

**State of Tennessee**

**Department of Health**

**Tennessee Board of Chiropractic Examiners**

**665 Mainstream Drive, 2<sup>nd</sup> Floor  
Nashville, TN 37243**

**(Toll Free In State) 1-800-778-4123  
Local Nashville Area 615-741-3807**

**[tn.gov/health](http://tn.gov/health)**



**Application and Procedures for Licensure**

**Chiropractic Physician**

## APPLICATION INSTRUCTIONS

<p>1. Complete, sign and have notarized the application pages 2 through 6. <i>(Only page 6 of the application must be notarized.)</i></p>	<p style="text-align: center;">_____</p>
<p>2. Attach a signed, passport style photograph taken within the last 12 months to the application. Computer generated images are not acceptable.</p>	<p style="text-align: center;">_____</p>
<p>3. Determine the correct amount of fees to be paid according to the fee schedule. Attach check or money order for the proper amount made payable to the Tennessee Board of Chiropractic Examiners.</p>	<p style="text-align: center;">_____</p>
<p>4. Official transcript sent directly to the Board office from the school of Chiropractic, which has status with the Commission on Accreditation of the Council on Chiropractic Education (CCE). Transcripts of grades must show four (4) school years of not less than nine (9) months each.</p>	<p style="text-align: center;">_____</p>
<p>5. A copy of your Chiropractic college diploma. If a diploma has not been awarded, a certified statement from the Chiropractic College must be submitted stating date of graduation and a diploma will be awarded on or before the scheduled examination.</p>	<p style="text-align: center;">_____</p>
<p>6. An official transcript of grades showing two (2) full academic years of college or university work of at least sixty (60) semester hours or its equivalent from an accredited institution. If you matriculated in Chiropractic school in the year 2000 and beyond you must show proof of a bachelor's degree.</p>	<p style="text-align: center;">_____</p>
<p>7. NBCE Scores – Submit proof of completion of the National Chiropractic Board Examination with a minimum grade of Three Hundred Seventy-Five (375) on Parts I, II, III, IV, and Physiotherapy. Verification must be submitted directly from the National Board to the Tennessee Board's office.</p>	<p style="text-align: center;">_____</p>
<p>8. Letter of Recommendation – One (1) recent (within the preceding twelve (12) months) original letter from a licensed chiropractic physician attesting to the applicant's personal character and professional ethics on the signator's letterhead.</p>	<p style="text-align: center;">_____</p>
<p>8. Verification of Licensure – Complete and mail the "<b>State Verification</b>" form (Attachment 1) to each state, community or province in which you hold or have held a license, certificate or permit to practice any profession. This form should be photocopied prior to signing if it must be submitted to more than one (1) state.</p>	<p style="text-align: center;">_____</p>
<p>9. Acupuncture Qualification – If you wish to obtain qualification to perform Acupuncture treatments, you must submit proof of certification of the required 250 hours from an accredited education institution, and evidence of passing the National Board examination for acupuncture given by NBCE. Verification must be submitted directly from the National Board to the Tennessee Board's office. (See Attachment 2)</p>	<p style="text-align: center;">_____</p>
<p>10. All Chiropractic Physician applicants must complete and return the Mandatory Practitioner Profile before licensure consideration. For instructions, <a href="#">click here</a>.</p>	<p style="text-align: center;">_____</p>
<p>11. Criminal background check – To obtain instructions for the criminal background check, <a href="#">click here</a>.</p>	<p style="text-align: center;">_____</p>
<p>12. All applicants must complete the Declaration of Citizenship attachment and have it notarized. A valid form of identification should be included. Please see examples provided in the form.</p>	<p style="text-align: center;">_____</p>
<p>13. If you are applying for an externship (temporary licensure), you must submit proof of successfully passing the National Chiropractic Board Examination with a minimum grade of Three Hundred Seventy-Five (375) on Parts I and II. Verification must be submitted directly from the National Board to the Tennessee Board's office. If you are eligible for temporary licensure, please complete the "<b>Externship/Temporary License Request</b>" form (Attachment 3). This form must be signed by your supervisor and notarized. <a href="#">Click here</a> to view the Externship Policy.</p>	<p style="text-align: center;">_____</p>

