University of Integrative Medicine

Application for membership: Date_____

Name_____, Phone_____

Address_____

City_____ State_____, Zip_____

Date of Birth_____, SS#_____ Citizenship_____

Business Address_____

City_____ State_____, Zip_____

Mailing address Check one: Home Business

*Email address_____

EDUCATION:

School: _____, Address_____

From/to _____, Degrees_____, Date_____

School: _____, Address_____

From/to _____, Degrees_____, Date_____

INTERSHIP/RESIDENCES:

Location_____, Date_____

Location_____, Date_____

Location_____, Date_____

University of Integrative Medicine

CERTIFCATIONS:

Board_____, Date_____

Board_____, Date_____

Fellowships_____, Date_____

LICENSING:

Type_____ County/State_____ Date_____No._____

Type_____ County/State_____ Date_____No._____

It is my desire to become a member of the University of Integrative Medicine and I hereby make application for inclusion into the University of Integrative Medicine.

Signature_____, Date_____

Please scan and email back to info@uhss.nyc