641(c)(2) and (3), victims’ children, or the parents of children who are victims, may also apply for benefits as qualified aliens.

Applicants claiming **qualified alien status** (question 7 above), please submit two of the following forms of “documentation of identity and immigration status” as determined by U.S. Homeland Security to be acceptable for verification through the SAVE program. Common types of documents used to verify immigration status are listed below. (Note: If you can provide only one document, your status will be verified through the U.S. Department of Homeland Security’s SAVE program):

I-327 (Reentry Permit)

I-551 (Permanent Resident Card or “Green Card”)

I-571 (Refugee Travel Document)

I-766 (Employment Authorization Card)

Machine Readable Immigrant Visa (with Temporary I-551 language)

Temporary I-551 stamp (on passport or I-94)

I-94 (Arrival/Departure record)

Unexpired foreign passport

WT/WB Admission Stamp in unexpired foreign passport

I-20 (Certificate of Eligibility for Nonimmigrant F(1) student status– “student visa”)

DS2019 (Certificate of Eligibility for Exchange Visitor (J-1) Status)

I affirm under the penalty of perjury that the above is true and correct.

Signed this \_\_\_\_ day of \_\_\_\_\_, 20\_\_.

\_\_\_\_\_  
Signature

Sworn to before me this \_\_\_\_ day of \_\_\_\_\_, 20\_\_.

\_\_\_\_\_  
NOTARY PUBLIC

AFFIX SEAL HERE

My Commission Expires: \_\_\_\_\_

**If an applicant is discovered to be an unqualified alien, or otherwise ineligible for benefits under the Act, all recurring benefits provided to that applicant must be immediately terminated. Anyone who purposefully makes a false, fictitious, or fraudulent claim of U.S. citizenship or qualified alien status will be liable under the Tennessee Medicaid False Claims Act, or Tennessee’s False Claims Act. Any person who conspires to defraud the state or any local health department by securing a false claim allowed or paid to another person in violation of the Act may be liable under Tennessee’s False Claims Act. Upon discovery of an applicant’s false, fictitious, or fraudulent claim of U.S. citizenship, state governmental entities and local health departments must also file a criminal complaint with the United States Attorney.**