



Bill Ritter, Jr.
Governor

Barbara J. Kelley
Executive
Director

REGISTRATION OF ACUPUNCTURE TRAINEES

INFORMATION REGARDING SUPERVISING ACUPUNCTURIST

NAME _____ LICENSE # _____
Last First Middle

ADDRESS(ES) OF TRAINING LOCATIONS(S)

Street Address City State Zip Code

Street Address City State Zip Code

INFORMATION REGARDING TRAINEE

NAME _____ DATE OF BIRTH _____
Last First Middle

SOCIAL SECURITY # _____

HOME ADDRESS OF TRAINEE:

Street Address City State Zip Code

PROPOSED TRAINING TIME FRAME:

DATE TRAINING BEGINS _____ ESTIMATE DATE TRAINING WILL END _____

The licensed supervising acupuncturist is responsible for notifying this office, in writing, within 10 days of the completed training or termination of this program.

I have read the rules for unlicensed persons in acupuncture training and agree to adhere to these rules. I state under penalty of perjury in the second degree, as defined in Section 18-8-503, C.R.S., that the information contained herein is true and correct to the best of my knowledge.

Signature of Supervising Acupuncturist

Date

Signature of Trainee

Date

