

**CHIROPRACTIC PHYSICIAN LICENSE ANNUAL RENEWAL FORM - 2021**

I WISH TO RENEW  
 I DO NOT WISH TO RENEW  
 Fax: (704) 793-1385

N.C. Board of Chiropractic Examiners  
 9121 Anson Way, Suite 200  
 Raleigh, NC 27615  
[ncboce@ncchiroboard.com](mailto:ncboce@ncchiroboard.com)



Name:

License #:

**Will you be submitting 2 hours of Self-Directed Professional Development CE?**  Yes,  No.

*If yes, please provide a short explanation of your Professional Development activity. For more information see 21 NCAC 10 .0210.*

**Enter any office information that has changed since last year's renewal:**

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 (Select if you have met criteria to list a specialty since last renewal)	<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 (Must be Diplomate per 21 NCAC 10 .0304 to list any Specialty).		
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"/> 2-Telehealth, <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-Mobile, <input type="checkbox"/> 25-Other _____		

**Enter any personal information that has changed since last year's renewal:**

Street Address			
City, State, Zip			
Home Phone		Cell Phone	
Do you own 100% of your Practice/Clinic? Yes _____ No _____ If not, who does? _____			
Are you incorporated? Yes _____ No _____ What is the name of your business entity? _____			

Any worker who is defined as an employee by N.C. Gen. Stat. §§ 95-25.2(4)(NC Department of Labor), 143-762(a)(3)(Employee Fair Classification Act), 96-1(b)(10)(Employment Security Act), 97(2)(Worker's Compensation Act), or 105-163.1(4)(Withholding; Estimated Income Tax for Individuals) shall be treated as an employee unless the individual is an independent contractor. Employee misclassification is defined as avoiding tax liabilities and other obligations imposed by Chapter 95, 96, 97, 105, or 143 of the North Carolina General Statutes by misclassifying an employee as an independent contractor. [N.C. Gen. Stat. § 143-762(5)]. I am in compliance with these statutes. Yes \_\_\_\_\_ No \_\_\_\_\_

*If no, please provide a short explanation. Attach another page if necessary.*

If I employ Certified Chiropractic Clinical Assistant(s) and/or Radiologic Technologist(s), I have verified that their certifications are current and displayed properly. Yes \_\_\_\_\_ No \_\_\_\_\_ N/A \_\_\_\_\_

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 is true and accurate to the best of my knowledge.***

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