



KENTUCKY BOARD OF CHIROPRACTIC EXAMINERS

Steven L. Beshear
Governor

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Facility Registration Form

Name _____ Lic # _____

Name of Facility _____

Owner(s) of Facility

Office Address _____

City _____ State _____ Zip _____

Work County (if in KY) _____

Office Phone # with area code _____ Fax _____

Email Address _____

Website Address _____

By signature below I acknowledge KRS 312.145 (3) and that the facility in which I have ownership or practice is in compliance.

_____ Date _____