ATTACH  
PHOTO HERE



Tennessee Board of Chiropractic Examiners  
665 Mainstream Drive, 2<sup>nd</sup> Floor  
Nashville, TN 37243  
615-741-3807

Examination/Reciprocity:

1108 – 001 \$ 350.00  
1108 – 006 \$ 10.00  
**\$ 360.00**

Externship/Temp License:

1108 – 001 \$ 100.00  
**\$ 100.00**

Upgrade from Temp License:

1108 – 001 \$ 350.00  
1108 – 006 \$ 10.00  
**\$ 360.00**

### APPLICATION FOR LICENSURE

FULL NAME: \_\_\_\_\_  
(Last) (First) (Middle) (Maiden)

MAILING ADDRESS: \_\_\_\_\_  
(Street and Number)

\_\_\_\_\_  
(City) (State) (Zip) (TN-County)

PHONE NUMBER: Home (\_\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_\_) \_\_\_\_\_

PLACE OF BIRTH: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_

*You must put your social security number on this form for the application to be complete. State and federal law require social security numbers on this application. Tenn Code. Ann. §36-5-1301(a), as authorized by 42 U.S.C. § 405(c)(2)(C)(i). The number will be used to verify your identity, to ask questions about your financial responsibility, and for any other purpose allowed by state or federal law. When you provide your social security number on this application and sign the form, you are agreeing that Department of Health may use your social security number in furtherance of federal and state law, for example, to collect delinquent fees.*

U.S. CITIZEN: Yes \_\_\_\_\_ No \_\_\_\_\_

**All applicants must complete the attached Declaration of Citizenship form**

SEX: Female \_\_\_ Male \_\_\_ (Optional for Statistical Purposes Only)

PRACTICE ADDRESS IN TENNESSEE: \_\_\_\_\_

E-MAIL ADDRESS \_\_\_\_\_

Do you wish to receive notification, including renewal notification, from the Department of Health via email?

\_\_\_ Yes \_\_\_ No

**EDUCATION**

	<u>Name of School</u>	<u>Dates Attended</u>	<u>Date Graduated</u>	<u>Diploma Degree</u>	<u>Major</u>
College(s):	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
Professional School(s):	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
Other Educational Training:	_____				
	_____				
	_____				

**NATIONAL EXAMINATION**

Have you taken and passed:

Part I	Yes	_____	No	_____
Part II	Yes	_____	No	_____
Part III	Yes	_____	No	_____
Part IV	Yes	_____	No	_____
Physiotherapy	Yes	_____	No	_____
SPEC	Yes	_____	No	_____
Acupuncture Examination	Yes	_____	No	_____

**STATE LICENSURE**

List below all states, countries, or provinces in which you have ever been or currently are licensed in any health care profession. Submit a copy of the Verification of Licensure form to all such states, countries, or provinces regarding such licensure. Use the back of this page if you need additional space.

STATE	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

## COMPETENCY INFORMATION

**PLEASE ANSWER THE FOLLOWING QUESTIONS.** If any answers to the questions in this part are in the affirmative, attach an explanation on a separate sheet. ***In support of your explanation, the final documents or orders from the issuing states, courts, or agencies must be submitted along with this application.***

For the purposes of these questions, the following phrases or words have the following meanings:

1. **"Ability to practice your profession"** is to be construed to include all of the following:
  - a. The cognitive capacity to exercise reasoned professional judgments and to learn and keep abreast of developments in your profession;
  - b. The ability to communicate those judgments and information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
  - c. The physical capability to perform tasks and procedures required of your profession, with or without the use of aids or devices, such as corrective lenses or hearing aids.
2. **"Medical Condition"** includes physiological, mental or psychological conditions or disorders, such as, but not limited to; orthopedic, visual, speech and/or hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.
3. **"Chemical substances"** is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.
4. **"Currently"** does not mean on the day of or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs or alcohol may have an ongoing impact on one's functioning as a licensee or within the past two (2) years.
5. **"Illegal use of controlled substances"** means the use of controlled substances obtained illegally (e.g. heroin or cocaine) as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

