



State of Arizona Board of Chiropractic Examiners

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Chiropractic Assistant Registration Transfer

Type or print in blue or black ink. Answer ALL questions. Answer "None" or "N/A" if it is the correct response.

Chiropractic Assistant:

Name: _____

Address: _____

City/State/Zip: _____

Telephone: () _____

Initial registration date: ____ / ____ / ____

Previous Supervising Doctor(s):

1st Doctor Name: _____ Lic. #: _____ PT #: _____ Acup. #: _____

2nd Doctor Name: _____ Lic. #: _____ PT #: _____ Acup. #: _____

New Supervising Doctor(s):

1st Doctor Name: _____ Lic. #: _____ PT #: _____ Acup. #: _____

2nd Doctor Name: _____ Lic. #: _____ PT #: _____ Acup. #: _____

Clinic Name: _____

Address: _____

City/State/Zip: _____

Telephone: () _____

Signatures:

Chiropractic Assistant

Date

Supervising Doctor

Date

Supervising Doctor

Date