

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
DIVISION OF HEALTH LICENSURE AND REGULATION
OFFICE OF HEALTH RELATED BOARDS
665 Mainstream Drive, Second Floor
Nashville, TN 37243
http://tn.gov/health

## **BOARD OF CHIROPRACTIC EXAMINERS**

## CLINICAL INTERNSHIP PERFORMANCE REPORT

This assessment of entry level minimal competence will be completed and submitted as part of the standard application for Chiropractic Therapy Assistants (CTAs) and Chiropractic X-Ray Technologists (CXTs). If hours were obtained in multiple facilities, please use separate forms for each. In addition to this form, please attach a log sheet of the weekly internship hours completed.

Certificate Holder's Name						
Dates of Supervision Period	Variable 40 - 244 (24) - 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2 -					
DC/CTA/CXT Supervisor						
License Number						
Alternate DC/CTA/CXT Supervisor						
License Number						
Name of Facility						
Phone Number of Facility						
Facility Address						
For Supervisor's Use Only:						
Based on the observations for the full term of affiliation ofhours, I affirm that this certificate holderDoes Not meet or exceed the entry level performance in demonstrating clinical competence in Chiropractic Therapy Practice and/or Chiropractic X-Ray Technology Practice within this facility.						
Supervisor's Signature	Date					



## **CTA Intern Hours Log**

Name of CTA Intern (	printed):	State Exam Pass Date:	State Exam Pass Date:		
clinical internship under d the certificate holder's per	lirect supervision. The rformance in each area	supervisor is required to poor of internship on forms pro	uires for CTA licensure, proof of twel rovide the Board of Chiropractic Exar- vided by the board to become certifie of examination, unless an extension is	niners a report concerning d as a chiropractic therapy	
medical or osteopathic ph	ysician, or chiropractic	therapy assistant supervis	or the purpose of training or teaching, or who monitors the performance of a spect to the skills and competencies or	in intern. The supervisor	
Date Range**	Completed Hours	Intern Initials	Supervisor Name	Supervisor Initials	
I verify that all informati	ion submitted in this I	og is accurate.	Total hours:		
Intern Signature:			Date signed:	<del></del>	
miem signature:				Date signed:	

<sup>\*\*</sup>Date Range recommended not to exceed one week



## **CXT Intern Hours Log**

Name of CXT Intern (printed):			Internship Start Date*:	Internship Start Date*:		
thousand and forty (1,040)	) hours of clinical inte Examiners a report co	rnship supervised by ncerning the applica	e) requires for CXT licensure, proof of successfa Tennessee licensed doctor of chiropractic who hat's performance in each area of the spine and exhaultenesses.	is required to provide		
	monitors the performa	ince of an individual.	ew, for the purpose of training or teaching, by a The supervisor provides regular documented fa supervised.			
Date Range**	Completed Hours	Intern Initials	Supervisor Name	Supervisor Initials		
			·			
		ñ				
		-				
I verify that all informati	on submitted in this l	og is accurate.	Total hours:			
Intern Signature:			Date signed:			

<sup>\*</sup> Based on receipt of notice of passing required examination \*\* Date Range recommended not to exceed one week