For Office Use Only
*Approved*_____ *Denied*_____
_____

Application for Chiropractic Board Intern/Resident Approval For Preceptorship

Iowa Department of Public Health/Bureau of Professional Licensure

PLEASE PRINT

Effective Dates for Preceptorship: _____ through _____
Month/Day/Year *Month/Day/Year*

Intern/Chiropractic Resident Information

1. _____ 2. _____
Last Name *First Name and Middle Name*

3. _____
Mailing Address

4. _____ 5. _____
City, State, Zip Code *E-Mail Address*

6. _____ 7. _____ 8. ☐ Intern ☐ Resident
Daytime Phone (Including Area Code) *Date of Birth* *Preceptorship Status*

9. ☐ Male ☐ Female 10. _____
Gender (optional question) *If any of your documentation is in a name other than your current name, list the previous names of record.*

Preceptor Information

11. _____ 12. _____
Last Name *First Name and Middle Name*

13. _____
Mailing Address

14. _____ 15. _____
City, State, Zip Code *E-Mail Address*

16. _____ 17. _____ 18. _____
Daytime Phone (Including Area Code) *Date of Birth* *Chiropractic License Number*

19. ☐ Male ☐ Female 20. _____
_____
Gender (optional question) *If any of your documentation is in a name other than your current name, list the previous names of record.*

Sponsoring Board Approved Chiropractic College Contact Information

21. _____
Board Approved Chiropractic College Names

22. _____
Mailing Address

23. _____
City, State, Zip Code

24. _____ 25. _____
Preceptor Program Coordinator 's Last Name *Preceptor Program Coordinator 's First Name and Middle Name*

26. _____ 27. _____

Preceptor Program Coordinator 's E-Mail Address *Daytime Phone (Including Area Code)*

Intern/Resident applicant must answer the following questions.	
28. As an intern have you met all requirements for graduation from the chiropractic college except for completion of the preceptorship period or as a resident and are participating in the postgraduate preceptorship program have you graduated from a board approved chiropractic college?	. ☐ Yes ☐ No
29. Do you understand that your preceptor shall not supervise more than one chiropractic intern or one chiropractic resident for the duration of the preceptorship period?	. ☐ Yes ☐ No
30. Do you understand that you shall: *a.* Be i**dentified by your preceptor as a chiropractic intern or chiropractic resident to the patients** of the preceptorship practice to ensure that no patient will misconstrue the status of you as the intern or resident. *b.* **Wear a badge identifying you as an intern or resident at all times** in the presence of preceptorship patients. *c.* Ensure that your preceptor **exercises direct, on-premises supervision of yourself at all times that you are engaged in any facet of patient care in the chiropractic physician preceptor's clinic**. *d.* Ensure that your preceptor directs you only in treatment care that is within the educational background and experience of the preceptor and within the scope of practice as defined by Iowa law and administrative rules.	. ☐ Yes ☐ No

I certify that I have carefully read and understand the questions and information on this application and have answered them completely and truthfully. I declare under penalty of perjury that my answers, and all other statements or information submitted by me in this application process, are true and correct. If it is determined at any time that I have provided misleading or false information on or in support of this application, I understand that my application may be denied.

I understand that I am required to update answers or information submitted herewith if the response or the information changes during the time period the application is pending. I also understand that this application is a public record in accordance with Iowa Code, Chapter 22 and that application information is public information, subject to the exceptions contained in Iowa law. Finally in submitting this application, I consent to any reasonable inquiry that may be necessary to verify the information I have provided on or in conjunction with this application.

31. _____ _____

Intern/Resident Applicant must sign here in ink **Date**

This application must be notarized. Note that there are multiple previous pages to this application requiring responses from the applicant.

32. _____ _____

Notary Signature/stamp **Date**

Mail the original completed application bearing signature in ink to:

Iowa Board of Chiropractic
Lucas State Office Bldg., 5th Floor
321 E. 12th Street
Des Moines, Iowa 50319-0075