CHIROPRACTIC BOARD
PO BOX 25101
SANTA FE, NM 87505
(505) 476-4622

RENEWAL APPLICATION

LIC#: ______________________

Full Name: ____

Address: ____

City: ____ State: __________ Zip Code: _________________

Email Address: ________________________________ Business Phone #: ______________________

☐ Check box for an address OR name change (Name change requires a copy of legal documentation (Marriage Certificate OR Divorce Decree)

To renew your Chiropractic License please complete this renewal application form and submit along with the renewal fee to the board office no later than **June 30**. All fees are non-refundable.

Mandatory Survey: All licensees of the Chiropractic Board must complete a mandatory survey and submit it to the board as part of the license renewal process. A license **WILL NOT BE RENEWED** unless the completed survey is submitted with the renewal application; NMSA 1978, Section 24-14C-5.

Penalty fees: A late fee penalty of $100.00 per month (not to exceed $1,000.00) will be assessed for failure to submit the applicable fees, attestation about continuing education, explanations to "yes" answers, completed questionnaire and properly executed renewal form by **June 30.**

Expedited License Renewal: If the licensee has not passed the following examinations in another jurisdiction that are required for licensure in New Mexico pursuant to 16.4.6.8 NMAC, the licensee must pass the exam prior to applying for renewal:

- the board's jurisprudence exam;
- national board exams I, II, III, and IV; and
- the physiotherapy exam conducted by the national board of chiropractic examiners.

CONTINUING EDUCATION INFORMATION:

All Chiropractic physicians licensed in New Mexico are required to complete a minimum of **16 hours** of board-approved continuing education annually. Credit hours must be earned from July 1 through June 30, immediately preceding the annual renewal. Rule 16.4.10.8 (A) NMAC.

Advanced Practice Certificate must complete a total of **10 hours** of APC continuing education in addition to the required 16 CE hours for a general chiropractic licensure. The CE hours must be from an approved institution or be approved by the board as stated in 16.4.15.8 NMAC. The education should include pharmacology, toxicology, medication administration or pharmacognosy appropriate to the current formulary and procedures authorized to be performed by the advanced practice chiropractic certification.

CONTINUING EDUCATION: AFFIDAVIT OF CERTIFICATION

☐ **Yes**, I have met all continuing education requirements for this renewal period as outlined in 16.4.10.8 NMAC.

Continuing education records must be maintained for three years following the renewal cycle in which they are earned; a licensee may be audited by the board at any time. If audited or upon request, I will provide the Board with proper documentation verifying attendance and completion of CE's.

ADVANCED PRACTICE RENEWAL and CONTINUING EDUCATION:

☐ **Yes,** I have met all continuing education requirements for this renewal period. Continuing education records must be maintained for three years following the renewal cycle in which they are earned and they may be audited by the board at any time. If audited or upon request, I will provide the Board with proper documentation verifying attendance and completion of CE's.

YOU MUST ANSWER ALL THE FOLLOWING QUESTIONS

"Disciplinary action" means any action that affects your ability to legally engage in the practice of chiropractic and includes, but is not limited to, any disciplinary action resulting in revocation, suspension, probation, practice limitations, reprimand, admonition or censure of a license. All these questions are limited to actions that occurred since your last renewal or events that you did not previously report to the board.

	Yes	No	
1.	☐	☐	Have you pled guilty or nolo contendere, been convicted of or received a deferred prosecution for a felony or misdemeanor (not including traffic infractions) in any state, territory or district of the United States?
2.	☐	☐	Have you had any disciplinary action taken, or is any disciplinary action pending, against your chiropractic license or any other professional license you may hold in any state, territory or district of the United States?
3.	☐	☐	Have you been a defendant in a legal action involving professional liability (malpractice), or has a professional liability claim been paid in your behalf, or you have paid such a claim yourself?
4.	☐	☐	Have you voluntarily surrendered a license or certification to practice chiropractic medicine or any other health related profession to any healthcare entity or done so in any state, territory or district of the United States?
5.	☐	☐	Are you currently participating in a supervised rehabilitation program or in a professional assistance program?
6.	☐	☐	Do you have any medical condition that in any way limits, impairs or alters your ability to practice chiropractic medicine with reasonable skill and safety?
7.	☐	☐	If you suffer from a medical condition that requires taking any medications or chemical substances that limit, impair or alter in any way your ability to practice your profession, are the limitations or impairments reduced or ameliorated because of ongoing treatment or your participation in a monitoring program? (A No answer is also a N/A answer)
8.	☐	☐	Do you certify that you have completed the required number of continuing education hours for this renewal period?
9.	☐	☐	The licensee is solely responsible for providing the information requested on this renewal form. Submission of the form means that the licensee personally assures that every statement contained is true and accurate.

