



Montana Board of Chiropractors  
PO Box 200513  
(301 S PARK, 4th Floor - Delivery)  
Helena, MT 59620-0513  
PHONE: (406) 444-6880  
[dlibsdhelp@mt.gov](mailto:dlibsdhelp@mt.gov) [www.chiropractor.mt.gov](http://www.chiropractor.mt.gov)

## **Registration of Chiropractic Intern and Preceptor Relationship**

### **Intern Requirements** Per [ARM 24.126.704](#)

- (1) Intern may perform "chiropractic" and the "functions of a licensed chiropractor".
- (2) Intern must be a chiropractic student approved by a chiropractic program for clinical experience.

### **Preceptor Requirements** Per [ARM 24.126.704](#)

Preceptor must be:

- (1) A chiropractor licensed for at least **three years**.
- (2) In good standing.
- (3) Accepted by a chiropractic program to act as a preceptor to an intern.

### **Before acting as a preceptor** Per [ARM 24.126.704](#)

Provide the Department with:

- (1) The intern's name and contact information.
- (2) The name and address of the chiropractic program sponsoring the preceptorship program and approving the chiropractor preceptor.

### **Preceptor Responsibilities** Per [ARM 24.126.704](#)

- (1) Maintain a license in good standing.
- (2) Be responsible for the acts and omissions of the intern.
- (3) Supervise no more than **one intern** at any time.
- (4) Clearly identify the intern to patients as a student.
- (5) Obtain informed consent from patients for treatment by the intern, offering the option for the chiropractor to be present.
- (6) Provide direct supervision on the premises and be readily available during patient care.
- (7) Do not allow the intern to sign insurance claims, workers' compensation claims, or other documents requiring a chiropractor's signature.
- (8) Comply with the preceptorship program requirements.



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## **Registration of Chiropractic Intern and Preceptor Relationship**

### **Sponsoring Chiropractic Program:**

School Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

### **Preceptor Information:**

Name: \_\_\_\_\_ License Number: \_\_\_\_\_

Practicing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

### **Intern Information:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

### **PRECEPTOR DECLARATION**

I hereby declare under penalty of perjury the information included in this registration to be true and complete to the best of my knowledge. I have read and will abide by the current licensure statutes and rules of the State of Montana governing the profession. I will abide by the current laws and rules that govern my practice.

Preceptor Signature: \_\_\_\_\_ Date: \_\_\_\_\_