Modifying Supervision for Certified Chiropractic Physician's Assistant Application

Board of Chiropractic Medicine
P.O. Box 6330
Tallahassee, FL 32314-6330
Website: www.floridaschiropracticmedicine.gov
Email: info@floridaschiropracticmedicine.gov
Phone: (850) 245-4355
FAX: (850) 922-8876

Florida HEALTH
Medical Quality Assurance

Certified Chiropractic Physician's Assistant Information

Any Certified Chiropractic Physician's Assistant (CCPA) certified under this section to perform services may perform those services **only**:

- In the office of the chiropractic physician to whom the CCPA has been assigned, in which office such physician maintains their primary practice;
- Under indirect supervision of the chiropractic physician to whom they are assigned as defined by board rule;
- In a hospital in which the chiropractic physician to whom they are assigned is a member of the staff; or
- On calls outside of the office of the chiropractic physician to whom they are assigned, on the direct order of the chiropractic physician to whom they are assigned.

Each chiropractic physician or group of chiropractic physicians utilizing CCPAs shall be liable for any act or omission of any CCPA acting under their supervision and control.

The terms **"certified chiropractic physician's assistant,"** or **"physician's assistant,"** or **"assistant"** as used herein refers to allied health personnel, certified by the department upon approval by the board, who are functioning in a dependent relationship with a supervising chiropractic physician and who are performing tasks or combinations of tasks traditionally performed by the chiropractic physician.

A CCPA may perform case histories, diagnostic testing, physical examinations, and therapeutic procedures. However, **an assistant cannot be assigned any tasks requiring manipulative or adjustive techniques, the rendering of diagnostic results, interpretations, or treatment advice, or the taking of x-rays unless properly certified by the Radiation Control office.**

"Supervision" means responsible supervision and control by the supervising chiropractic physician. Except in cases of emergency, supervision shall require the "easy availability" or physical presence of the licensed chiropractic physician for consultation and direction of the actions of the CCPA.

"Easy availability" means the supervising physician must be in a location to enable them to be physically present with the CCPA within no more than 30 minutes and must be available to the CCPA when needed for consultation and advice either in person or by communication devices, such as telephone, two-way radio, medical beeper, or other electronic means.

Once an application is complete, the applicant and supervisor must participate in an interview with the CCPA Committee. If the Committee approves the application, it is placed on the agenda for the next regularly scheduled board meeting for ratification. The Committee may recommend denial; in such instance, the application will be presented to the board for review.

Rule 64B2-18.007, Florida Administrative Code (F.A.C.): Method of Performance

(1) An assistant must clearly identify himself or herself by appropriate identification as a certified chiropractic physician's assistant to insure that he or she is not mistaken for a licensed physician (for example, a name tag).

(2) The assistant must generally function in reasonable proximity to the supervising physician. If he or she is to perform away from the supervising physician, these duties must be clearly specified in the supervising physician's application to the board.

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Do Not Write in this Space
For Revenue Receipting Only

Modify Supervision for CCPA (8075) **$205.00**

CI License #: _____

Total fee of $205.00 includes the following:

Application Fee	$100.00
Supervision Physician Fee	$100.00
Unlicensed Activity Fee	$5.00

Fees must be paid in the form of a cashier's check or money order, made payable to the Department of Health.

1. PERSONAL INFORMATION

Name: _____ **Date of Birth:** _____
Last/Surname First Middle MM/DD/YYYY

Mailing Address: (The address where mail and your license should be sent)

_____ _____ _____
Street/P.O. Box Apt. No. City

_____ _____ _____ _____
State ZIP Country Home/Cell Telephone (Input without dashes)

Physical Location: (Required if mailing address is a P.O. Box - This address will be posted on the Department of Health's website)

_____ _____ _____
Street (Place of Employment) Apt. No. City

_____ _____ _____ _____
State ZIP Country Work/Cell Telephone (Input without dashes)

EQUAL OPPORTUNITY DATA:

We are required to ask that you furnish the following information as part of your voluntary compliance with 41 CFR 60-3-Uniform Guidelines on Employee Selection Procedure (1978); 43 FR 38295 and 38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

Gender: ☐ Male ☐ Female

Race: ☐ Native Hawaiian or Pacific Islander ☐ American Indian or Alaska Native ☐ Two or More Races ☐ Hispanic or Latino ☐ Black or African American ☐ White ☐ Asian

Email Notification: To be notified of the status of your application by email, check the "Yes" box and fill in your email address on the line provided. If you choose to be notified via email you will be responsible for checking your email regularly and updating your email address with the board office.

