ACI
8033 Sunset Blvd., PMB 270
Los Angeles, CA 90046-2427

Auriculotherapy Certification Institute

Application Form for Auriculotherapy Certification (AFAC)

Name: ____

First Middle Last Degree *(Degree is used for certificate, optional)*

Please state your name in the above space exactly how you would like your name listed on your certificate. Please list below your primary address to be used in the ACI online directory. Mail will be sent to this address unless you specify another address.

Business Name:

Street Address:

City, State, Zip:

Work Phone and / or Fax:

Business E-mail:

Business Website:

Credential or License:

1. [ ] I **do** practice independently with a state health care credential / license ; Please furnish the following information:

State & Issuing Agency: ____

Field or Profession: ____

Current Credential / License No.: ______________________ *Expiration Date*: __________

2. [ ] I **do not** practice independently, but I work in association with a credentialed / licensed practitioner.

Have you ever been professionally disciplined, or had your credential / license revoked by a disciplinary agency, or, are you currently under review by a disciplinary agency? [ ] Yes [ ] No If yes, please attach a letter of explanation.

I am applying for ACI certification in: [ ] Auricular Acupuncture [ ] Auriculotherapy [ ] Ear Reflexology

In order to apply for the *Auricular Acupuncture Certificate,* one must have a degree from an acupuncture college, or an indication of acupuncture training as part of some other health care license. The *Ear Reflexology Certificate* is designed for individuals who practice using a reflexology or massage license with non-invasive procedures. ACI does not discriminate among applicants as to age, gender, race, religion, national origin, handicap status, marital status or sexual orientation. ACI has the prerogative to establish and reverse polices / procedures, including fees and dates for recertification, as deemed appropriate.

Name listed on Credit Card or Check or PayPal: ____

Total Amount of Payment: $ __________ Date of Payment: __________ Payment by [ ] Check [ ] Credit Card [ ] PayPal

* You may alternatively pay with a credit card over the Phone to (323) 656 – 2084 or by Fax to (323) 656 – 2085.

I agree to pay to ACI the total amount according to credit card issuer agreement:

Credit Card: [ ] Visa ; [ ] Mastercard ; [ ] Discover Expiration Date: ________________ CC#: _______

I understand and agree that ACI and its affiliates assume no responsibility for my health care practice actions or activities. I practice at my own risk and hereby release ACI from any and all liability for any practice decisions that I make. I hereby give permission to the ACI to contact individuals or agencies for verification of the information submitted on this form. I understand that any falsification of information is grounds for not granting, or for loss of ACI certification. I understand that in all instances, for both the ACI written and practicum exams, fees are non-refundable.

Signature:____ Date:______________