IF YOU ANSWERED "YES" TO ANY QUESTION, PLEASE PROVIDE A DETAILED EXPLANATION ON A SEPARATE SHEET OF PAPER AND OFFICIAL DOCUMENTATION FROM INSURANCE COMPANIES, COURTS, HOSPITALS, ETC.

I CERTIFY THAT ALL OF THE ABOVE INFORMATION IS TRUE AND CORRECT.

SIGNATURE: ____ DATE: _____________________

RENEWAL APPLICATION FORM REQUIREMENTS CHECKLIST:

CHECK APPLICABLE STATUS: ______________**ACTIVE** ________________**INACTIVE**
In order to properly renew my license, I have enclosed the following:
____ Check or money order for $300.00 for all active Chiropractic license renewals.
____ Check or money order for $100.00 for Advanced Practice Certification registration renewal.
____ Check or money order for $100.00 for Inactive renewal. Continuing education is not required while your license is on inactive status. However, you may not engage in the practice of chiropractic in New Mexico.
____ Penalty Fee, if the application packet is postmarked after **June 30.** (See Penalty Fees to determine late fee)
____ Renewal application completed and signed. All questions must be answered and "yes" answers must be explained.
____ Mandatory Survey is completed and returned with application.
____ Certification of 16 hours of continuing education for all licensees (except for inactive renewal).
____ Certification of 10 hours of continuing education (for renewal for Advanced Practice Certification).

MANDATORY SURVEY

New Mexico License Number: ___________________

CURRENT WORK STATUS (Select all that apply)

☐ Practice in New Mexico

☐ Practice Medicine in another state: ☐ TX ☐ CO ☐ AZ ☐ Other

☐ Permanently or Temporarily Inactive in New Mexico

☐ Retired, but maintain an active license

☐ Retired and do not maintain an active license

☐ Current Resident of Fellowship Training

CURRENT ACTIVITIES

How many weeks per year do you practice in NM? ____________

How many hours per week do you practice in NM? ____________

For you practice in New Mexico, approximately what percent of your time was spent on the following activities (percentage of all selected activities should total 100%)

	Direct Patient Care
	Teaching/Precepting
	Research
	Healthcare Administration

	Other, please specify:__________________________

For Direct Patient Care, approximately what percent of your time was spent in the following types of facilities (percentage should total 100%)

	Hospital/Inpatient
	Outpatient/Clinic
	Mobile Services
	Other, please specify:___________________

LOCATION OF EDUCATION AND TRAINING

	New Mexico	Other U.S. state or Canada	Foreign country	Not Applicable
Location of the high school from which you graduated:	☐	☐	☐	☐
Location of the undergraduate college or university from which you graduated:	☐	☐	☐	☐
Location of the licensure training from which you graduated:	☐	☐	☐	☐
Location of primary specialty training:	☐	☐	☐	☐
Location of secondary specialty training:	☐	☐	☐	☐

PRACTICE SPECIALTY (IES) IN WHICH YOU SPEND MOST OF YOUR PROFESSIONAL TIME

Primary Specialty: ______________________________

% Patient care time for primary specialty: ________

Secondary Specialty: ____________________________

% Patient care time for secondary specialty:________

TRAINING AND CERTIFICATION

	Yes	No
Completed accredited residency programs for primary specialty?	☐	☐
Board certified/Certificate of Added/Special Qualifications for primary specialty?	☐	☐
Completed accredited residency programs for secondary specialty?	☐	☐
Board certified/Certificate of Added/Special Qualifications for secondary specialty?	☐	☐

HOSPITAL ADMITTING PRIVILEGES

Number of hospitals in New Mexico at which you have admitting privileges

☐None ☐One ☐Two ☐Three or more

REIMBURSEMENT: PAYMENT SOURCES

Primary source of payment for patient care (**select top 3**):

- ☐ Medicare
- ☐ Medicaid
- ☐ Tricare/VA/HIS
- ☐ Private Insurance
- ☐ Self-pay
- ☐ Bad Debt/Charity
- ☐ Other
- ☐ Do Not Know or Not Applicable
- ☐ Other: ________________________

