APPLICATION FORM
VETERINARY SPINAL
MANIPULATIVE THERAPY – POST GRADUATE
CERTIFICATION PROGRAM

Name: _____

Degree (please circle one): DC, DVM, VMD
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. Please include a $200.00 (USD drawn on a US Bank) deposit with application form. **Deposit include a $100.00USD non-refundable fee.
9. Tuition and a non-refundable application fee is $6,810.00 USD (**drawn on a US Bank**). The remaining tuition ($6,610.00) is due during the interview (total cost of $6,810.00). **No foreign checks please**,

****Please note, that a 2.5% charge will be applied to all credit card transactions***
***Depositincludes a $100.00 non-refundable fee*
**Checks payable to:
National UniversityNational 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 individual licensing board and that they are not currently under investigation for unprofessional conduct.