CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE
BOARD OF CHIROPRACTIC

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV
EMAIL: customerservice.dpr@delaware.gov

VERIFICATION OF CHIROPRACTIC PRACTICE

INSTRUCTIONS

The applicant named below has filed an application for Delaware Chiropractic licensure. The purpose of this form is to verify that the applicant actively practiced as a chiropractor in another jurisdiction for the five years before filing his/her Delaware application. The form is required ***only if no examinations were available*** when the applicant graduated from chiropractic college.

APPLICANT INFORMATION – To be completed by applicant

1. Applicant Name: _____ _____ _____
   Last/Family First Middle

INFORMATION ABOUT LICENSED PROFESSIONAL PEER – To be completed by licensed professional peer.

2. Your Name: _____ _____ _____
   Last/Family First Middle

3. Enter the following information about your license:
   Type of License: ☐ Chiropractor ☐ Other – specify: _____
   License Number: _____ Jurisdiction: _____

VERIFICATION OF PRACTICE – To be completed by licensed professional peer.

4. Enter the following information about the practice where the applicant actively practiced as a chiropractor:
   Practice Name: _____
   Practice Address: _____
   _____ _____ _____
   City State Zip Code

5. When did the applicant practice at the practice above? From: _____ To: _____ Total: _____
   month/day/year month/day/year

AFFIDAVIT

I declare and affirm under penalty of perjury that the foregoing statements are true and complete to the best of my knowledge and belief.

Signature: _____ Date: _____

City of _____ County of _____

Sworn to before me and subscribed in my presence this _____ day of _____.

Signature of Notary: _____

SEAL

My commission expires: _____

Mail the completed, signed, notarized form *directly* to Board at the address above.
Forms submitted by the applicant cannot be accepted.