Sutherland Cranial Teaching Foundation, Inc.

Please complete and send with check or credit card information to:
Susan LeMaster – 11637 SE 34th Ave, Milwaukie, OR 97222
Email: lemastersctf@gmail.com PHONE: 971-212-1096 FAX: 503-905-6050

Name:________________________________Title: D.O. /PGY1/ PGY2/ PGY3 /MS4 /MS3 /MS2 (circle)

Address:___________________________________City State Zip_______________________________

Day Phone: __________________ Mobile Phone:_______________________

Email:_______________________________

SCTF is utilizing Constant Contact for our course advertising along with the OCA Journal/Letter, and at the AAO Convocation. It is necessary to have your permission for me to add you to our list. **YES** you MAY add me to your SCTF Mailing List. (Initials) _____ NO thank you ____

Name & Dates of Course Desired: ____

AOA # (if applicable): ___________ Year of Medical Graduation:___________
Year & Type of Residency Completed:______________________________________
Years in Practice:_______

Advanced Degrees (BS, MA, Masters, PhD, DO, MD,) Institution & Year:
Degree:______Year:__________Institution:__________________________
Degree:______Year:__________Institution:__________________________
Degree:______Year:__________Institution:__________________________

Previous OCF Courses: Fill in all that apply. If you need space for additional data, please provide an attachment.

SCTF Basic Courses:
Year:____ Location:___________________ Hours:____ Course Director:__________________

Year:____ Location:___________________ Hours:____ Course Director:__________________

Other OCA Courses:
Year:____ Location:___________________ Hours:____ Course Director:__________________

Year:____ Location:___________________ Hours:____ Course Director:__________________

Year:____ Location:___________________ Hours:____ Course Director:__________________

OCF Study Groups, Mentors, and other pertinent information:
____
____
____

___ Check enclosed (see website for course cost)www.sctf.com
___ MC/Visa ____ Code ____ Exp date:________