

Certification of Three Month Clinical Experience/Internship



College of
Chiropractors
of Ontario

This information is requested pursuant to s.4(1) 3 of the Registration Regulation *O.Reg. 830/93*

SECTION I:

To be completed by applicant and forwarded to the school of chiroprody/podiatry, clinic, hospital or a practising registered chiroprodist/podiatrist who can validate the applicant's clinical experience.

SURNAME		GIVEN NAME(s)		FORMER NAME(s)	
ADDRESS					
CITY	PROVINCE	POSTAL CODE	COUNTRY	TELEPHONE	
GRADUATED FROM (name and address of applicant's school of chiroprody/podiatry)					
GRADUATION DATE (dd/mm/yy)			DEGREE/DIPLOMA OBTAINED		

SECTION II:

To be completed by the registered practitioner and forwarded directly to the College of Chiropractors of Ontario.

I _____ (Given Name) _____ (Surname) certify that
 _____ (Applicant's Given Name) _____ (Surname) has completed three months
 clinical experience/internship in the period from _____ (dd/mm/yy) to _____ (dd/mm/yy) and demonstrated competent
 practice in chiroprody/podiatry.

SIGNATURE: _____ DATE: _____

POSITION: _____ TELEPHONE: _____

NAME OF INSTITUTION / PRACTICE: _____

ADDRESS: _____

FAX NUMBER: _____ EMAIL: _____