### QUESTIONS:

	YES	NO
1. Do you currently have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety?	_____	_____
a. If yes, are they reduced or ameliorated because you receive ongoing treatment (with or without medication) or participate in a monitoring program?	_____	_____
b. If you have any limitations or impairments caused by an existing medical condition, are they reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice?	_____	_____

*[If you receive such ongoing treatment or participate in such a monitoring program, the Board will make an individual assessment of the nature, the severity, and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure.]*

**COMPETENCY INFORMATION CONTINUED**

<b>QUESTIONS:</b>	<b>YES</b>	<b>NO</b>
2. Do you currently use chemical substances?  If yes, do they in any way impair or limit your ability to practice your profession with reasonable skill and safety?	_____	_____
3. Are you currently engaged in the illegal use of controlled substances?  If yes, are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you in order to assure that you are not engaged in the illegal use of controlled substances?	_____	_____
4. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, or voyeurism?	_____	_____
5. If you have ever held or applied for a license or certificate to practice Chiropractic in any state, country, or province, has it been or was it ever denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, voluntarily surrendered under threat of investigation, or disciplinary action?	_____	_____
6. If you have ever had staff privileges at any hospital or health care facility have they ever been revoked, suspended, curtailed, restricted, limited, otherwise disciplined, voluntarily surrendered under threat, or restriction or disciplinary action?	_____	_____
7. Have you ever been convicted of a felony or a misdemeanor other than a minor traffic violation?	_____	_____
8. In relation to the performance of your professional services in any profession: <ul style="list-style-type: none"> <li>a. Have you ever had a final judgment rendered <u>against</u> you;</li> <li>b. Have you ever had settlement of any legal action rendered <u>against</u> you; or</li> <li>c. Are there any legal actions pending <u>against</u> you or to which you are a party?</li> </ul>	_____	_____
9. If you have ever held a license or certificate in any health care profession, has it ever been reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, voluntarily surrendered under threat of investigation, or disciplinary action?	_____	_____

**APPLICANT: FILL OUT THE FOLLOWING AFFIDAVIT IN THE PRESENCE OF A NOTARY PUBLIC**

**AFFIDAVIT AND RELEASE**

I, \_\_\_\_\_, of \_\_\_\_\_  
(Applicant's Name) (City) (State)

being duly sworn and identified as the person referred to in this application, attests to the truth of each statement made in said application. I further swear that I have read and understand the law and the rules and regulations, which were enclosed in the application packet, and agree to abide by them in the practice of my profession in the State of Tennessee.

**I HEREBY:**

**SIGNIFY** my willingness to appear to answer such questions as the Board may find necessary, which may include an interview.

**RELEASE** to the Board, its staff, and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safely practice my profession.

**AUTHORIZE** the Board, its staff, and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others, and any other qualifications;

**RELEASE** from liability the Board, its staff, and all their representatives and any and all organizations which provide information for their acts performed and statements made in good faith and without malice concerning my competence, ethics, character, and other qualifications for licensure.

**ACKNOWLEDGE** that I, as an applicant for licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical, other qualifications, and for resolving any doubts about such qualifications.

