



## MISSISSIPPI STATE BOARD OF CHIROPRACTIC EXAMINERS

P.O. DRAWER 775  
LOUISVILLE, MS 39339  
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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:

\_\_\_\_\_

\_\_\_\_\_