☐ Yes ☐ No Email Address: _____

Under Florida law, email addresses are public records. If you do not want your email address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

2. SOCIAL SECURITY DISCLOSURE

This information is exempt from public records disclosure.

Pursuant to Title 42 United States Code § 666(a)(13), the department is required and authorized to collect Social Security numbers relating to applications for professional licensure. Additionally, section (s.) 456.013(1)(a), Florida Statutes (F.S.), authorizes the collection of Social Security numbers as part of the general licensing provisions.

Last Name: _____

First Name: _____

Middle Name: _____

Social Security Number: _____
(Input without dashes)

Social Security Information- * Under the Federal Privacy Act, disclosure of Social Security numbers is voluntary unless specifically required by federal statute. In this instance, Social Security numbers are mandatory pursuant to Title 42 United States Code § 653 and 654; and s. 456.013(1), 409.2577, and 409.2598, F.S. Social Security numbers are used to allow efficient screening of applicants and licensees by a Title IV-D child support agency to ensure compliance with child support obligations. Social Security numbers must also be recorded on all professional and occupational license applications and will be used for license identification pursuant to Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act. 104 Pub. L. Section 317). Clarification of the SSA process may be reviewed at www.ssa.gov or by calling 1-800-772-1213.

Name: _____

3. APPLICANT BACKGROUND

A. List any other name(s) by which you have been known in the past. Attach additional sheets if necessary.

_____

B. Have you ever been a defendant in a military court-martial? Do not include parking or speeding violations.
☐ Yes ☐ No

4. DISASTER

Would you be willing to provide health services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster? ☐ Yes ☐ No

5. SUPERVISOR ADD / REMOVE (Attach additional sheets if necessary.)

A. Do you need to change your supervisor? ☐ Yes ☐ No

B. Do you only need to update your practice location address? ☐ Yes ☐ No

I am ADDING this supervisor:	
Supervisor Name:	Supervisor License #: **CH**
I am REMOVING this supervisor:	
Supervisor Name:	Supervisor License #: **CH**
I am UPDATING my Practice Location address:	
Address:	

6. DISCIPLINE HISTORY

Have you ever had any disciplinary action taken by the licensing authority of any state or are you the subject of any pending investigation or disciplinary action? ☐ Yes ☐ No

If you responded "Yes," complete the following:

Name of Agency	State	Action Date (MM/DD/YYYY)	Final Action	Under Appeal?
				☐ Y ☐ N
				☐ Y ☐ N
				☐ Y ☐ N
				☐ Y ☐ N

If you responded "Yes" to any of the questions in this section, you must provide the following:

☐ **A written self-explanation**, describing in detail the circumstances surrounding the disciplinary action.

☐ A copy of the **Administrative Complaint** and **Final Order**.

Name: _____

7. CRIMINAL HISTORY

Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to any crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies, even if adjudication was withheld.

Reckless driving, driving while license suspended or revoked (DWSLR), driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question. ☐ Yes ☐ No

If you responded "Yes," complete the following:

Offense	Jurisdiction	Date (MM/DD/YYYY)	Final Disposition	Under Appeal?
				☐ Y ☐ N
				☐ Y ☐ N
				☐ Y ☐ N

If you responded "Yes" to any of the questions in this section, you must provide the following:

☐ **A written self-explanation**, describing in detail the circumstances surrounding each offense; including dates, city and state, charges and final results.

☐ **Final Dispositions** and **Arrest Records** for all offenses. The Clerk of the Court in the arresting jurisdiction will provide you with these documents. Unavailability of these documents must come in the form of a letter from the Clerk of the Court.

☐ **Completion of Sentence Documents**. You may obtain documents from the Department of Corrections. The report must include the start date, end date, and that the conditions were met.

8. APPLICANT SIGNATURE

I, the undersigned, state that I am the person referred to in this application for the state of Florida.

I recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to s. 456.067 and 775.083, F.S.

Florida law requires me to immediately inform the board of any material change in any circumstances or condition stated in the application which takes place between the initial filing and the final approval or denial of the application and to supplement the information on this application as needed.

Section 456.013(1)(a), F.S., provides that an incomplete application shall expire one year after the initial filing with the department.

CCPA Signature _____ Date _____
MM/DD/YYYY

Supervising Chiropractic Physician Signature _____ Date _____
MM/DD/YYYY

These signature fields cannot be typed. You must print out the application and sign it.

This form must be completed by each chiropractic physician who will supervise the CCPA.

