



Secretary of State
Office of Professional Regulation

CHIROPRACTOR
Verification of Employment and Supervision

A separate form must be completed for each supervising chiropractor.

Applicant:

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

Information Below to Be Completed by Supervising Chiropractor:

Name of supervising chiropractor		License #	
Business Location/Address		Telephone #	
Date applicant will begin working in your practice			

Statement of Supervising Chiropractor

I certify that the above statements are true and accurate to the best of my knowledge and I do hereby acknowledge that I am legally liable for any activities performed by the above-named intern.	
Signature of Supervising Chiropractor	Date