



*Establishing and Advancing the
Chiropractic Family Wellness Lifestyle*

I.C.P.A. Continuing Education Verification Form

(Please Print Clearly)

Module Title: _____ Instructor: _____

Module Location: _____ Date: _____

Name: _____

Address: _____

City: _____ St/Pro: _____

Zip/Postal: _____

Office Phone: (____) _____ Fax: (____) _____

Email: _____

States/ Provinces applying for: 1- _____ License # _____

2- _____ License # _____

\$35 charge per state/ province

Total Charge: _____ Signature: _____

Pay by: Check: ____ Check # _____ (US Funds Only)

Credit Card: _____ Type: ____ Exp Date: _____

******In order to receive credit for continuing education, this form must be filled out in its entirety including name, address, payment information and your signature.*****