NORTH DAKOTA MEDICAL IMAGING AND RADIATION THERAPY BOARD
PO BOX 398 BISMARCK, ND 58502 701-425-0861
info@ndmirtboard.com www.ndmirtboard.com

Letter of Attestation

From: _____
Chiropractor's Name

_____
Chiropractor's Clinic Address

_____
City, State, ZIP Code

_____
Date

To:
North Dakota Medical Imaging & Radiation Therapy Board
PO Box 398
Bismarck, North Dakota 58502
701-425-0861

To Whom It May Concern,

By signing below, I,_____, certify the following:
Chiropractor's Name

I have reviewed and shall abide by and uphold the requirements and standards set forth in the **ND Conditional Chiropractic Limited X-Ray Machine Operator Clinical Information Packet** and the **Practice Standards of a Restricted Scope for the Limited X-Ray Machine Operator ND licensed Certified Clinical Chiropractic Assistant**.

This section must be completed in the presence of a notary public.

State of _____

County of _____

Signed and acknowledged before me this _____

day of _____, _____. *(Notary Seal/Stamp)*

_____
Signature of Notary Public

My commission expires: _____

_____ _____
Chiropractor's Name Chiropractor's Signature

February 2024