

GETPROLO.COM

Prolotherapy Referral Network Application

Return completed application to: GETPROLO.COM

715 Lake Street, Suite 600, Oak Park, IL 60301 or fax to 708-848-7763

1. NAME:	
2. DEGREE(S): (Please list Degree, Major, University, Year)	
3. OFFICE ADDRESS: (Please include city, state, zip)	
4. PHONE/FAX:	Phone: _____ Fax: _____
5. E-MAIL ADDRESS (Work):	
6. WEBSITE(s):	
7. BOARD CERTIFICATIONS: (Please list specialty, date of certification, and location)	
8. MEMBERSHIP IN PROFESSIONAL SOCIETIES: (Please list name of society, date and membership)	
9. DESCRIBE YOUR EXPERIENCES IN PROLOTHETAPY. ARE THERE ANY AREAS YOU DO NOT TREAT?	

10. TRAINING IN PROLOTHERAPY (List course title, location, year attended)	
11. STATE LICENSURE (Include license #, state, and date of licensure. If licensed in more than one state, please list all but asterisk primary area of practice.)	
12. OTHER NOTABLE ITEMS YOU WISH TO INCLUDE	

State licensure as a medical doctor, doctor of osteopathy, Physican's Assistant, is required for membership. Please include a copy of your license and curriculum vitae.

I certify that I am licensed in the state of _____.

Name (print): _____

Signature: _____

Date: _____

**MAKE CHECKS PAYABLE TO BEULAH LAND CORPORATION.
 SEND \$1,500 (\$500 A YEAR FOR A MINIMUM 3 YEAR LISTING).**

**RETURN THIS FORM WITH YOUR CHECK BY MAIL TO
 GETPROLO.COM, 715 LAKE STREET, SUITE 600, OAK PARK, IL 60301**

**PHONE IN WITH YOUR CREDIT CARD 1-800-RX-PROLO
 OR INCLUDE IT WITH THIS APPLICATION**

CC TYPE: (circle one) AMEX VISA MC DISC

CC #: _____ EX. DATE: _____

Fees are non-refundable.