

**HEALING OASIS WELLNESS CENTER
CONTINUING EDUCATION
Neurology Review
Application Form**

Name: _____ CE seminar scheduled for (date): _____

Degree (please circle appropriate one): DC, DVM, VMD, Other: _____

Address: _____

Work phone number: _____ Fax number: _____

Email (required): _____

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

Admissions requirements:

1. Must comply with the minimum requirements for the specific CE seminar. Requirements may vary from being a licensed chiropractor (DC) or veterinarian (DVM, VMD); licensed or registered veterinary technician; registered nurse; licensed or registered massage therapist or licensed physical therapist. All applicants must also sign the application form attesting to being in good standing with their particular state / provincial / governmental licensing board.
2. Provide a **copy of their current** (not expired) license / registration or official state / provincial permit.
3. 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 the use of "integrative or alternative" health care for animals as set forth by their State Veterinary Licensing & Regulation office for Integrative and / or Alternative Modalities **and** those set forth by **their individual Health Care Licensing Boards**.
4. All applicants **must provide** a copy of the certificate of successful completion of their approved school if it is required (see individual description. If in doubt, please contact our office).
5. Please include a check for the **total amount of \$525.00** (five hundred twenty five USD, **drawn on a US Bank**). **No foreign checks please,**
6. REFUND criteria:
 - a. 75% refund if more than 7 weeks of scheduled date
 - b. 50% refund if more than 5 weeks but less than 7 weeks of scheduled date
 - c. 25% refund if more than 4 weeks but less than 5 weeks of the scheduled date
 - d. NO REFUND if less than 4 weeks of the scheduled date.

***Please note that **ALL CANCELLATIONS** must be done in writing (no messages will be accepted as cancellation). All cancellation notices must be sent via email at CONTACT@HEALINGOASIS.EDU.

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

Healing Oasis Wellness Center
2555 Wisconsin St
Sturtevant, WI 53177-1825
262-898-1680; 262-886-6460FAX
US Toll Free: 866-203-7584

CONTACT@HEALINGOASIS.EDU OR WWW.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.