



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

<input type="checkbox"/> Approved <input type="checkbox"/> Disapproved

DOCTOR'S APPLICATION FOR PRECEPTORSHIP

Please complete form online then print

Name:	SS#:
Clinic Name:	
Address:	
Office #:	Home/Cell #:
Chiropractic College Attended:	Graduation Date:
Oklahoma License Number:	Issue Date:
National Affiliation: <div style="display: flex; justify-content: space-around; width: 100%;"> ACA ICA </div>	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 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		
i. Electric		
ii. Needle		
iii. Laser		
What are your x-ray facilities?		
Type of Machine:		
MA ____		
KVP ____		
Type of x-ray cassettes used:	YES	NO
i. 8X10		
ii. 10X12		
iii. 14X17		
iv. 14X36		
<i>*please list additional sizes on back if needed</i>		
Do you use a radiologist as a consultant?		
List the name of your liability insurance company:		
a. amount of coverage:		
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