

SACRO OCCIPITAL RESEARCH SOCIETY INTERNATIONAL, INC.

APPLICATION FOR SORSI MEMBERSHIP

Please return application and fee (\$200 for doctors) to:

SORSI Headquarters
P O Box 24361
Overland Park, KS 66283

NAME: _____ BIRTHDATE _____

OFFICE ADDRESS: _____

CITY/STATE: _____ ZIP: _____

TELEPHONE: _____ E mail: _____

HOME

ADDRESS: _____

CITY/STATE: _____ ZIP: _____

TELEPHONE: _____ E mail: _____

HEALTH/ CHIROPRACTIC EDUCATION: Applicant will give the name and location of each institution attended, specifying date of entry and date of termination at each institution.

1. _____ DEGREE _____ from: (mo/yr) _____
to: (mo/yr) _____

2. _____ DEGREE _____ from: (mo/yr) _____
to: (mo/yr) _____

3. _____ DEGREE _____ from: (mo/yr) _____
to: (mo/yr) _____

4. _____ DEGREE _____ from: (mo/yr) _____
to: (mo/yr) _____

LIST ALL SPECIALTIES/CERTIFICATION: List all professional specialists and evidence of expertise. For Example: Orthopedics, Applied Kinesiology, Roentgenology

1. _____ Date of Certification: _____

2. _____ Date of Certification: _____

3. _____ Date of Certification: _____

4. _____ Date of Certification: _____

Has any license entitling you to practice in any state or territory been suspended or revoked? _____

If YES, attach paper and give details. (yes/no)

Have you ever been convicted of or pled guilty, or nolo contendere to any violation of any law or any state, the United States or a foreign country? (Please exclude violations which resulted in a fine of less than \$50.00).

If YES, attach a full and complete explanation with documentation. (yes/no)

Do you hold a license to practice previous to this date? Provide photocopy. _____

(yes/no)

If YES, What State, Province, Country? _____

Signature of Applicant _____ Date: _____

_____ Check _____ Money Order _____ VISA _____ MasterCard
Credit Card # _____ Expiration Date _____