NORTH AMERICAN INSTITUTE OF ORTHOPAEDIC MANUAL THERAPY, CLINICAL FELLOWSHIP PROGRAM

(Postprofessional Supervised Clinical Education Program for Physical Therapists)

REQUEST FOR FELLOWSHIP INFORMATION AND APPLICATION PACKAGE

Name		Designation	
Home address		Work address	
Home phone		Work phone	
Home fax		Work fax	
Home e-mail		Work e-mail	

PT training and further certifications

PT training: U of _		Year & degree	
PT license: State		PT license #	
Highest degree/year		Other certifications	
Andrews DSc student		Pacific/TWU t-DPT	

NAIOMT courses and examinations (attach sheet if preferred)

NAIOMT courses completed		NAIOMT exams completed	

Postprofessional orthopaedic PT experience (attach sheet if preferred)

Hours of orthopaedic clinical experience		Facility & locations	
OCS: Yes/No		Year of OCS	

I am considering applying to the NAIOMT clinical fellowship program, and requesting an information and application package

___ The clinical component would take place ___ at my work-site, ___ at the instructor's work-site, ___ at an independent site

___ I have discussed the fellowship with the following NAIOMT faculty and/or Clinical Fellowship Instructors (CFI): ________________

___ The ideal time to start the 12-36 month clinical fellowship would be (projected Fellowship start date) _________________________

___ I prefer to be contacted ____at home _____at work ____ by phone ____ by e-mail

I have reviewed the information on the NAIOMT web site – programs – clinical fellowship – FAQs. I also understand that my personal information is protected and will only be used by NAIOMT to contact me regarding the NAIOMT fellowship program or courses.

This request is for detailed fellowship information, the application package and a follow-up 20-minute telephone consultation

$45	*Clinical Fellowship Program: Request for fellowship information and application package* (Effective 7/1/10)	*#4051*

PAYMENT OPTIONS — *#1 preferred** Once the payment is made, **there is no reimbursement**

1	**Pay online*	*Click the link or copy/paste into your browser. If problems, e-mail admin@naiomt.com or telephone* *http://www.naiomt.com/vp-asp/shopdisplayproducts.asp?id=34&cat=Clinical+Fellowship+Program*
2	*Telephone your credit card info*	*1-800-706-5550 — mail box #1*
3	*Send a check*	*NAIOMT Inc., Attn Registrar, 1574 Coburg Rd, #129, EUGENE, OR 97401*