% of patients with Medicare as their primary payer:_________
% of patients with Medicaid as their primary payer:_________
% of patients with Tricare/VA/HIS as their primary payer:_________
% of patients with Private Insurance as their primary payer:_________
% of patients with Self-pay as their primary payer:_________
% of patients with Bad Debt/Charity as their primary payer:_________
% of patients with Other as their primary payer: _________

Provide an approximate monetary value for the **uncompensated** patient care you provided during the last year for **emergency** services: ☐

Provide an approximate monetary value for the **uncompensated** patient care you provided during the last year for **non-emergency** services: ☐

PATIENT CARE PRACTICE LOCATIONS

For PRIMARY location of patient care:

PRIMARY patient care street address:	
PRIMARY patient care city/town:	
PRIMARY patient care state:	
PRIMARY patient care 5-digit zip code:	
Weekly PRIMARY patient care hours:	
Weekly PRIMARY number of patients:	

For SECONDARY location of patient care:

SECONDARY patient care street address:	
SECONDARY patient care city/town:	
SECONDARY patient care state:	
SECONDARY patient care 5-digit zip code:	
Weekly SECONDARY patient care hours:	
Weekly SECONDARY number of patients:	

PRACTICE SETTINGS

What best describes your PRIMARY location practice?

- ☐ Independent Practice
- ☐ Group Practice-Employee/Staff
- ☐ Organizationally affiliated (i.e. University, or Health Plan staff)
- ☐ Hospital-Inpatient
- ☐ Hospital-Outpatient dept./satellite clinic
- ☐ Hospital-Emergency room
- ☐ Federal Qualified Health Clinic (FQHC)
- ☐ Nursing home/Home Health agency
- ☐ Private health center/clinic
- ☐ Public/Non-profit community health center (non-FQHC)
- ☐ Other licensed community clinic
- ☐ Military/VA health facility
- ☐ Indian Health Service clinic
- ☐ Locum tenens
- ☐ Multi-Specialty Practice-Employee/staff
- ☐ Nurse Managed Clinic
- ☐ Other (please specify): ______________________________

What best describes your PRIMARY location practice size?

- ☐ Solo Independent Practitioner
- ☐ Solo Independent Practitioner + Intermediate
- ☐ Two Independent Practitioners
- ☐ Three or Four Independent Practitioners
- ☐ Five to Nine Independent Practitioners
- ☐ Ten or More Independent Practitioners

What best describes your SECONDARY location practice?

- ☐ Independent Practice
- ☐ Group Practice-Employee/Staff
- ☐ Organizationally affiliated (i.e. University, or Health Plan staff)
- ☐ Hospital-Inpatient
- ☐ Hospital-Outpatient dept./satellite clinic
- ☐ Hospital-Emergency room
- ☐ Federal Qualified Health Clinic (FQHC)
- ☐ Nursing home/Home Health agency
- ☐ Private health center/clinic
- ☐ Public/Non-profit community health center (non-FQHC)
- ☐ Other licensed community clinic

☐ Military/VA health facility
☐ Indian Health Service clinic
☐ Locum tenens
☐ Multi-Specialty Practice-Employee/staff
☐ Nurse Managed Clinic
☐ Other (please specify): ______________________________

What best describes your SECONDARY location practice size?
☐ Solo Independent Practitioner
☐ Solo Independent Practitioner + Intermediate
☐ Two Independent Practitioners
☐ Three or Four Independent Practitioners
☐ Five to Nine Independent Practitioners
☐ Ten or More Independent Practitioners

CURRENT PRACTICE CAPACITY

What describes your current patient care practice capacity?

☐ My practice is full: I cannot accept any new/additional patients
☐ My practice is nearly full: I can accept a few new/additional patients
☐ My practice is far from full: I can accept new/additional patients
☐ Not Applicable

MEANINGFUL USE OF HEALTH INFORMATION TECHNOLOGY (HIT) AND ELECTRONIC HEALTH RECORD (EHR) IN YOUR PRACTICE

Does your practice CURRENTLY have the following HIT/EMR capacity? (select all that apply)	
☐	Computerized Provider Order Entry (CPOE)
☐	E-Labs (Order, Retrieve and Store results)
☐	Create Registries (e.g. registry of patient with diabetes)
☐	Quality Reporting
☐	Record Demographics (e.g. patient race/ethnicity, insurance status)
☐	Patient access to electronic copy of health records
☐	E-Prescribing
☐	Patient timely access to labs, x-ray and other results
☐	Record Vital Signs (e.g. height, weight, blood pressure)
Does your practice PLAN TO HAVE IN THE NEXT YEAR? (select all that apply)	
☐	Computerized Provider Order Entry (CPOE)
☐	E-Labs (Order, Retrieve and Store results)

