



TENNESSEE CHIROPRACTIC ASSOCIATION

48 HOUR CHIROPRACTIC
X-RAY TECHNOLOGY PROGRAM
Fall 2009 Course Application

Dates & Times (All hours must be attended for the full 48 hour requirement):

Session I	October 3, Saturday	8:00 - 6:00, with hour break - no lunch provided
	October 4, Sunday	8:00 - 3:00, with no break – boxed lunch provided
Session II	October 17, Saturday	8:00 - 6:00, with hour break - no lunch proved
	October 18, Sunday	8:00 - 3:00, with no break – boxed lunch provided
Session III	October 24, Saturday	8:00 - 6:00, with hour break - no lunch provided
	October 25, Sunday	8:00 - 3:00, with no break- boxed lunch provided
	Exam	following final session -Testing in meeting room

Location: TBA

Please Print or Type:

CA Name: _____ C.A. Home Phone: _____

CA Home Address: _____ C.A. Date of Birth: _____

CA City, State, Zip: _____

CA Personal E-mail: _____ Social Security #: _____

Employer Name: _____ Office Name: _____

Office Phone: _____ Office Fax: _____

Address: _____ C.A. Date of Hire: _____

City, State, Zip: _____

Please fax or mail your application and program fee prior to September 1, 2009.

Program Fee: \$1000.⁰⁰ **Exam Fee:** \$130⁰⁰ (Submitted with Exam Application)

Mail Application & Fee to: Tennessee Chiropractic Association
628 West Iris Drive Nashville, TN 37204
Phone (615) 383-6231 FAX (615) 383-6233

Charge My Application Fee:

MC/VISA #: _____ Exp. Date: _____

Print Name & Sign: _____

All fees are non-refundable & non-transferable. For further information about this program you may contact the TCA at (615) 383-6231. Please reply a.s.a.p. as the program date is fast approaching and space is limited!

AMERICAN CHIROPRACTIC REGISTRY OF RADIOLOGIC TECHNOLOGISTS
52 WEST COLFAX STREET, PALATINE, ILLINOIS 60067
PHONE / FAX: (847) 705-1178
www.acrrt.com

LIMITED PERMIT EXAM
RADIOLOGIC TECHNOLOGIST

Please indicate current AND
permanent address if different

APPLICATION FEE \$130^{.00}

FEE WILL NOT BE REFUNDED

PLEASE TYPE OR PRINT

LAST NAME FIRST NAME MIDDLE INITIAL

STREET ADDRESS CITY

STATE ZIP HOME PHONE

MALE ___ FEMALE ___ BIRTHDAY _____
MONTH/DAY/YEAR WORK PHONE

BIRTHPLACE _____
CITY STATE FAX

SOCIAL SECURITY NUMBER EMAIL

EMPLOYER

EMPLOYER ADDRESS CITY STATE ZIP

APPLICANT SIGNATURE DATE

NOTE:

THE LIMITED PERMIT EXAMINATION IS ADMINISTERED UNDER THE AEGIS OF THE AMERICAN CHIROPRACTIC REGISTRY OF RADIOLOGIC TECHNOLOGISTS. SUCCESSFUL COMPLETION AND ANY AWARD OF PROFICIENCY FOR THE LIMITED PERMIT EXAMINATION DOES NOT MEET THE CRITERIA FOR ACRRT CERTIFICATION OR MEMBERSHIP STATUS.