ASSOCIATION DES CHIROPRATICIENS DU QUÉBEC
7960, Metropolitan Blvd. East
Anjou (Québec) H1K 1A1
Telephone: (514) 355-0557 Fax: (514) 355-0070
E-Mail: acq@chiropratique.com Web: www.chiropratique.com

REGISTRATION FORM

Last name ____________________________ First name)s) ________________________

Work address ____
Number and Street

____
City Province Postal Code

____
Telephone Fax

Date of Birth _____________________________

Home address ____
Number and Street

____
City Province Postal Code

____
Telephone

Education: University ____

Chiropractic ____

Date of graduation ____

Years of practice in Québec ____________ Elsewhere _______ Newly Graduated ___

I, undersigned, holder of license number ___________ of the Ordre des chiropraticiens du Québec since __________________apply to obtain a membership with the Association des chiropraticiens du Québec, and agree to abide by its rules.

Signed in ____________________ on this______day of _____________________ 20___.

____
Signature

Please join:
Photo
Photocopy of diploma