



"Practical Experience" Registration

Date Requested: _____ Today's Date _____

Amount Enclosed: \$ _____

Check one: THERAPY PRACTICUM ___ OFFICE PRACTICUM ___ BOTH ___

RSVP: Print page, complete application info, include check, mail to:

Shari Green, C.O.M.

4160 Illinois Route 83 - Suite 203 - Long Grove, Il. 60047

Application

Attendee Name _____

Profession/Credentials _____

I am an IAOM member Y___ N___ C.O.M. ___ R.D.H. ___ S.L.P. ___ M.D. ___
D.D.S. ___ C.D.A. ___ Other (please list) _____

Address _____

City _____ State _____ Zip _____

Email _____ Cellphone _____

For more info, contact Shari Green by phone @ 847-641-4444 or

You may email her at: thumblady@yahoo.com

I hereby confirm that the qualification/credentials I've listed above are true and verifiable. Signed _____ Date _____

Each course is IAOM approved for 16 IAOM/AGD CE's. Only one 16 hour practicum may be utilized towards IAOM CE's, but both may be taken together for practical purposes

Image of finger-sucking baby above courtesy of: Image Creator and FreeDigitalPhotos.net

