Secretary of State
Office of Professional Regulation

CHIROPRACTOR
Verification of Chiropractic Intern Education

Applicant completes the top portion of this form and forwards to the school where you receive/completed your education.

Applicant:

First Name		Last Name & Title (Jr., Sr., II, III, etc.)	Former/Maiden
Mailing Address:	P.O. Box		
	Street/Apt #		
	City/State/Zip		
	Country		

I hereby authorize the_____(name of the school) to furnish to the Vermont Office of Professional Regulation the information requested below.

Signature_____Date:_____

TO BE COMPLETED BY THE INSTITUTION GRANTING DEGREE(S): The school/college must send this form directly to the Board at the address above.

Name of Applicant:			
Name of Institution:			
Address:			
Date Admitted:	/ /	**Anticipated Graduation Date:**	/ /
Signature of Authorized Agent		**Date**	/ /
(Seal)			