

PARKER

COLLEGE OF CHIROPRACTIC

CONFIDENTIAL APPLICATION

FOR A POSITION ON THE
ALUMNI ASSOCIATION
BOARD OF DIRECTORS

Return completed application by mail to:
PARKER COLLEGE OF CHIROPRACTIC
OFFICE OF ALUMNI RELATIONS
2500 WALNUT HILL LANE
DALLAS, TX 75229

By fax to:
(214) 902-3453

APPLICATION FOR DIRECTORSHIP
PARKER COLLEGE OF CHIROPRACTIC ALUMNI ASSOCIATION

BIOGRAPHICAL

Name: _____ Spouse: _____

S.S.N.: _____ Driver's License: _____

Date and Place of Birth: _____

U.S. Citizen: Yes No If naturalized give date: _____

CONTACT INFORMATION

Home address:

Street 1 _____

Street 2 _____

City _____ State _____ Zip _____

Telephone: _____ Fax: _____

Business address:

Clinic Name _____

Street 1 _____

Street 2 _____

City _____ State _____ Zip _____

Website: WWW. _____

Telephone: _____ Fax: _____

Preferred Email: _____

Cell phone: _____

EMPLOYMENT

If you are employed outside of chiropractic, please state the nature of your business:

Do you (or any of your family members or any of your business interests) currently have, or have had, any business relationships with Parker College of Chiropractic, or any member (or former members) of the Alumni Association, or the administrative staff?

Yes No Please describe the nature and duration of any relationship:

Please describe any issue which may create the appearance of a conflict of interest in your service on the Board: _____

Check *no more than four* (4) techniques you practice regularly;

- | | | |
|--|--|---|
| <input type="checkbox"/> Activator methods | <input type="checkbox"/> Diversified | <input type="checkbox"/> Myofacial |
| <input type="checkbox"/> Applied kinesiology | <input type="checkbox"/> Extremity adjusting | <input type="checkbox"/> SOT |
| <input type="checkbox"/> Bio Energetic Sync (BEST) | <input type="checkbox"/> Gonstead | <input type="checkbox"/> Upper Cervical |
| <input type="checkbox"/> Cranial | <input type="checkbox"/> Thompson | |
| <input type="checkbox"/> Cox/Flexion-distraction | <input type="checkbox"/> Other: _____ | |

Do you specialize in any areas such as Pediatrics, Geriatrics, Radiology, etc? If so, list your areas of specialization. _____

EDUCATION

Name of School or College	Location	Date of Admission	Date of Graduation	Degree(s)

Licenses of Certificates Held (Type, Issuing Agency and Date of Issuance):

Professional Memberships and Affiliations (*Spell out name of organization and start year*):
