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. ____________________ 3. ____________________
Last Name                                      First Name and Middle Name  Mailing Address

4. ____________________ 5. ____________________ 6. ____________________ 7. ____________________ 8. ☐ Intern ☐ Resident
City, State, Zip Code  E-Mail Address  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. ____________________ 13. ____________________
Last Name                                      First Name and Middle Name  Mailing Address

14. ____________________ 15. ____________________ 16. ____________________ 17. ____________________ 18. ____________________
City, State, Zip Code  E-Mail Address  Daytime Phone (Including Area Code)  Date of Birth  Chiropractic License Number

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. ____________________ 22. ____________________ 23. ____________________ 24. ____________________ 25. ____________________
Board Approved Chiropractic College Names  Mailing Address  City, State, Zip Code  Preceptor Program Coordinator’s Last Name  Preceptor Program Coordinator’s First Name and Middle Name
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 identified 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. [signature]

   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. [signature]

   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