Applicant Name:_____

Board *of* Chiropractic Medicine
4052 Bald Cypress Way Bin C-07
Tallahassee, FL 32399-3257

Board *of* Chiropractic Medicine
Chiropractic Physician Information

Application Type: ☐ Individual ☐ Group

1. SUPERVISING CHIROPRACTIC PHYSICIAN DATA

Name: _____
Last/Surname First Middle

Chiropractic License Number: CH _____

Primary Practice/Physical Address:

_____ _____ _____
Street Apt. No. City

_____ _____ _____
State ZIP Country

Telephone: _____ _____
Home/Cell Telephone (Input with dashes) Work/Cell Telephone (Input with dashes)

Email Address: _____
Under Florida law, email addresses are public records. If you do not want your email address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

2. ADDITIONAL PRACTICE LOCATIONS

List **ALL** additional practice locations including any location where the chiropractic physician serves as a medical doctor.

Physical Address	Medical Doctor
_____	☐ Yes ☐ No
_____	☐ Yes ☐ No

3. BACKGROUND

List the professional background of the chiropractic physician.

_____

_____

Applicant Name:_____

Board *of* Chiropractic Medicine
Chiropractic Physician Information

4. DESCRIPTION OF PRACTICE & UTILIZATION OF CCPA

a. Describe your practice and the way in which the CCPA will be utilized; be specific, give details.

_____

_____

b. Is this CCPA going to be performing services away from the primary practice location of the supervisor?

☐ Yes ☐ No

If "Yes," indicate the specific reason for sending the CCPA to see patients outside your primary practice location.

_____

_____

c. What are the specific duties you have assigned the CCPA when seeing patients outside your primary practice location?

_____

_____

d. What is your specific method of supervision and communication with the CCPA when outside the office?

_____

_____

5. CURRENTLY SUPERVISED CCPA'S DATA

Name: _____ **License Number:** _____
Last/Surname First Middle

Practice Address:_____
(Physical practice address/location where CCPA works)

Name: _____ **License Number:** _____
Last/Surname First Middle

Practice Address: _____
(Physical practice address/location where CCPA works)

6. REQUIRED SIGNATURES

CCPA _____ Date _____
MM/DD/YYYY

CCPA _____ Date _____
MM/DD/YYYY

Supervising
Chiropractic Physician _____ Date _____
MM/DD/YYYY

Board *of* Chiropractic Medicine
Certified Chiropractic Physician's Assistant
Work Arrangement Proposal

CCPA Name: _____
Last/Surname First Middle

DC Name: _____
Last/Surname First Middle

License Number: CH _____

Practice Address: (Physical practice address/location where CCPA works)

_____ _____
Street Apt. No.

_____ _____ _____
City State ZIP

Is the clinic licensed under Part X of Chapter 400, F.S.? ☐ Yes ☐ No

Work hours: From:_____AM To:_____PM

Workdays: (Check all that apply) ☐ Mon ☐ Tues ☐ Wed ☐ Thur ☐ Fri ☐ Sat ☐ Sun

Describe the duties the CCPA will be performing:

_____

_____

Describe how the supervising physician will oversee the work being performed by the CCPA:

_____

_____

By signing this document, we agree to be bound by this work arrangement until such time as this agreement is modified and approved by the Florida Board of Chiropractic Medicine.

Supervising
Chiropractic Physician _____,DC Date _____
MM/DD/YYYY

Certified Chiropractic
Physician Assistant _____,CCPA Date _____

Complete verifications must be mailed directly from the licensing agency to:

Board *of* Chiropractic Medicine
4052 Bald Cypress Way Bin C-07
Tallahassee, FL 32399-3257

Florida Board *of* Chiropractic Medicine License Verification Request

Part I: To be completed by applicant (Florida requires verification of all your current and previously held licenses.)

Name: _____

Address: _____

Name original license was issued under: _____

License Number: _____ State: _____

I hereby authorize release of any information regarding my licensure status to the Florida Board of Chiropractic Medicine.

Applicant Signature: _____ Date: _____
MM/DD/YYYY

Part II: To be completed by state licensing agency

All verifications must be in English and include the following criteria:

* Typed on an official state form or letterhead
* Include an official board seal
* Signature and title of state board official

The following information must be included in all verifications:

* Licensee name * License number * State or jurisdiction of licensure
* Licensure status * Is license in good standing?
* Date of issuance and expiration
* Licensure method (examination, reciprocity/endorsement)
* Has this license ever been encumbered (denied, revoked, suspended, surrendered, limited, placed on probation)?
* If this license has ever been encumbered, please provide certified copies of documentation regarding the action with the completed license verification.