PALMER College of Chiropractic

POST-GRADUATE PRECEPTOR PROGRAM

Intern Application Checklist:

Before proceeding with this application process, please read the Post Graduate Preceptor Program Handbook. The items below must be returned as part of the Intern's application:

- **Intern application** - Complete and sign
- **Intern Affidavit** – Please read and sign
- **Insurance Application** – Submit the NCMIC application for extern malpractice insurance directly to NCMIC by email at submissions@ncmic.com or by fax at 800-996-2642
- **National Board Part 1 Scores** – You may submit and unofficial
- **Fees** – An application/registration fee of $300 for the Davenport campus, and $225 for the West and Florida campuses is required with your application. An additional fee of either $300 or $225 per term or participation is due at the beginning of each academic term. Please refer to the information about program fees in the program handbook.
- **Graduates who are not US citizens** must contact the DSO (Designated School Official) at Palmer College to discuss post-graduate training requirements related to Visa status.

Note: Submission of the application and fees does NOT guarantee acceptance into the program. The Intern and doctor are accepted into the program only when they receive written approval from Palmer College. If the graduate participates in activities requiring chiropractic license before acceptance into the program or receiving their license, the graduate and field doctor may be subject to disciplinary action from the State Chiropractic Board.

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Application:

Graduate's Full Legal Name: _____

Mailing Address: _____

_____

Phone/Cell #: (_____)_____

Palmer email address: _____

Alternate email address: _____
Indicate the Palmer Campus you graduated from: ___ Davenport ____West _____ Florida
Graduation Date: _____/_____/____
Month Day Year

Are you a United States citizen? Yes No
If not, what type of Visa do you have and when does it expire? _____

If not, have you visited with the College DSO (Designated School Official)? Yes No

Date you expect to receive a chiropractic license: _____

Requested Start Date:_____/_____/_____
Month Day Year

Date you expect to receive a chiropractic license: _____

Doctor's Name: _____

Office Address: _____

_____

Doctor's email address: _____

Office Ph. # (_____)_____Fax # (____)_____

Is this Doctor credentialed in Palmer's preceptor program? Yes No Unsure

(Continued)

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Program Fees:
A payment of $300 (Davenport) or $225 (West/Florida) must be included with this application. Make checks payable to Palmer College of Chiropractic or pay by credit card by contacting the Student Services office on the campus from which you graduated. The initial payment will cover the first term you are participating in the program but will not be prorated should you start the term late or end the term early. By your signature below, you acknowledge that you have been informed of the required fees for each term you participate in the program that you have reviewed the fee information in the program handbook. Further, by your signature below, you acknowledge that you have been informed that failure to pay the fee each term will result in dismissal from the program.

_____ _____

Applicant's Signature Date

PALMER College of Chiropractic

INTERN AFFIDAVIT

1. I have read the Post-Graduate Program Handbook and am aware of the duties I am allowed to perform, as well as any restrictions, as an intern in the program.

2. Upon entering into the program, I agree to hold harmless Palmer College of Chiropractic, the Board of Trustees, and employees in any actions that may arise from the practice within the preceptor's office(s), and while traveling to and from that office in which I am working.

3. I have read the state law, rules and regulations for the state in which I intend to do my post graduate preceptorship and understand those laws affecting preceptorship.

4. I agree to abide by the rules and regulations set forth by the state law and Palmer College of Chiropractic while I am an intern. I further agree that I will refuse to perform duties outside of the state law or college handbook and that I will report to the college any requests by the preceptor that would violate state law or the program handbook.

5. I understand that violation of the state law or college rules could result in my immediate termination from the program.

6. I agree not to present myself as a licensed doctor of chiropractic and to wear a name badge while working in the office identifying myself as an intern.

7. I understand that I am required to pay a fee for each term I am participating in this program and that I will be sent a billing notice from the college's Student Administrative Services office. Terms are based on each campus' academic calendar. I understand that fees will not be prorated. I further understand that failure to make the required payment by the stated deadline will result in dismissal from the program.

8. I understand that Palmer College of Chiropractic may need to notify the state chiropractic board if my post-graduate preceptorship is terminated prior to my obtaining a chiropractic license.

9. I understand that enrollment in this program or payment of fees does not constitute a contract beyond any single month or term.

10. I understand that I may not begin to provide patient care under this program until I have received written confirmation from the program director.

_____ _____

Applicant's Signature Date

PALMER College of Chiropractic

PATIENT ACKNOWLEDGEMENT FORM
(Please use form on your clinic's letterhead)

Patient's Name_____ Date _____

Address _____City_____State_____Zip_____

Age_____ Date of Birth _____/_____/_____ Social Security # _____
M D Y

I, (Patient's Name) _____, a patient at

(Office Name)_____ am aware that

(Intern's Name) _____is an unlicensed graduate chiropractic intern within this office in cooperation with Palmer College of Chiropractic. I understand that the intern is not a licensed doctor of chiropractic, but is practicing under the direct supervision of a licensed doctor of chiropractic in this office as part of an educational program.

_____ _____
Patient's / Guardian's Signature Date

_____ _____
Doctor's Signature Date

_____ _____
Intern's Signature Date