



IOM Online Master Level Program Application

The Master Level Traditional Chinese Medicine Online Training Program is designed specifically for physicians licensed to practice medicine under one of the following credentials: M.D., D.O., and D.C. or health care professionals wherein Acupuncture 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 ___Student ___TCM Practitioner Certifications: _____

Work Affiliation (name of employer) _____

Address _____ City: _____ State: _____ Zip _____

Phone Number _____ Fax Number _____ Email _____

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

Specialty/Primary profession – Please indicate 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)

Requirement - Please attach a copy of curriculum vitae including work experience and photocopy of your current, active license to the admission office

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

Amount Encl: \$ _____ Charge: ___ MasterCard ___ Visa Acct # _____ - _____ - _____

_____	_____	_____
Authorizing signature	Exp Date (Mo/Yr)	Billing Address if different from above

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: 316-691-8822
Toll Free: 1-888-717-7053 ♦ Fax: 316-691-8868