BOARD OF CHIROPRACTIC MEDICINE
MONITOR'S QUARTERLY REPORT

Please print or write legibly.

Respondent's Name:			
Respondent's License Number:		Case Number:	
Address: City State Zip			
Telephone Number			
Monitor:			
Address: City State Zip			
Telephone Number			
Quarter (3 months)	From:	To:	

Brief statement of why Respondent is on probation:

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____
____

Description of current practice (type and composition) and location:

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Brief statement of compliance with probationary terms:

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Description of relationship with supervisor:

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A summary of the dates the Monitor went to Respondent's office, the number of records reviewed, the overall quality of the records reviewed, and the dates Respondent contacted the Monitor:

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Signature: ________________________________ Date: ________________________

STATE OF ____________________________

CITY/COUNTY OF ______________________

Before me personally appeared ____________________________ whose identity is known to me by _________________________ (type of identification) and who acknowledges that his/her signature appears above.

Sworn to or affirmed by Affiant before me this _____day of __________, 20_____

________________________________ ________________________

Notary Public - State Of Florida My Commission Expires

____

Type or Print Name

Mailing Address: Department of Health, Compliance Management Unit
4052 Bald Cypress Way, Bin C76 • Tallahassee, FL 32399
Fax: (850) 488-0796