



Application to Registered Advanced Practitioner Training Program

Please print clearly

Name _____ Date _____

Address _____ City _____

Province _____ Postal Code _____ Email _____

Home Phone (____) _____ Business Phone (____) _____ Fax (____) _____

*Program Advisor _____ Signature _____
Printed name

*Program Advisor _____ Signature _____
Printed name

*Having a second Advisor is optional.

Enrollment Fee: \$100.00

Make your cheque or money order payable to Ortho-Bionomy Association of Canada. **Please do not send cash.** Mail your payment to the address below. Your Program Record form will be sent in the mail.

Documentation of Entrance Requirements:

1. Completion of Registered Practitioner Program

Date _____ Certificate Number _____

2. You must be a current Practitioner Member of the Association

Membership Number _____

