



VERIFICATION OF PRECHIROPRACTIC HOURS

NAME OF APPLICANT: _____
Last First Middle

Date of Birth: _____ Last Four Digits of SSN: _____

Matriculation Date: _____ Total Semester Credits: _____

Pursuant to the Chiropractic Initiative Act section 5, each applicant for licensure must have satisfactorily completed prechiropractic college credits prior to matriculation into the Doctor of Chiropractic program. These credits must be in accordance with the standards adopted by the Council on Chiropractic Education. Below provide the name(s) of colleges where the units were completed.

LIST NAME(S) OF COLLEGES AND/OR UNIVERSITIES ATTENDED (if additional space is needed attach a separate sheet)

1.	2.
3.	4.
5.	6.

I certify that the above-named individual, did satisfactorily meet or exceed, the prechiropractic college credits required prior to matriculation into the Doctor of Chiropractic program. I declare that the information provided is true, correct and complete to the best of my knowledge.

Only the Registrar or a chiropractic college official authorized to verify academic records may sign this form.

PRINT NAME	TITLE	DATE
SIGNATURE	CHIROPRACTIC COLLEGE	PHONE #
	CITY, STATE	

(Place imprint of the Chiropractic School Seal anywhere within this area)