# Functional Cranial Release Institute

2033 Wood Street #210
Sarasota, FL 34237
Office 941.330.8553 FAX 941.330.9853
www.functionalcranialrelease.com

## APPLICATION FOR FCR COURSE

**Please complete all sections of this application. If a section is not applicable, mark it N/A. Please print or type information. If there are any questions, please contact a representative at the Functional Cranial Release Institute at the information listed above. Please FAX or mail completed application to the information listed above.**

### GENERAL INFORMATION

Name: _____
First Middle Last

Any other name under which you have been known? _____

Date of Birth: _____ Social Security Number: _____

NPI (National Provider Number): _____ UPIN: _____

Any Board Certifications: _____
(Divisions of ABMS, AOA, ABPS, ABOPM, or ADA)

### PRACTICE INFORMATION

Type of Practice: ❒Sole ❒Multispecialty ❒Group ❒Single Specialty Group ❒Hospital

Office name: _____

Address: _____

City:_____ State: _____ ZIP: _____

Office Voice: _____ Office FAX: _____

Office manager: _____

What hours are you available to see patients?

| | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
|---|---|---|---|---|---|---|---|
| From/To | | | | | | | |

Age group(s) treated: ❒0-11 years ❒12-18 years ❒19-40 years ❒41-65 years ❒over 65 ❒all ages

List foreign language spoken by provider: _____

### PARTNERS IN GROUP/CALL COVERAGE

Please list all members of your group and indicate if they collaborate with you regarding patient care.

| Name | Specialty | Patient Collaboration |
|---|---|---|
| _____ | | ❒Yes ❒No |

_____ ❒Yes ❒No

_____ ❒Yes ❒No

**EDUCATION AND TRAINING**

Please provide the following information and account for all time from highest degree completed to present date. A curriculum vitae that includes the information requested may be attached as a supplement. Please note that dates (mo/yr) must be in chronological order and work history must be identified from completion of education/training through present.

**Medical/Chiropractic/Osteopathic Institution**

Institution Name: _____

Address: _____

Telephone: _____ Academic Advisor: _____

Attended from (Mo/Yr): _____ to (Mo/Yr): _____ Degree Conferred: _____

**Fellowship/Post Graduate Studies**

Institution Name: _____

Address: _____

Affiliated Hospital/Clinic: _____Telephone:_____

Attended from (Mo/Yr): _____ to (Mo/Yr): _____ Type of Residency: _____

Did you complete the program? ❒Yes ❒No If no, when will you complete the program? _____

**Neurology Experience**

Do you have any post graduate training in neurology or neuroscience? ❒Yes ❒No
Have you completed any courses with the Carrick Institute? ❒Yes ❒No
If Yes, please list the courses you have completed: _____
Any experience with cranial therapy? ❒Yes ❒No
Do you have any experience completing a full neurological assessment? ❒Yes ❒No

**WORK/PRACTICE HISTORY**

Practice Name: _____

Address: _____

Telephone: _____ From (Mo/Yr): _____ To (Mo/Yr): _____

Practice Name: _____

Address: _____

Telephone: _____ From (Mo/Yr): _____ To (Mo/Yr): _____

If you need additional space, please attach on a separate sheet.

**LICENSURE/CERTIFICATION**
Please complete the following section. Do not leave any section blank.

Medical/Professional Licensure (list all states in which you currently hold a valid license to practice)

License Number: _____ State: _____

License Number: _____ State: _____

Certification: _____ State: _____

Certification: _____ State: _____

**PROFESSIONAL LIABILITY INSURANCE**
Your current professional liability insurance certification (face sheet) showing carrier name, liability limits, and expiration date of policy should be supplied.

**LEGAL/CRIMINAL ISSUES**
Have there ever been any misdemeanor or felony criminal charges brought against you? In answering this question, you may disregard most traffic offenses, but you should answer affirmatively if you have been charged with driving a motor vehicle under the influence of intoxicating substance(s), regardless of whether that charge was later reduced to a lesser offense. ❒Yes ❒No

Have you ever had your board certification administratively or involuntarily revoked, suspended, or failed to recertify? ❒Yes ❒No

Have you ever had any of the following items involuntarily denied, revoked, suspended, or not renewed, placed under probation, subject to disciplinary action or otherwise limited or curtailed; or have you voluntarily relinquished any item in anticipation of any of these actions; or are any of these actions pending with respect to any of the following items?

