State of Ohio
Ohio State Chiropractic Board

**Intern Name:**_____

**Date of Preceptorship:**

_____**to**_____
Month/Day/Year Month/Day/Year

## PRECEPTOR APPLICATION

Name: _____

License Number: _____ Number of years licensed: _____

Email Address: _____

**Facility where Preceptorship will take place:**

Name of Clinic: _____

Address:_____

Phone:_____ Fax: _____

*Malpractice Insurance Carrier: _____
***Attach proof of current and valid malpractice insurance**.

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**Check each box to acknowledge:**

- ☐ I have been continuously licensed and actively practicing in Ohio for the past 5 years.
- ☐ I have no pending disciplinary action against me.
- ☐ I have had no disciplinary action in any jurisdiction within the preceding 7 years.
- ☐ I have been approved by the doctor of chiropractic degree program to supervise the intern.
- ☐ I will maintain current valid malpractice insurance for the duration of the preceptorship.
- ☐ I will remain on the premises and provide direct supervision of the intern at all times during which the intern is engaged in any facet of patient care during the preceptorship.
- ☐ I will identify the intern to patients in such a way that no patient will be misled as to the intern's status.
- ☐ The intern will display a name badge identifying the intern's status at all times when the intern is providing direct care to patient.

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☐ I will monitor and track the intern's activity and regularly evaluate the intern's performance.

☐ I will ensure the intern documents all patient encounters, including observation, in a logbook that accurately reflects patient identification, involvement and services rendered.

☐ I will maintain a copy of all logbook records for one year following conclusion of the preceptorship program.

**I understand the intern is prohibited from (check to acknowledge):**

☐ diagnosing the condition of a patient;

☐ establishing a plan of treatment or prognosis for a patient;

☐ performing any service, except at my direction and supervision;

☐ billing independently for any service rendered;

☐ signing insurance forms or any other forms that require a licensed chiropractic physician's signature.

**By signing this form I attest that I have fully reviewed, understand, and will abide by the Board's Preceptorship Rule.**

**Preceptor Signature**
**(May sign electronically)**

**Date**