

# SOTO-USA SEMINAR REGISTRATION FORM

Today's Date \_\_\_\_\_

Name \_\_\_\_\_

D.C.  Chiropractic Student  SOTO-USA Member  NYCC Graduate  ICPA Member

Office \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone 1 \_\_\_\_\_  Office  Home  Cell  Fax

Phone 2 \_\_\_\_\_  Office  Home  Cell  Fax

Phone 3 \_\_\_\_\_  Office  Home  Cell  Fax

Phone 4 \_\_\_\_\_  Office  Home  Cell  Fax

Email \_\_\_\_\_

Chiropractic License No. \_\_\_\_\_ State \_\_\_\_\_

Seminar	Dates	Location	Fee

\_\_\_\_\_ Seminars @ \_\_\_\_\_ ea. = \_\_\_\_\_  
 \_\_\_\_\_ SOTO DC Membership @ 150.00 ea. = \_\_\_\_\_  
 \_\_\_\_\_ SOTO Student Membership @ 90.00 ea. = \_\_\_\_\_  
 Total Fee: \_\_\_\_\_

METHOD OF PAYMENT:  Mastercard  Visa  Check  Money Order

Card Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Name on card: \_\_\_\_\_ Security Code: \_\_\_\_\_

Billing address: \_\_\_\_\_

Notes:

**Scan and email this form to [wellesleychiro@verizon.net](mailto:wellesleychiro@verizon.net)  
 or FAX it to (508) 651-2209  
 Any questions, call (781) 237-6673**