

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 contendere 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 \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

Graduated from \_\_\_\_\_

Graduated from \_\_\_\_\_

State of Graduation \_\_\_ Year of Graduation \_\_\_

State of Graduation \_\_\_ Year of Graduation \_\_\_

State Licensed In: \_\_\_ License No. \_\_\_\_\_

State Licensed In: \_\_\_ License No. \_\_\_\_\_

Signature \_\_\_\_\_

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 Credit Card # \_\_\_\_\_

\_\_\_ Appropriate Fee Expiration Date \_\_\_\_\_ Security Code \_\_\_\_\_

#### FOR OFFICIAL USE ONLY

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

Two (2) Photographs Required

Written : Passed Failed Practical: Passed Failed

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

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

Bust size

BOE. Chairman \_\_\_\_\_

Proof photo not acceptable

Examining Doctor #1 \_\_\_\_\_

Examining Doctor #2 \_\_\_\_\_