MISSISSIPPI STATE BOARD OF CHIROPRACTIC EXAMINERS

P.O. DRAWER 775
LOUISVILLE, MS 39339
(662) 773-4478
FAX (662) 773-4433
www.msbce.ms.gov

Intern form

Date:

To Whom It May Concern,

I _____ hereby acknowledge that I have a student,
Print Doctor's Name
(Mr./Ms./Mrs.) _____from the following
Print Student's Name
school/institution:

_____
Print School/University/Institution Name

that is serving in an intern position under the guidance of their Student Advisor in a class credit program and **will not be a paid** employee of my facility. Said student will be interning in my office directly under my supervision for no more than one fall, spring or summer semester at student's stated School or University. Class credit will be granted toward said student's curriculum for a final grade. If student stays on past stated fall, spring, or summer program, they will be formally sent to an accredited seminar in the State of Mississippi for formal licensing as a Chiropractic Assistant in the State of Mississippi.

_____
Doctor's Signature

_____
Print Name

Facility/Office:

_____

_____