MISSISSIPPI STATE BOARD OF CHIROPRACTIC EXAMINERS
P. O. DRAWER 775
LOUISVILLE, MS 39339

Phone: 662.773.4478 **Fax: 662.773.4433**

This application must be submitted to the above address twenty (20) days before a Board Meeting. The Board meets the 4th Thursday of January, April, July, and October.

Extern Sponsoring Doctor's Application

Name: ________________________________ SS#: __________________________

Address: ____

Phone - Office: ___________________________ Home: _________________________

Chiropractic College: ____

Graduation Date: ______________________________

Mississippi License Number: _____________________

Date License Issued: ____________________________

National Affiliation: _______ACA ________ ICA _________None

Approximate Number Patient Care Visit Per Week: ______________________________

Graduate Degrees: ____

Post Graduate Certification: ____

1. Do you use any of the following: Circle One

		Circle One	
a.	Nutritional Supplements	Yes	No
b.	Orthotics and supports	Yes	No
c.	Physical therapy:		
	Heat	Yes	No
	Cryotherapy	Yes	No
	Electrical muscle stimulation	Yes	No
d.	Traction:		
	Intersegmental	Yes	No
	Static	Yes	No
	Manual	Yes	No
e.	Interferential current	Yes	No
f.	Ultrasound	Yes	No
g.	Vibratory therapy	Yes	No
h.	Paraffin	Yes	No
i.	Diathermy	Yes	No
j.	Infrared heat therapy	Yes	No

2. What are your x-ray facilities?
   a. Type of machine ______________________________
      MA ____
      KVP _______________________________________

   b. Type of x-ray cassettes _________________________
   c. Type of screen _______________________________
   d. Size of cassettes used:

8x10	Yes	No
10x12	Yes	No
14x17	Yes	No
14x36	Yes	No

      List additional sizes: ___________________________

3. Do you use a radiologist as a consultant? Yes No

4. List the name of your liability insurance company ______________________________
   Amount of coverage _________________________
   Address and phone number for verification _________________________________
   ____

5. Give brief explanation of examination procedures applied in your practice:
   ____
   ____
   ____
   ____

6. Do you have teaching experience? Yes No

   If yes, give description of such experience and where performed:
   ____
   ____
   ____
   ____

7. Do you have any other doctors employed at your clinic? Yes No

8. What are the names, license numbers, and qualifications of the doctors employed by you?
   ____
   ____
   ____
   ____

____
Signature