



ASSOCIATION DES CHIROPRACTIENS DU QUÉBEC

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RE-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

Date of graduation _____

Ordre des chiropraticiens du Québec license number _____

I hereby apply for re-registration to the Association des chiropraticiens du Québec as of _____

Signed in _____ on this _____ day of _____ 20____.

Signature

**PLEASE RETURN THIS FORM
ALONG WITH THE REQUIRED FEES**