



IOM Application

IOM Training Programs are designed specifically for physicians licensed to practice medicine under one of the following credentials: M.D., D.O., D.C. and DVM or health care professionals wherein Acupuncture and Herbal Medicine falls within their current scope of practice. Participants must be currently licensed and have access to an active clinical practice to participate.

Name (print clearly) _____

Current Credential: MD DO DC DVM Certifications: _____

Work Affiliation (name of employer) _____

Address _____ City: _____ State: _____ Zip _____

Phone Number _____ Fax Number _____ Email _____

- | | | |
|--|---|---|
| <input type="checkbox"/> Administration | <input type="checkbox"/> Geriatrics | <input type="checkbox"/> Renal Care |
| <input type="checkbox"/> Alternative medicine | <input type="checkbox"/> Home and Alternate Site Care | <input type="checkbox"/> Research |
| <input type="checkbox"/> Cardiology | <input type="checkbox"/> Internal Medicine | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Clinical Management | <input type="checkbox"/> Gynecology | <input type="checkbox"/> Veterinary |
| <input type="checkbox"/> Critical Care | <input type="checkbox"/> Neurology | <input type="checkbox"/> Large Animal |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Obesity | <input type="checkbox"/> Small Animal |
| <input type="checkbox"/> Drug-nutrient Interaction | <input type="checkbox"/> Oncology | <input type="checkbox"/> Exotic Animal |
| <input type="checkbox"/> Education | <input type="checkbox"/> Pediatrics/Neonatal | <input type="checkbox"/> Other (please specify) |
| <input type="checkbox"/> Gastroenterology | <input type="checkbox"/> Rehabilitation | _____ |

Specialty/Primary profession – Please indicate above which category best describes your specialty or primary profession.

Emergency Contact

Please list a personal contact in case of emergency:

_____	_____	_____
Name of Emergency Contact	How Related?	Phone Number

Referral Code: _____ (From Sponsor or Regional Leader if any)

License Number _____ **State** _____ **Date of Issue** _____

Check enclosed payable to: **International Institute of Oriental Medicine (IOM)**

Amount Encl: \$ _____ Charge: MasterCard Visa _____ - _____ - _____

_____	_____	_____
Authorizing signature	Expiration Date (Mo/Yr)	Security Code

I certify that the facts contained in this application and accompanying documents are true and complete to the best of my knowledge and understand that, if accepted, falsified statements shall be grounds for dismissal.

Signature _____ Date _____

Send to: IOM Attn: Janet L. Gao, VP Administration
9235 E. Harry ♦ Wichita, KS 67207 ♦ Phone: 316-618-8528
Toll Free: 1-888-717-7053 ♦ Fax: 316-691-8868