**STATE OF OKLAHOMA**
**BOARD OF CHIROPRACTIC EXAMINERS**
421 NW 13th Street, Suite 180
Oklahoma City, OK 73103
(p): 405/522.3400 (f): 866/245.2748
*www.chiropracticboard.ok.gov*

- ❑ Approved
- ❑ Disapproved

# DOCTOR'S APPLICATION FOR PRECEPTORSHIP

*Please complete form online then print*

| | |
|---|---|
| Name: | SS#: |
| Address: | |
| Office #: | Home/Cell #: |
| Chiropractic College Attended: | Graduation Date: |
| Oklahoma License Number: | Issue Date: |
| National Affiliation:<br>ACA ICA | Approx. # of Patient Care Visit per Week: |
| Graduate Degrees: | Post Graduate Certification: |

**Please answer the following:*

| Do you use any of the following: | YES | NO |
|---|---|---|
| Nutritional Supplements | | |
| Injectables: vitamins/minerals/nutritional supplements<br>If yes, date of your certification: | | |
| Orthotics and Supports | | |
| Physical Therapy | | |
| i. Heat | | |
| ii. Cryotherapy | | |
| iii. Electrical Muscle Stimulation | | |
| Traction | | |
| i. Intersegmental | | |
| ii. Static | | |
| iii. Manual | | |

| | | |
|---|---|---|
| Interferential Current | | |
| Ultrasound | | |
| Ultraviolet | | |
| Vibratory Therapy | | |
| Paraffin | | |
| Transcutaneous Electrical Stimulation | | |
| Iontophoresis | | |
| Diathermy | | |
| Infrareds Heat Therapy | | |
| Acupuncture<br>i. Electric<br>ii. Needle<br>iii. Laser | | |

| What are your x-ray facilities? |
|---|
| Type of Machine: |
| MA<br><br>KVP |

| Type of x-ray cassettes used: | YES | NO |
|---|---|---|
| i. 8X10 | | |
| ii. 10X12 | | |
| iii. 14X17 | | |
| iv. 14X36<br>***please list additional sizes on back if needed*** | | |
| Do you use a radiologist as a consultant? | | |

| |
|---|
| List the name of your liability insurance company:<br><br>a. amount of coverage:<br>b. Address and phone number for verification: |
| Give a brief explanation of examination procedures applied in your practice: |

| | | |
|---|---|---|
| Do you have teaching experience? | | |
| If yes, give a description of such experience and where performed: | | |
| Do you have any other doctors employed at your clinic? | | |
| What are the names, license numbers, and qualifications of the doctors employed by you? | | |

Signature

License Number

Print Name

Date