Complete forms must be sent directly to
MQA.Chiropractic@flhealth.gov
or mailed to:

Board *of* Chiropractic Medicine
4052 Bald Cypress Way Bin C-07
Tallahassee, FL 32399-3257

Board *of* Chiropractic Medicine
Supervision and Competency of Dry Needling Practice

Part I: Applicant Information

Applicant Name: _____

Chiropractic Physician License #: _____ Telephone Number: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Have you submitted the Application for Chiropractic Dry Needling Certification? ☐ Yes ☐ No

Date of Application: _____
(MM/DD/YYYY)

Part II: Supervisor Information

Supervisor Name: _____

Profession: _____ License #: _____

Telephone Number: _____

Dates of Supervised Practice: From: _____ To: _____
(MM/DD/YYYY) (MM/DD/YYYY)

Total Patient Sessions: _____

I state the information provided on this form is true and correct and attest that the chiropractic physician has demonstrated competency and does not need additional supervision to perform dry needling.

Supervisor Signature _____ Date _____
(MM/DD/YYYY)