

Chiropractic Student Preceptorship Program  
**Preceptor's Application**

1. Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Telephone: \_\_\_\_\_

2. From what college and what year did you graduate?  
 \_\_\_\_\_

3. Date of original licensure: \_\_\_\_\_ License # \_\_\_\_\_

4. How many years have you been in Active practice? \_\_\_\_\_

5. Do you have a valid malpractice policy as listed under Rule (d)(3) of the preceptorship rules that also covers all physical therapy modalities? \_\_\_\_\_  
 Please specify company: \_\_\_\_\_  
***Please provide a copy of your policy with this application.***

6. Do you presently have or have you ever had charges filed against you before the Arkansas State Board of Chiropractic Examiners? \_\_\_\_\_  
 If yes, please explain \_\_\_\_\_

7. Do you perform the following procedures on each new patient?  
 a. History/Consultation \_\_\_\_\_  
 b. Physical/Examination \_\_\_\_\_  
 c. Working/Final Diagnosis \_\_\_\_\_  
 d. Health Care Regimen \_\_\_\_\_

8. Please indicate the percentage of the following techniques that are used in your practice.

	Diversified		Specific Upper Cervical		Cranial
	Gonstead		Biophysics		Acupuncture
	Thompson		Pettibon		Taping/Strapping
	Cox Flexion Distraction		SOT		Therapeutic Exercise
	Activator		Applied Kinesiology		
	Instrument Manipulation/Adjustment			Extremity Manipulation/Adjustment	
	Other Please specify:				

9. Please indicate the following physical therapy modalities used in your practice:  
 (please check all that apply.)

	Diathermy		Ultrasound		Iontophoresis
	G-5/Massage		Traction Devices		AC-DC Muscle Stimulation
	Infrared		Ultraviolet		Laser
	Cryotherapy		Galvanic		Spray-Stretch with vapo-coolant spray
	Hydrotherapy		Hydrocollator Pac		
	Other, please specify:				

## Chiropractic Student Preceptorship Program

10. Do you use supports and appliances (orthotics)? \_\_\_\_\_
11. Do you have an X-ray device? \_\_\_\_\_
12. Nutritional Counseling / Diet Therapy? \_\_\_\_\_
13. Do you do your own lab work? \_\_\_\_\_  
If no, do you send your work out? \_\_\_\_\_  
If yes, please specify the facility \_\_\_\_\_
14. Are you able to order any diagnostic procedures from your local hospital(s)? \_\_\_\_\_  
If yes, please specify the facility \_\_\_\_\_
15. Do you handle insurance, P.I., Worker's Compensation, etc. cases? \_\_\_\_\_
16. Will your office teach insurance, personal injury, workers compensation, etc., procedures to the student? \_\_\_\_\_

I have read, understand and will conform to the laws, rules and/or guidelines set by the Arkansas State Board of Chiropractic Examiners and the respective Chiropractic College's criteria for the Chiropractic Student Preceptorship Program. I state herewith that I will abide by the Chiropractic College and the Arkansas State Board of Chiropractic Examiners program rules.

***I will be on the premises, directly supervising, at all times when the student performs any chiropractic procedures in the office/hospital/clinic.***

\_\_\_\_\_  
Preceptor's Signature

Chiropractic Student Preceptorship Program

**FINANCIAL AGREEMENT**  
(if applicable)

---

Preceptor

Date

Student's Duties:

Terms of Compensation:

---

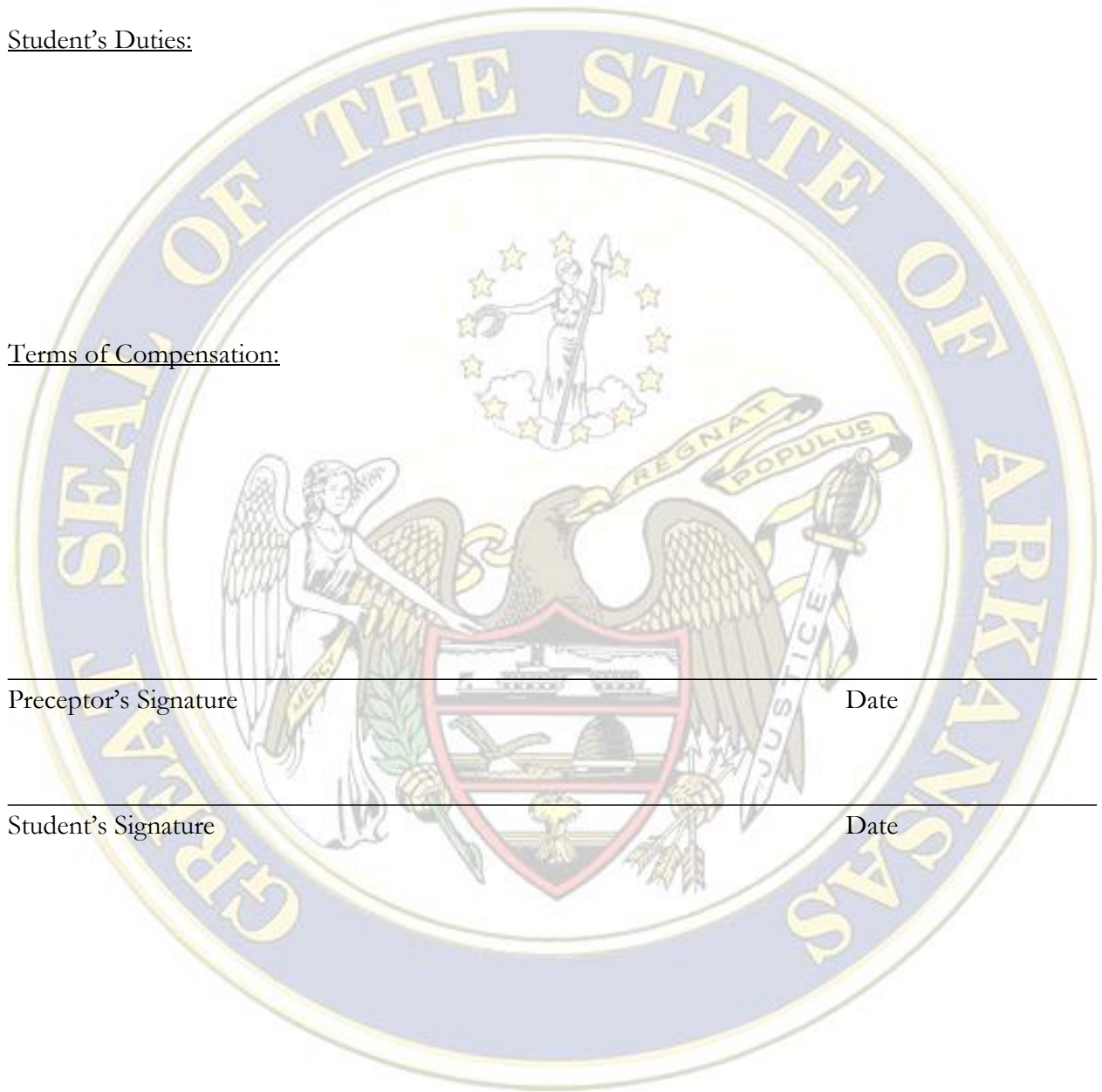
Preceptor's Signature

Date

---

Student's Signature

Date



Chiropractic Student Preceptorship Program

**AFFIDAVIT  
PRECEPTOR'S STATEMENT OF UNDERSTANDING**

I, \_\_\_\_\_, have read the provisions of the Chiropractic Student Preceptorship Program, and do hereby swear and affirm that I am familiar with and will fully comply with all statutory and rule requirements. I further understand that while the student is participating in the program, I and the approved student must be covered under a malpractice insurance policy. Students participating in the office or hospital will perform only the procedures approved in this program. I agree to be on the premises, directly supervising, at all times when the student performs any chiropractic procedures. I understand this agreement to be binding as long as I remain a preceptor and/or retain adjunct faculty status through a chiropractic college participating in the Chiropractic Student Preceptorship Program.

Student: \_\_\_\_\_

Dates of preceptorship: \_\_\_\_\_ to \_\_\_\_\_

Location: \_\_\_\_\_

I realize that failure to properly supervise this student may result in disciplinary action being taken by the Board.

Preceptor's Signature

Date

State of Arkansas

County of \_\_\_\_\_

On this the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, before me, \_\_\_\_\_, the undersigned notary, personally appeared \_\_\_\_\_ known to me (or satisfactorily proven) to be the person whose *name is* subscribed to the within instrument and acknowledged that he/she executed the same for the purposes therein contained.

In witness whereof I hereunto set my hand and official seal.

\_\_\_\_\_  
Notary Public

My Commission expires: \_\_\_\_\_