**THIS CERTIFIES THAT THE INFORMATION SUBMITTED BY ME IN THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I HEREBY AUTHORIZE RELEASE, USE OF DISCLOSURE OF OTHERWISE HIPAA PROTECTED HEALTH INFORMATION TO THE LIMITED EXTENT NECESSARY FOR MY APPLICATION TO RECEIVE FULL CONSIDERATION UP TO AND INCLUDING DISCUSSION IN A PUBLIC FORUM SHOULD THAT BECOME NECESSARY.**

\_\_\_\_\_  
**SIGNATURE**

\_\_\_\_\_  
**DATE**

Sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

\_\_\_\_\_  
**NOTARY PUBLIC**

Affix Seal Here

My Commission expires \_\_\_\_\_

**FEE SCHEDULE FOR THE BOARD OF CHIROPRACTIC EXAMINERS**

SELECT AND PAY ONLY **ONE** METHOD OF APPLICATION

**CHIROPRACTIC PHYSICIAN**

<input type="checkbox"/> By Examination or by Reciprocity		(Total fee due \$ 360.00)
<input type="checkbox"/> Add Acupuncture		(No additional fee)
\$350.00	APPLICATION FEE	08-001
\$10.00	STATE REGULATORY FEE	08-006

<input type="checkbox"/> By Examination with Temporary License (Externship)		(Total fee due \$ 100.00)
\$100.00	APPLICATION FEE	08-001

NAME OF APPLICANT: \_\_\_\_\_  
(PLEASE PRINT)

ATTACH CHECK OR MONEY ORDER PAYABLE TO **STATE OF TENNESSEE** TO THIS PAGE AND ATTACH THIS PAGE TO THE FRONT OF THE APPLICATION IF APPLYING AS A CHIROPRACTIC PHYSICIAN.

**FEE SCHEDULE FOR THE BOARD OF CHIROPRACTIC EXAMINERS**

**ATTACHMENT 1**



**Tennessee Board of Chiropractic Examiners**  
665 Mainstream Drive, 2<sup>nd</sup> Floor  
Nashville, TN 37243  
615-741-3807

**CLEARANCE FROM OTHER STATE LICENSURE BOARDS**

**APPLICANT:** Please provide the information requested in the top box and then mail one (1) form to the licensure board in each state where you hold or have ever held a license to practice any profession. (Copies of this form can be used.) **NOTE:** Some states require a fee for providing clearance information. To expedite your application, you may wish to contact the applicable state(s).

**To Be Completed By Applicant (Please Print In Ink)**

I, the undersigned applicant, was granted a license/certificate to practice \_\_\_\_\_  
(Profession)

with **(check one)** License / Certificate / Registry number \_\_\_\_\_ on \_\_\_\_\_  
(Date)

in the State of \_\_\_\_\_. The Tennessee Board of Chiropractic Examiners requests that I submit evidence of the current status of that license/certification in your state. You are hereby authorized to release any information in your files, favorable or otherwise, directly to the Tennessee Board of Chiropractic Examiners.

\_\_\_\_\_  
Applicant's Signature

Date: \_\_\_\_\_

\_\_\_\_\_  
Applicant's typed or printed name

**To Be Completed By Administrative Office of State Licensure Board**

Name In Full As It Appears On License/Certificate or Permit.

\_\_\_\_\_  
(First) (M.I.) (Last)

License/Certificate/Permit Number: \_\_\_\_\_ Profession: \_\_\_\_\_

Date Issued: \_\_\_\_\_

Basis of issuance: (Check One) \_\_\_\_\_ Endorsement/Reciprocity State of: \_\_\_\_\_

\_\_\_\_\_ Name of Written Examination: \_\_\_\_\_

The License is currently active and registered? \_\_\_\_\_ Yes \_\_\_\_\_ No

Is there any derogatory information on file? \_\_\_\_\_ Yes \_\_\_\_\_ No

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

State Board: Please return this form to:

**Tennessee Board of Chiropractic Examiners**  
665 Mainstream Drive, 2nd Floor  
Nashville, Tennessee 37243

**ATTACHMENT 2**



**Tennessee Board of Chiropractic Examiners**  
665 Mainstream Drive, 2<sup>nd</sup> Floor  
Nashville, TN 37243  
615-741-3807

**ACUPUNCTURE EDUCATION VERIFICATION**

**APPLICANT:** Supply the information requested in this box and then mail this entire form to the school at which you completed your acupuncture training. **NOTE:** Some schools require a fee, so you may wish to contact the institution before mailing this form so that you can attach the applicable fee(s).

