



**CHIROPRACTOR SUPPLEMENT**  
Forming part of the Professional Liability Application

\_\_\_\_\_  
Name of Applicant

**Provide name and location of university where DPM degree obtained:**

\_\_\_\_\_  
\_\_\_\_\_

**Are you a member of your provincial College of Chiropractors or equivalent body?**  Yes  No

**Do you meet the education and training standards set out by the Canadian federation of Chiropractic Regulatory and Educational Accrediting Boards?**  Yes  No

**Number of years of experience excluding medical training:** \_\_\_\_\_  
Years

**Are new patients required to provide medical history and information so that you aware of any potential risk factors?**  Yes  No

**Are patients supplied with comprehensive information on treatment procedures and possible risks and side effects?**  Yes  No

**Is every patient required to complete and sign a consent form for each treatment / procedure?**  Yes  No

**Does the consent form include a statement that the patient understands and accepts the risk?**  Yes  No

**How long do you keep your patient's information/documentation on file?** \_\_\_\_\_  
Years

\_\_\_\_\_  
Print Name and Title

\_\_\_\_\_  
Signature of Applicant or Authorized Representative

DATE: | D | D | M | M | Y | Y |