



5. Primary Technique used in your practice:

- |   |                                   |                                       |
|---|-----------------------------------|---------------------------------------|
| <input type="checkbox"/> Diversified Full Spine | <input type="checkbox"/> Thompson | <input type="checkbox"/> Logan Basic  |
| <input type="checkbox"/> Gonstead               | <input type="checkbox"/> S.O.T.   | <input type="checkbox"/> Activator    |
| <input type="checkbox"/> Upper Cervical         | <input type="checkbox"/> A.K.     | <input type="checkbox"/> Other: _____ |

6. Other Techniques used in your practice:

- |   |                                   |                                       |
|---|-----------------------------------|---------------------------------------|
| <input type="checkbox"/> Diversified Full Spine | <input type="checkbox"/> Thompson | <input type="checkbox"/> Logan Basic  |
| <input type="checkbox"/> Gonstead               | <input type="checkbox"/> S.O.T.   | <input type="checkbox"/> Activator    |
| <input type="checkbox"/> Upper Cervical         | <input type="checkbox"/> A.K.     | <input type="checkbox"/> Other: _____ |

7. Other Practices used in your office:

- |   |                                       |                                       |
|---|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Diet Supplementation | <input type="checkbox"/> Thermography | <input type="checkbox"/> Stress Mgmt. |
| <input type="checkbox"/> Other: _____         |                                       |                                       |

8. Office Hours: Mon. \_\_\_\_\_ Tues. \_\_\_\_\_ Weds. \_\_\_\_\_ Thurs. \_\_\_\_\_ Fri. \_\_\_\_\_  
Sat. \_\_\_\_\_ Sun. \_\_\_\_\_

9. Are you willing to provide the Board with monthly and a final evaluation of the student working in your office, including the number of hours worked?

- YES       NO

I agree to comply and carry out all rules and regulations pertaining to the Board's externship program. I agree to allow the chiropractic college to make inquiry of the Board and State Chiropractic Association relative to my status of good standing.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

***Please attach a copy of the front page of your malpractice insurance policy.***

***Malpractice Policy No.:*** \_\_\_\_\_