

VETERINARY ACUPUNCTURE POSTGRADUATE CERTIFICATION PROGRAM
APPLICATION FORM

Name: _____ Degree (please circle appropriate): DVM / VMD/ Lic. Acup.

Address: _____, _____

Work phone number: _____ Fax number: _____

Email (required): _____

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

Registration for program starting: _____ (date of first module)

Admissions requirements: (ALL requirements to be submitted through regular USPS)

1. Licensed veterinarian (DVM, VMD), or licensed acupuncturist (Lic.Acup) in good standing with their particular state /provincial/governmental licensing board.
2. For professionals registering from outside the North American continent, please provide a copy of the pertinent Visa, Diploma, and proper governmental current licensure of the country that you are actively practicing.
3. All applicants must include a **COPY OF THEIR DIPLOMA** and a **COPY of the STATE OR PROVINCIAL UNEXPIRED LICENSE** under which they practice.
4. Include two-character reference letters from non-family members. If self-employed, one of the two letters must briefly describe your practice.
5. **For Non-veterinary licensed professionals**, please include the signed, initialed, and completed "Waiver for Non-Veterinary Licensed Professionals".
6. Two (2) photos – or appropriate digital passport-size pictures.
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 Veterinary Acupuncture as set forth by their Veterinary Licensing & Regulation office for Integrative and Alternative Modalities **and** those set forth by **their individual Health Care Licensing Boards. You must read BOTH Acupuncture and Veterinary regulations.**
8. Please include a \$200.00 (USD drawn from a US Bank) Deposit with the application form. **Deposit includes a \$100.00 non-refundable fee.
9. The total tuition (which includes a deposit) is \$8,100.00 (**drawn on a US Bank**). The remaining tuition of \$7,900.00 is due two weeks before the scheduled first day of class. **No foreign checks, please.**

Please NOTE that a 3.5% charge will be applied to all credit card transactions

***Deposit includes a \$100.00 non-refundable fee*

**Checks payable to:
Healing Oasis Wellness Center
2555 Wisconsin St.
Sturtevant, WI 53177-1825
262-898-1680 Office; 262-886-6460 Fax
INFO@HEALINGOASIS.EDU

CREDIT CARD NUMBER (Visa, MC, or Discover **only**): _____

Exp. Date: _____ Security code on the back of the card: _____

BILLING Address: _____ Zip code: _____

Signature of Applicant: _____ Date: _____

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