

Applicant Name: _____

Board of Chiropractic Medicine
Chiropractic Physician Information
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c. What are the specific duties you have assigned the CCPA when seeing patients outside your primary practice location?

d. What is your specific method of supervision and communication with the CCPA when outside the office?

4. CURRENTLY SUPERVISED CCPA'S DATA

Name: _____ **License Number:** _____
Last/Surname First Middle

Practice Address: _____
(Physical practice address/location where CCPA works)

Name: _____ **License Number:** _____
Last/Surname First Middle

Practice Address: _____
(Physical practice address/location where CCPA works)

5. ADDITIONAL PRACTICE LOCATIONS

List **ALL** additional practice locations including any location where the chiropractic physician serves as a medical doctor.

Physical Address	Medical Doctor
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

6. REQUIRED SIGNATURES

CCPA _____ Date _____
MM/DD/YYYY

CCPA _____ Date _____
MM/DD/YYYY

Supervising
Chiropractic Physician _____ Date _____
MM/DD/YYYY