1. State license ❒Yes ❒No
2. DEA registration or other applicable narcotics registration ❒Yes ❒No
3. Hospital or other health care facility staff membership/privileges ❒Yes ❒No
4. Professional organization membership ❒Yes ❒No
5. Medicare, Medicaid, local, state, and/or federal government program participation ❒Yes ❒No
6. HMO, PPO, or other health plan participation ❒Yes ❒No
7. Other regulatory agency (OSHA, etc) ❒Yes ❒No

Do you have physical or mental health condition, with or without accommodation, which in any way impairs your ability to practice or in any way poses a risk of harm to your patients? ❒Yes ❒No

Are you currently involved in illegal/illicit drug usage? ❒Yes ❒No

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**If you asked "Yes" to questions 1 through 7, please explain completely on a separate sheet of paper and attach to this application.**

**MEDICAL MALPRACTICE CLAIMS HISTORY**

1. In the past five years has your professional liability insurance coverage ever been denied, cancelled, or not renewed? ❒Yes ❒No

2. Are you or have you ever been involved in a malpractice suit(s), grievance(s), filed with county or state medical society or licensing agency or arbitration proceeding(s)? ❒Yes ❒No

3. In the past five years has your current or any previous professional liability carrier ever made an out-of-court settlement or paid judgment of professional liability claim on your behalf? ❒Yes ❒No

**If you asked "Yes" to questions 1 through 3, please explain completely on a separate sheet of paper and attach to this application.**

**PROFESSIONAL REFERENCES**

Please provide the FCRI the names and contact information for three professional references that we may contact regarding your professional knowledge, skills, and abilities.

_____
Name Telephone Number

_____
Name Telephone Number

_____
Name Telephone Number

**STATEMENT OF INTEREST**

Please provide us with a brief statement of interest. Why are you interested in taking the course? What do you expect to gain from completing the course? Where do you so a clinical need for FCR in your practice?

_____

_____

_____

_____

## REGISTRATION INFORMATION

It is required that **half** of the total cost of the course fee be paid when the application is approved. The 50% payment will be used to advertise and promote the course for patients also arranging for proper accommodation and material. Due to this there will be no refund in any initial payment. If there is an emergency you can be approved to make arrangements to attend a future course. The balance of any remaining fees associated with this course are due on the first day of the course.

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Course registration fees are as follows:
If payment is received:

**March 12th-17th 2016 Course**
If payment is received:

- ❒ Before 12/12/16 $5995 US Dollars
- ❒ After 1/12/16 $6995 US Dollars
- ❒ After 2/12/16 $7995 US Dollars

**June 4th-9th 2016 Course**
If payment is received:

- ❒ Before 2/5/16 $5995 US Dollars
- ❒ After 3/5/16 $6995 US Dollars
- ❒ After 4/5/16 $7995 US Dollars

**Sept 10th-15th 2016 Course**
If payment is received:

- ❒ Before 6/10/16 $5995 US Dollars
- ❒ After 7/10/16 $6995 US Dollars
- ❒ After 8/10/16 $7995 US Dollars

**Credit Card Payment Authorization Form**
I authorize the Functional Cranial Release Research Institute (FCRRI) to charge my 2016 course fees to my credit card as indicated below:

❒VISA ❒MasterCard ❒American Express

Name as it appears on credit card: _____

Fee to Be Charged: $ (course registration): _____

Address of Cardholder: _____

Daytime Phone Number: _____

Credit Card Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Name of Registrant (if different from cardholder): _____

Expiration Date: _____ Cardholder Signature: _____

Payment of course fees and attendance of the course is NOT a guarantee that certification will be conferred. The student must demonstrate knowledge, skills, and abilities at the introductory level. If proficiency of knowledge, skills, and abilities are not demonstrated, it is at the instructor's discretion as to whether the student may remediate the course. A student may remediate the course twice within a lifetime in order to obtain certification with the Functional Cranial Release Institute (FCRRI).