

Complete and return to: **Chiropractic Physicians' Board of Nevada**
4600 Kietzke Lane, Suite M-245, Reno, NV 89502

Or Fax to: (775) 688-1920

**REGISTRATION INFORMATION FOR SERVICES TO BE PROVIDED TO
PATIENTS IN A CHIROPRACTIC OFFICE**

DC Licensee's Name: _____
Telephone No.: _____ License No.: _____

Name of person who will be providing services for your patients: _____

Description of services: _____

Address where above person will provide services for your patients: _____

Date on which above person will begin providing services for your patients: _____

Acknowledgments of Licensee:

The above named person will not be providing chiropractic services, including, without limitation, taking X rays, services that involve the use of physiotherapeutic equipment and massage therapy;

The above named person will be employed by me or will be retained by me as an independent contractor;

A copy of the license(s) or certificate(s) that authorize(s) the above named person to provide the services that he/she will be providing for my patients is/are attached.

A copy of any license or certificate for the above named person that is provided herewith shall be available to each of my patients for whom the above named person provides services.

Date: _____

_____, DC
Signature of Licensee