Hospital Qualifying Application

Name:

Address:

Phone: **Email:**

State(s) and License(s) #'s:

Malpractice/Licensure actions against your license:

None _____ (please initial)

or describe date, action and circumstances briefly and understand we will be verifying all below with your licensure board.

1.

2.

3.

4.

I have taken or equivalent (please check off) and supply the curriculum of equivalent course

__ Interprofessional Hospital Based Spine Care: Year Taken ____

__ MRI Spine Interpretation: Year Taken ____

__ Trauma Care - Personal Injury: Year Taken _____

__ Spinal Biomechanical Engineering: Year Taken _____

__ Head Trauma - Brian Injury - Concussion: Year Taken _____

The following 3 courses are included in the Academy of Chiropractic's bi-annual Primary Spine Care Symposium and don't need retaking if you attended

__ Hospital Administration, Clinical Triage & Documentation: Year Taken _____

__ Chiropractic Adjustment - Central Nervous System Connection: Year Taken _____

__ Emergency Department Protocols & Spine Care: Year Taken _____

Signature and Date:

PLEASE FILL THIS OUT & SEND IT WITH THE $500 FEE PAID TO PROCESS

Please print, fill out and then fax to 661-843-1062