

**CHIROPRACTIC PHYSICIAN LICENSE ANNUAL RENEWAL FORM - 2019**

- I WISH TO RENEW  
 I DO NOT WISH TO RENEW

N.C. Board of Chiropractic Examiners  
 6070 Six Forks Rd. Ste. L  
 Raleigh, NC 27609  
[ncboce@ncchiroboard.com](mailto:ncboce@ncchiroboard.com)



Name:

License #:

To Renew your License for 2019, you must complete the following:

- Pay your renewal fee of \$300 online at the Board’s website ([www.ncchiroboard.com](http://www.ncchiroboard.com)).
- Complete and Report 18-Hours of Board Approved Continuing Education to the Board Office.
- Complete, Sign and Return the Annual Renewal Form to the Board Office.

All requirements must be completed and received in the Board office by 5:00 PM, January 8, 2019. Your license will automatically be cancelled if you have not completed your renewal requirements by 5:00 PM, February 7, 2019 and you will not be authorized to practice chiropractic in North Carolina until you complete the Reinstatement Process.

**Will you be submitting Professional Development CE’s**  Yes,  No **If yes, how many hours? (not to exceed 2 hours)** \_\_\_\_\_  
*If yes, please provide a short explanation of your Professional Development activity.*

**Please enter your current office/practice data below:**

Street Address	
City, State, Zip	
Office Phone	
Office Fax #	
Email	
Active Practice? If no, Inactive Code	<input type="checkbox"/> Active <input type="checkbox"/> 1-Working in another Field, <input type="checkbox"/> 2-Retired, <input type="checkbox"/> 3-Non-practicing/at home, <input type="checkbox"/> 4-In professional training, not practicing <input type="checkbox"/> 5-Other _____
Specialty Code	<input type="checkbox"/> 1-Neurology, <input type="checkbox"/> 2-Orthopedics, <input type="checkbox"/> 3-Internal Disorders, <input type="checkbox"/> 4-Radiology, <input type="checkbox"/> 5-Pediatrics, <input type="checkbox"/> 6-Sports Injuries, <input type="checkbox"/> 7- Nutrition, <input type="checkbox"/> 8-Rehabilitation, <input type="checkbox"/> 9-Acupuncture, <input type="checkbox"/> 10-Other _____
Employment Code	<input type="checkbox"/> 1-Individual, <input type="checkbox"/> 2-Independent Contractor, <input type="checkbox"/> 3-Partnership, <input type="checkbox"/> 4-Loc.Gov. <input type="checkbox"/> 5-Co. Gov., <input type="checkbox"/> 6-St. Gov., <input type="checkbox"/> 7-Fed. Gov., <input type="checkbox"/> 8-Other _____
Setting (PS) Code	<input type="checkbox"/> 11-Hospital, <input type="checkbox"/> 12-Nursing Home, <input type="checkbox"/> 13-Clinic, <input type="checkbox"/> 14-Group Health Facility, <input type="checkbox"/> 15-Dr.’s Office, <input type="checkbox"/> 21-Military, <input type="checkbox"/> 22-VA, <input type="checkbox"/> 23- Indian Public Health, <input type="checkbox"/> 24-Other _____

**Please enter your personal information below:**

Street Address	
City, State, Zip	
Home Phone	
Cell Phone	

Do you own 100% of your Practice/Clinic? Yes \_\_\_\_\_ No \_\_\_\_\_ If not, who does? \_\_\_\_\_

Have you been convicted of a crime other than a traffic violation since your last renewal? \_\_\_\_ Yes \_\_\_\_ No  
*If yes, please provide a short explanation. Attach another page if necessary.*

***By signing this document, I attest that the information provided in this document is true and accurate to the best of my knowledge.***

**Licensee Signature** \_\_\_\_\_ **Date** \_\_\_\_\_