# Board *of* Chiropractic Medicine
# Certified Chiropractic Physician's Assistant
# Work Arrangement Proposal

**CCPA Name:** ______________________________________________________________
Last/Surname First Middle

**DC Name:** ______________________________________________________________
Last/Surname First Middle

**License Number: CH** _______________

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

_____________________________________________________________ _______
Street Apt. No.

______________________________ _______________ _____
City State ZIP

**Is the clinic licensed under Part X of Chapter 400, F.S.?** ☐ Yes ☐ No

**Work hours:** From:__________AM To:__________PM

**Workdays: (Check all that apply)** ☐ Mon ☐ Tues ☐ Wed ☐ Thur ☐ Fri ☐ Sat ☐ Sun

**Describe the duties the CCPA will be performing:**

______________________________________________________________________

______________________________________________________________________

**Describe how the supervising physician will oversee the work being performed by the CCPA:**

______________________________________________________________________

______________________________________________________________________

By signing this document, we agree to be bound by this work arrangement until such time as this agreement is modified and approved by the Florida Board of Chiropractic Medicine.

Supervising
Chiropractic Physician ________________________________________,DC Date _______________
MM/DD/YYYY

Certified Chiropractic
Physician Assistant ________________________________________,CCPA Date _______________