



PRECEPTOR REQUEST

Instructions: Complete Sections 1 and 2 of this form. Submit this form to the Board, at the address below, with a check or money order in the amount of \$72.00 made payable to "BOCE". Please allow 2-4 weeks for processing.

Section 1: College Information: Date _____

Name _____

Contact _____

Phone # _____

Address _____

City, State, Zip Code _____

Check how you would like to receive the response:

Fax # _____

Email _____

Section 2: Preceptor – Doctor of Chiropractor:

Chiropractor Name _____ License # DC - _____

Address _____

City, State, Zip Code _____

Phone # _____

***NOTE:** If the chiropractor will also be training at additional locations, please include a listing of locations with the address and satellite certificate numbers.

Student - Intern

Name _____

Graduation Date _____

FOR OFFICE USE ONLY

APPROVED

DENIED Reason for denial _____

Signature _____

Date _____