Texas Chiropractic College Mentor Program Application

Doctor Profile Information:

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Office Phone: _____ Office Fax: _____

Cell Number: _____ Years in Practice: _____

Chiropractic College Graduated from: _____

Graduation Year: _____ States Where Currently Licensed: _____

_____

(Please list all college degrees conferred by accredited higher education institutions)

Doctor Practice Information:

Do you have a solo practice? ☐ yes ☐ no

If no,

Number of Associates _____

Names of Associates _____

Number of Staff _____

Please indicate the physical medicine modalities used in your office.

☐ Diathermy ☐ Ultrasound ☐ Moist Heat ☐ Interferential

☐ Traction ☐ Electrical Stim ☐ TENS ☐ Acupuncture

☐ Other: _____

Please indicate the examination procedures you utilize.

☐ Temperature ☐ Pulse ☐ Respiratory ☐ BP

☐ EENT ☐ Heart/Lung ☐ DTRs ☐ Cranial

☐ Orthopedic ☐ Neurological ☐ Area of Complaint

☐ Other: _____

Please indicate the techniques you use most frequently.

☐ Diversified ☐ Gonstead ☐ Thompson

☐ Activator ☐ Flexion Distraction

☐ Other: _____

Please indicate which modalities or procedures you use.

☐ Rehablitiation ☐ Acupuncture ☐ Hair Analysis ☐ Thermographs

☐ Other _____

My customary office hours are from:

Monday _____ Tuesday _____

Wednesday _____ Thursday _____

Friday _____ Saturday _____

Customary Lunch hour: _____

Please mark the insurance programs you most frequently accept.

- ☐ Third Party
- ☐ Individual Accident/Health
- ☐ Group Plans
- ☐ Personal Injury
- ☐ Worker's Compensation
- ☐ Medicare
- ☐ Medicaid
- ☐ HMO
- ☐ PPO
- ☐ Other: _____

Which code of ethics does your office subscribe to?

- ☐ ACA
- ☐ TCA
- ☐ ICA
- ☐ Other (Please fax to Mentor Program Mgr.): _____

Doctor Agreement

I, _____, a currently license doctor of chiropractic, qualified by the appropriate jurisdiction to practice the healing art of chiropractic, do hereby make application to participate in the Mentor Program offered by Texas Chiropractic College. I certify that I have received a copy of the ***guidelines***, and have read and understood the content.

Signed: _____ Date: _____

Applying Doctor

Signed: _____ Date: _____

Director of Alumni Relations

Return this form to:
Gabrielle Greenwade, Director of Alumni Relations
Texas Chiropractic College
5912 Spencer Highway
Pasadena, TX 77505
ggreenwade@txchiro.edu