**TO WHOM IT MAY CONCERN:**

I am applying for a license or permit to practice chiropractic acupuncture in the State of Tennessee. The Board of Chiropractic Examiners requires verification of educational attainment. Please forward an original transcript showing degree/diploma/certification awarded and bearing the institution's official seal to the Board's address below.

Applicant's Full Name: \_\_\_\_\_  
(First) (Middle) (Last) (Maiden)

Applicant's Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Applicant's Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Applicant's Student Identified Number: \_\_\_\_\_

Year of Graduation/Completion: \_\_\_\_\_

Please forward an original graduate transcript bearing the institution's official seal to:

**Board of Chiropractic Examiners**  
665 Mainstream Drive, 2<sup>nd</sup> Floor  
Nashville, TN 37243

Thank you for your cooperation and prompt response.

\_\_\_\_\_  
Applicant's Signature Date

**ATTACHMENT 3**



**Tennessee Board of Chiropractic Examiners**  
**665 Mainstream Drive, 2<sup>nd</sup> Floor**  
**Nashville, TN 37243**  
**615-741-3807**

**EXTERNSHIP / TEMPORARY LICENSE REQUEST**

Tennessee only issues temporary licensure to those individuals who are scheduled to take either Part 3 or 4 of the examination. Complete this form only if you are eligible to sit for the next scheduled NBCE exam and are requesting an externship to work in Tennessee.

**To Be Completed By Applicant**

**PLEASE PRINT IN INK**

I, \_\_\_\_\_, an applicant for licensure by  
(Applicant's Name)  
examination, do hereby request a temporary license for use until receipt of my examination results. The Tennessee Chiropractic Physician who will be providing my supervision is:

\_\_\_\_\_  
(Supervisor's Name) (License #)

The name and address of the facility where the externship/temporary license will be used is:

Facility Name: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Facility Phone Number: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**EXTERNSHIP AFFIDAVIT OF SUPERVISOR**

**PLEASE PRINT IN INK (To be completed by supervisor in the presence of a notary public)**

I \_\_\_\_\_, will have the responsibility  
(Supervisor's Name)  
for direct supervision of the chiropractic services delivered by the above-named applicant, who has applied for licensure as a Chiropractic Physician in Tennessee, during the tenure of his/her externship.

\_\_\_\_\_  
(Supervisor's Name) (License #)

Supervisor's Facility Address:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Subscribed and sworn before me this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

\_\_\_\_\_  
My Commission Expires \_\_\_\_\_

Notary Public

AFFIX SEAL



STATE OF TENNESSEE  
DEPARTMENT OF HEALTH  
HEALTH RELATED BOARDS  
665 MAINSTREAM DRIVE, 2<sup>ND</sup> FLOOR  
NASHVILLE, TN 37243

DECLARATION OF CITIZENSHIP  
MUST ACCOMPANY ALL APPLICATIONS FOR INITIAL LICENSURE OR REINSTATEMENT OF LICENSURE

The "SAVE Act" requires Tennessee Department of Health (including all Boards, Commissions, and contractors), along with every local health department in the State, to verify that every adult applicant for a professional license is either a U.S. citizen, a "qualified alien," or a nonimmigrant who meets the requirements set out at 8 U.S.C. 1621.

I am a(n) \_\_\_\_\_  
Healthcare Profession (Please Print) License number if applicable

