Application Form

TANAKA CHIROPRACTIC MISSIONS

Contact Information

Name	
Street Address	
City ST ZIP Code	
Date of Birth	
Country of Citizenship	
Cell Phone	
Work Phone	
E-Mail Address	

		DC license number	
Chiropractic College		Years in Practice	
Graduation Date		Malpractice company/ policy number	

Do you speak any secondary languages? If so, list: _____

Do you have a current passport?

____ Yes ____ No ____ Applying for it (Date of approval: _____)

Passport #: _____ & Expiration Date: _____

(Note: In accordance with Public Law 107-56, "The Patriot Act", please ensure that the expiration date on your passport is greater than 6 months past the return date of your travel.)

Do you have a portable table and other chiropractic equipment?

____ Yes ____ No

List equipment:

_____

_____

Please check all chiropractic techniques you use in patient care (Rate: 0 – No Experience, 3 – Poor Experience, 5 – Fair Experience, 7 – Good Experience, 9 – Excellent, 10 – Master)

____ Gonstead	____ Thompson	____ Activator
____ AK	____ NUCCA	____ Pettibon
____ Kinesiology	____ Extremity	____ CBP
____ Logan basic	____ ART	____ SOT
____ Diversified/Full Spine	____ Upper Cervical	____ Other: _____

Special Skills or Qualifications

List any additional certifications and /or special awards attained since chiropractic school. If you are a student or first year doctor, list how many chiropractic seminars, conferences and workshops you have attended.

Previous Volunteer Experience

List and describe your previous volunteer experience, especially with chiropractic.

Emergency Medical Information Form

Please complete so that health care providers can be aware of your personal health needs. This form must be completed and carried by all event participants.

Does the participant have:

Allergies	☐ Yes ☐ No	*If yes, please explain:*
Heart Issues	☐ Yes ☐ No	*If yes, please explain:*
Asthma	☐ Yes ☐ No	*If yes, please explain:*

Is the participant subject to:

Seizures	☐ Yes ☐ No	*If yes, please explain:*
Motion Sickness	☐ Yes ☐ No	*If yes, please explain:*
Fainting	☐ Yes ☐ No	*If yes, please explain:*
Upset Stomach	☐ Yes ☐ No	*If yes, please explain:*

Does the participant have a reaction to:

Bee Stings	☐ Yes ☐ No	*If yes, please explain:*
Penicillin	☐ Yes ☐ No	*If yes, please explain:*
Other Drugs	☐ Yes ☐ No	*If yes, please explain:*

Person to Notify in Case of Emergency

Name	
Street Address	
City ST ZIP Code	
Home Phone	
Work Phone	
E-Mail Address	

Initial _____ * REFUND POLICY: All fees are NON- REFUNDABLE in any circumstances. *****

Please note that should you choose to travel on days outside of the designated mission dates, you will be responsible for the additional associated costs.

Agreement and Signature

By submitting this application, I affirm that the facts set forth in it are true and complete. I understand that if I am accepted as a volunteer, any false statements, omissions, or other misrepresentations made by me on this application may result in my immediate dismissal.

Name (printed)	
Signature	
Date	

Our Policy

It is the policy of this organization to provide equal opportunities without regard to race, color, religion, national origin, gender, sexual preference, age, or disability.

Please mail your application form along with your non-refundable application fee of $25.00. Once your application is reviewed by the board, you will receive an email of acceptance. If you were to be accepted, your application fee will go towards your participant fee. Please write legibly.

Mail your application and check to:
Tanaka Chiropractic Mission
1800 Fair Oaks Ave., Suite C
South Pasadena, CA 91030

OR email your application to: info@tanakachiromissions.org and send check to above address.

Thank you for completing this application form and for your interest in volunteering with us.