☐	Create Registries (e.g. registry of patient with diabetes)
☐	Quality Reporting
☐	Record Demographics (e.g. patient race/ethnicity, insurance status)
☐	Patient access to electronic copy of health records
☐	E-Prescribing
☐	Patient timely access to labs, x-ray and other results
☐	Record Vital Signs (e.g. height, weight, blood pressure)

REFERRAL DIFFICULTIES

Identify the specialties that you or your patients have the greatest difficulty scheduling/obtaining/arranging a timely appointment **when making referrals** (MARK UP TO 3 SPECIALTIES)

☐ Advanced practice certified chiropractor
☐ Social Worker
☐ Social Worker - Clinical Specialty
☐ Social Worker - Medical Specialty
☐ Social Worker - School Specialty
☐ Social Worker - Researcher
☐ Social Work - Community Organizer
☐ Social Work Administrator
☐ Dental Public Health
☐ Endodontic
☐ Oral and maxillofacial surgery
☐ Orthodontics and dento-facial orthopedics
☐ Oral pathology
☐ Pediatric dentistry
☐ Periodontology
☐ Acupuncturists
☐ Cardiology/Vascular Specialists
☐ Chiropractors
☐ Dermatology
☐ Diabetic Educators
☐ Gynecology (only)
☐ Endocrinology and Metabolism
☐ Primary Care - Internal Medicine, Family
☐ Practice, Pediatrics, Geriatrics
☐ Infectious Disease
☐ Mental Health Adult, Child and Adolescent
☐ Nephrology
☐ Neurology
☐ Nutritionists
☐ Occupational /Rehabilitation-Physiary
☐ Medicine
☐ Oncology/Hematology
☐ Orthoptists/Prosthetics
☐ Pain Management
☐ Physical Therapy
☐ Rheumatology
☐ Other - ___________________________

RECRUITMENT EXPERIENCES

How would you describe your experience in recruiting:	Easy	Somewhat Difficult	Very Difficult	Not Known or Now Applicable
Physicians	☐	☐	☐	☐
Nurses	☐	☐	☐	☐
Nurse Practitioners	☐	☐	☐	☐
Physician Assistants	☐	☐	☐	☐
Other Health Professionals	☐	☐	☐	☐

DEMOGRAPHIC INFORMATION

Gender: ☐Male ☐Female

Hispanic, Latino or Spanish Origin: ☐Yes ☐No

Race (Select all that apply):

☐White or Caucasian
☐Black or African American
☐Native American or Alaska Native
☐Asian or Pacific Islander
☐Other: ________________

NEAR FUTURE PRACTICE PLANS

In the next 12 months I plan to (select all that apply):

☐Retire from patient care
☐Significantly reduce patient care hours
☐Move my practice to another geographic location in New Mexico
☐Move my practice out of New Mexico

☐ None of the above

If you are retiring, moving or reducing patient care hours in the next 12 months, what are the factors that led to that decision? (Select all that apply)

☐ Age
☐ Geographic preference
☐ Health
☐ Practice Environment
☐ Lack of Job Satisfaction
☐ Gross Receipts Tax
☐ Increasing Administrative/Regulatory Burden
☐ Reimbursement Issues
☐ Other: ________________________________
☐ N/A

PROFESSIONAL LIABILITY INSURANCE INCREASE THRESHOLDS

At what percent increase in your annual liability insurance above your current level would you consider:

Retiring from patient care?	%
Significantly reduce patient care hours?	%
Moving practice out of state?	%

MEDICARE PAYMENT DECREASE THRESHOLDS

At what percent decrease to your Medicare payment level would you consider:

Retiring from patient care?	%
Closing practice to NEW Medicare patients	%
Closing practice to ALL Medicare patients	%
Significantly reduce patient care hours?	%
Moving practice out of state?	%

When billing for services:

☐ Submit billing through own license
☐ Submit billing through someone else's license
☐ Submit billing through Group/Hospital ID
☐ Do not know
☐ Other (please specify): ____________________