

**APPLICATION FORM
VETERINARY SPINAL
MANIPULATIVE THERAPY – POST GRADUATE
CERTIFICATION PROGRAM**

Name: _____

Degree (please circle appropriate one): DC, DC student, DVM/VMD, DVM student
Address: _____

Work phone number: _____ Fax number: _____

Email (required): _____

Emergency / cell phone number (will be kept private): _____

Requesting registration for program starting: _____ (date of first module)

Admissions requirements:

1. Licensed chiropractor (DC) or veterinarian (DVM, VMD) in good standing with their particular state / provincial / governmental licensing board.
2. Professionals registering from outside the North American continent please provide a copy of the pertinent Visa, Diploma and proper governmental licensure of the country that you are currently practicing.
3. All applicants must include a **COPY OF YOUR DIPLOMA**.
4. All applicants must include a **COPY of the STATE OR PROVINCIAL LICENSE** under which they are currently practicing.
5. Two character reference letters, one from a non-family member and one from an employer. If self-employed, please include a letter with a brief description of your practice.
6. Two photos (passport size).
7. ALL licensed professionals must include a signed letter stating that they understand their state's and or provincial rules and regulations as they apply to "animal chiropractic" or veterinary spinal manipulative therapy as set forth by their Veterinary Licensing & Regulation office for Integrative and / or Alternative Modalities **and** those set forth by **their individual Health Care Licensing Boards**.
8. Include a \$200.00 USD deposit (**drawn on a US Bank**) with the application form. The remaining tuition (\$5,975.00) is due during the interview (total tuition cost of \$6,175.00). **No foreign checks please**,

****Please note, that a 2.1% charge will be applied to all credit card transactions****

Deposit includes a \$100.00 non-refundable fee **Checks payable to: National University**



National University of Health Sciences

200 E. Roosevelt Road

Lombard, IL 60148

630-889-6622 Office

630-889-6482 Fax

POSTGRAD@NUHS.EDU or CONTACT@HEALINGOASIS.EDU

Signature of Applicant: _____ Date: _____

By signing above, applicant acknowledges that they have read the catalog, are in good standing with their particular licensing board and that they are not currently under investigation for unprofessional conduct.