



STATE OF MISSOURI
Division of Professional Registration

STATE BOARD OF CHIROPRACTIC EXAMINERS
PO BOX 672
JEFFERSON CITY MISSOURI 65102-0672

AUTHORIZATION

INSTRUCTIONS

All information requested on this application must be typewritten or printed.
Use black ink.

FOR OFFICE USE ONLY

Fee Paid ___ **Yes** ___ **No**

AUTHORIZED REPRESENTATIVE

NAME

TELEPHONE NUMBER

ADDRESS (STREET, CITY, STATE, ZIP CODE)

INCORPORATORS AND/OR SHAREHOLDERS

NAME	LICENSE NO	ADDRESS (STREET, CITY, STATE, ZIP CODE)

I, the authorized representative of the incorporators and/or shareholders listed above, propose that the name of the professional corporation shall be:

PROSED NAME:

SIGNATURE OF AUTHORIZED REPRESENTATIVE

DATE