

Date Application & Fee Received _____
 Approved for License _____

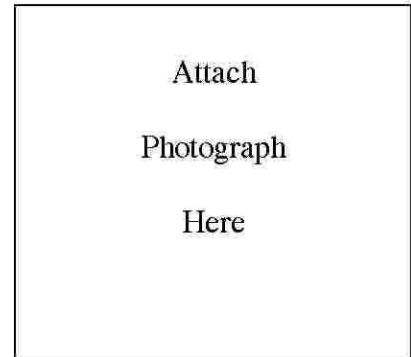
License Number _____
 Issue Date _____

APPLICATION FOR LICENSURE

WYOMING BOARD OF CHIROPRACTIC EXAMINERS

1800 Carey Avenue Suite 4th Floor
 Cheyenne WY 82002
 (307) 777-7387

Please type or print neatly.



1. Name:

| | | | |
|------|-------|----------------|---------------------|
| Last | First | Middle Initial | Previous Names Used |
|------|-------|----------------|---------------------|

2. Social Security:

Date of Birth: _____

3. Citizenship:

U.S. Other

(U.S. Code Title 8, Chapter 14, Section 1621 requires proof of legal presence in the United States. Attach acceptable documentation from enclosed List A and B.)

4. Home Address:

_____ Telephone Number(s):
 ()

5. Business Address:

_____ Telephone Number(s):
 ()
 _____ Telephone Number(s):
 ()

6. Preferred Mailing Address: Home Business

The Board often receives requests for a list of license holders from organizations offering continuing education courses, or other information, which could be of interest to you. The list provided includes your name, license information and business mailing address, which by law are public records. If you have not provided a business address, your address appears on this list as "Address Not Available". The Board will not release your home address without your expressed consent.

I consent to the release of my resident address in the absence of a business address.

7. I hereby apply for licensure by the following method:

By Reciprocity (Licensed over 2 years in another state) New License

A personal appearance before the Board at scheduled exam is required of ALL applicants.

If additional space is needed to detail any answer in this application, please attach additional sheets. At the heading of each additional sheet, include your full name as presented on the application as well as your social security number.

8. Indicate registration(s) or license(s) in all states where you are currently or have been previously registered or licensed in any health care profession. Begin with your original registration license. Note carefully any registrations not currently in good standing.

| STATE(S) | LICENSE NUMBER | ISSUE DATE Month/Day/Year | EXPIRATION DATE Month/Day/Year | CURRENT STATUS Active, Inactive, Other | LICENSED BY |
|----------|----------------|------------------------------|-----------------------------------|---|-------------|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

9. References

Give the names of two individuals (not related to you) who will be submitting letters of reference to the Board on your behalf, who have recent knowledge of your character, ability and professional performance in the practice of chiropractic.

| NAME | ADDRESS | TELEPHONE |
|------|---------|-----------|
| | | |
| | | |
| | | |

10. Education

List ALL universities and colleges attended. Begin with the institution from which your associates degree was obtained. Official transcripts of ALL college or university coursework must be sent DIRECTLY to the Board.

| UNIVERSITY/COLLEGE | ADDRESS | DATES ATTENDED | MAJOR(S) | DEGREE(S)/DATE(S) |
|--------------------|---------|----------------|----------|-------------------|
| | | | | |
| | | | | |
| | | | | |

11. Has any state rejected your application for licensure or restricted, revoked or suspended your license? Yes No
12. Have you ever voluntarily surrendered your license in order to avoid disciplinary action by a regulatory agency? Yes No
13. Have you ever been convicted of a felony or high misdemeanor?
(A plea of no contest shall create a reputable presumption of guilt to the underlying criminal charges.) Yes No
14. Do you now use, or within the last five (5) years have you used, alcoholic beverages habitually to excess? Yes No
15. Do you now use, or within the last five (5) years have you used, hallucinogenics, barbiturates, narcotics habitually to excess? Yes No

If you answer "YES" to any of questions 11 through 15 above, please attach a written explanation.

