



Arkansas State Board of Chiropractic Examiners
Application for Temporary License

Send form and related materials to:
ASBCE
101 E. Capitol, Ste.209
Little Rock, AR 72201

1. Last Name:	First Name:	Middle Initial:
2. Address: _____		
City _____ State _____ Zip _____		
3. Date of Birth: _ / _ / _	4. Social Security Number:	
5. Telephone: ()		
6. Education: Name of Chiropractic College Attended: _____ Location: _____ Date of Graduation: _____		
7. Will you be submitting scores for the following: National Board Part I _____ Part II _____ Part III _____ Part IV(optional) _____ Physiotherapy _____		
8. Licensure: List states in which you are currently licensed:		
9. Supervision: <i>Only if applicant does not have a current license in another state.</i> Name of Supervising AR Chiropractic Physician: _____ License # _____		
10. Have you had any previous sanctions, convictions, or disciplinary action by any state licensing board? Yes _____ No _____ <i>* If yes, please attach an explanation and copies of legal documents.</i>		

Affidavit of Applicant:

County of: _____ State of: _____

Personally appeared before me, the undersigned official authorized to administer oaths, came the applicant _____ who deposes and swears that he/she is the person who executed this application for a temporary license to practice Chiropractic in the State of Arkansas; and that all of the statements contained herein are true to the best of his/her knowledge and belief.

Signature of Applicant _____

Sworn to and subscribed before this _____ day of _____, 20_____.

(Notary Public)

My commission expires _____

For Office Use Only: Check # _____ Amount: _____ Date: _____
