APPLICATION FOR ABFP RE-CERTIFICATON

Please print or type.

NAME:____
LAST FIRST MIDDLE

MAILING
ADDRESS:____

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____
CITY STATE ZIP

OFFICE
ADDRESS:____

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CITY STATE ZIP

PHONE #'s_(____)________________________(____)________________
WORK FAX

E-MAIL: ____

ABFP IMPAIRMENT CERTIFICATE #_________________________

PLEASE PROVIDE THE FOLLOWING WITH THE APPLICATION:

1. COPY OF CURRENT CHIROPRACTIC LICENSE
2. COPY OF PROFESSIONAL LIABILITY DECLARATION PAGE
3. THE FOLLOWING FEES:
   Re-Certification Fee (non-refundable) __$150____

Mail your application, required documents and check (payable to ABFP)

ABFP
5001 E. 5th St.
Tucson, AZ. 85711
Voice: 520-323-2888 Fax: 520-323-9102 e-mail: sbaker@rinconchiropractic.com