SACRO OCCIPITAL RESEARCH SOCIETY INTERNATIONAL, INC.

APPLICATION FOR CERTIFICATION EXAMINATIONS

Must be received 60 days prior to exam date

Check One: ___ Doctor: Proficiency in Sacro Occipital Technic Exam
___ Doctor: Advanced Proficiency in Sacro Occipital Technic Exam
___ Doctor: Certified Craniopath (ICS) Examination
___ Student: Proficiency in Sacro Occipital Technic Exam

ANSWER ALL QUESTIONS:

Name: ____

Office Address: ____

Home Address: ____

Telephone: Work: ______________ Home: ________________ Cell: _________________

Date of Birth: _______________ E-mail: _______________________________________

Professional Education/College

Name of School and Location ____
Degree and Major: _____________ Period of Attendance: _____________

Name of School and Location ____
Degree and Major: _____________ Period of Attendance: _____________

Health/Chiropractic Education – Applicant will give the name and location of each institution attended, specifying date of entry and date of termination of each institution.

1. _______________________ Degree______ Location ________ Date: _________
2. _______________________ Degree______ Location ________ Date: _________
3. _______________________ Degree______ Location ________ Date: _________
4. _______________________ Degree______ Location ________ Date: _________

List all professional specialists and evidence of expertise. For Example:Orthopedics, Applied Kinesiology, Roentgenology

Speciality	Evidence of Certification	Date of Certification
1. ________________________	_____________	___________
2. ________________________	_____________	___________
3. ________________________	_____________	___________
4. ________________________	_____________	___________

Has any license entitling you to practice in any state or territory been suspended or revoked? Yes ___ No ___
If YES, attach paper and give details.
Have you ever been convicted of or pled guilty, or nolo contenders to any violation of any law of any state, the United States or a foreign country? (Please exclude violations which resulted in a fine of less than $50). Yes ___ No ___

Do you hold a license to practice previous to this date? Provide photocopy Yes ___ No ___
If YES, What State, Province, Country? ___

Where was Sacro Occipital Technique Training Acquired? ___
When? ___
2 Days SORSI Seminars, Where and When? ___
Are you a current member of SORSI? Yes ___ No ___
Do you currently have Malpractice insurance? Yes ___ No___ Please make a copy and submit with application.

CERTIFICATE OF MORAL CHARACTER

No person shall sign this recommendation who is not personally acquainted with the applicant and who is not willing to furnish additional information concerning his or her character, education and standing on request on request of the Board)

THIS CERTIFIES, that we, the undersigned, are personally acquainted with ___ and know ___ to be of good moral character and hereby recommend ___ to the Sacro Occipital Research Society International Board of Examiners as a most worthy person to be issued a Certificate of Competency.

Name ___
Address ___
Graduated from ___
State of Graduation ___ Year of Graduation ___
State Licensed In: ___ License No. ___
Signature ___

Name ___
Address ___
Graduated from ___
State of Graduation ___ Year of Graduation ___
State Licensed In: ___ License No. ___
Signature ___

I hereby certify (or declare), under penalty of perjury, that the foregoing information contained in this application and any attachments is true and correct, and that the attached photo and duplicate copy are a true likeness of myself, the applicant identified herein.

Signature of Applicant ___ Date ___

Please enclose the following with your application: ___ Check ___ Money Order ___ VISA ___ Mastercard

___ Photocopy of current chiropractic license

___ Two (2) photographs. Attach to application form

___ Appropriate Fee

Credit Card #___

Expiration Date ___ Security Code ___

FOR OFFICIAL USE ONLY

Two (2) Photographs Required

Attach 3 x 4 photo of applicant taken within 60 days of application

Bust size

Proof photo not acceptable

1. Payment ___
2. Written Exam: Date: ___ Grade ___
   Pass / Fail
3. Practical Exam: Date: ___ Grade ___
   Pass / Fail

Written : Passed Failed Practical: Passed Failed

1. Doctor Proficiency 2. Doctor Advanced Proficiency
3. Student Proficiency 4. Certified Craniopath

B.O.E. Chairman ___

Examining Doctor #1 ___

Examining Doctor #2 ___