Please Print Legibly

1. Name: \_\_\_\_\_  
Last First Middle Maiden
2. Mailing Address: \_\_\_\_\_
3. Phone Number: Home: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Office: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_ - \_\_\_\_
4. I am a United States Citizen: \_\_\_Yes \_\_\_No
5. I am a foreign national not physically present in the United States \_\_\_Yes \_\_\_No. If you answered yes, to this question please sign this form in the presence of a notary and return it with your application. No further documentation is required.
6. Applicants Claiming United States Citizenship **MUST** provide one of the following:
  - a) Tennessee Driver's License, or photo ID issued by Department of Safety.
  - b) A valid driver license or ID issued by another state, provided its issuance requirements meet Department of Safety criteria.
  - c) An official birth certificate issued by a U.S. state, territory, or other jurisdiction. Puerto Rican birth certificates issued before July 1, 2010 do not count.
  - d) A federally issued birth certificate.
  - e) A valid, unexpired U.S. passport.
  - f) A report of birth abroad of a U.S. citizen.
  - g) A certificate of citizenship.
  - h) A certificate of naturalization.
  - i) A U.S. citizen ID card.
  - j) Any successor document to #'s a-i above.
  - k) SSN that the entity or local health department may verify with the Social Security Administration in accordance with federal law.
7. If you checked "No" in question 4 please indicate from the list below which category applies to you: (circle one)
  - a) Permanent Residents
  - b) A nonimmigrant applicant for a professional or commercial license whose visa for entry into the United States is related to such employment, or a nonimmigrant under the Immigration and Nationality Act (8 U.S.C. 1101 *et seq.*).

- c) Asylees who meet the qualifications set out in 8 U.S.C. 1158
- d) Refugees who meet the qualifications set out in 8 U.S.C. 1157
- e) Persons who have been “paroled into the United States,” under 8 U.S.C. 1182(d)(5) or whose deportation has been withheld under 8 U.S.C. 1253.
- f) Cuban or Haitian entrants as defined by section 501(e) of the Refugee Education Assistance Act of 1980
- g) Persons granted conditional entry into the U.S. under 8 U.S.C. 1153(a)(7) before April 1, 1980, because of persecution or fear of persecution on account of race, religion, or political opinion or because of being uprooted by catastrophic national calamity.
- h) An alien who has been “battered” or subjected to “extreme cruelty” by a parent or spouse as defined by 8 U.S.C. 1641(c), and also meets the qualifications set out 8 U.S.C. 1641(c)(1)(B). Under the circumstances set out in 8 U.S.C. 1641(c)(2) and (3), victims’ children, or the parents of children who are victims, may also apply for benefits as qualified aliens.

Applicants claiming **qualified alien status** (question 7 above), please submit two of the following forms of “documentation of identity and immigration status” as determined by U.S. Homeland Security to be acceptable for verification through the SAVE program. Common types of documents used to verify immigration status are listed below. (Note: If you can provide only one document, your status will be verified through the U.S. Department of Homeland Security’s SAVE program):

- I-327 (Reentry Permit)
- I-551 (Permanent Resident Card or “Green Card”)
- I-571 (Refugee Travel Document)
- I-766 (Employment Authorization Card)
- Machine Readable Immigrant Visa (with Temporary I-551 language)
- Temporary I-551 stamp (on passport or I-94)
- I-94 (Arrival/Departure record)
- Unexpired foreign passport
- WT/WB Admission Stamp in unexpired foreign passport
- I-20 (Certificate of Eligibility for Nonimmigrant F(1) student status– “student visa”)
- DS2019 (Certificate of Eligibility for Exchange Visitor (J-1) Status)

I affirm under the penalty of perjury that the above is true and correct.

Signed this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
Signature

Sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
NOTARY PUBLIC

AFFIX SEAL HERE

My Commission Expires: \_\_\_\_\_

**If an applicant is discovered to be an unqualified alien, or otherwise ineligible for benefits under the Act, all recurring benefits provided to that applicant must be immediately terminated. Anyone who purposefully makes a false, fictitious, or fraudulent claim of U.S. citizenship or qualified alien status will be liable under the Tennessee Medicaid False Claims Act, or Tennessee’s False Claims Act. Any person who conspires to defraud the state or any local health department by securing a false claim allowed or paid to another person in violation of the Act may be liable under Tennessee’s False Claims Act. Upon discovery of an applicant’s false, fictitious, or fraudulent claim of U.S. citizenship, state governmental entities and local health departments must also file a criminal complaint with the United States Attorney.**