



Ohio State Chiropractic Board
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Columbus, Ohio 43215
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oscb.chirobd@chr.state.oh.us

Intern Name: _____

Date of Preceptorship:
_____ to _____
Month/Day/Year Month/Day/Year

PRECEPTOR APPLICATION

Name: _____

License Number: _____ Number of years licensed: _____

Email Address: _____ Website: _____

Facility where Preceptorship will take place:

Name of Clinic: _____

Address: _____

Phone: _____ Fax: _____

*Malpractice Insurance Carrier: _____

***Attach proof of current and valid malpractice insurance.**

Initial each box to acknowledge:

I have fully reviewed, understand, and will abide by the Board's Preceptorship Rule.

I have been continuously licensed and actively practicing in Ohio for the previous seven years and there are no disciplinary actions, pending disciplinary actions or malpractice claims against me in any jurisdiction.

I am a member of the faculty or extension faculty of the chiropractic educational institution from which I am accepting an intern into the preceptorship program.

My practice will provide the intern with an adequately diverse, broad, and extensive clinical experience and I utilize practice procedures that include appropriate history, physical examinations and diagnostic procedures.

Preceptor Signature

Date