Sutherland Cranial Teaching Foundation, Inc.

2024 FACE Course Application

Applicant Name: _____ ☐ D.O. ☐ M.D.

AOA # _____

Address:_____

Day Phone: _____ Cell Phone: _____

Email Address:_____

May SCTF add you to our mailing list for course updates and announcements? ☐ Yes ☐ No

Medical School & Year of Graduation: _____

Year & Type of Residency Completed: _____

Have you previously completed an SCTF Face Course? If so, when?_____

If not, then Do You Qualify? To take this course, you are required to have a minimum of 3 years clinical practice (residency counts towards one of those three years) and at least 2 basic courses of Osteopathy in the Cranial Field, one of which must have been an SCTF Basic course.

Actual years in Practice *(minimum of 3 years clinical practice required)*: _____

Previous OCF Basic Courses *(at least 2 basic courses are required, one of which must be **SCTF**):*

SCTF Basic Courses:

Year:_____ Location:_____ Hours:_____ Course Director: _____

Year:_____ Location:_____ Hours:_____ Course Director: _____

Non-SCTF Basic Courses:

Year:_____ Location:_____ Hours:_____ Course Director: _____

Year:_____ Location:_____ Hours:_____ Course Director: _____

Other OCF Courses, Study Groups, Mentors, and Other Pertinent Experience:

_____

_____

Food: ☐ I eat anything!

☐ I eat most anything but avoid: _____

☐ I have serious reaction(s) to: _____

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Applicant Name: _____

If approved, how will you be providing payment?

- ☐ Check
- ☑ Credit Card: Mastercard / Discover / VISA

  Card # _____ Exp. Date: _____ CVV: _____

  Name on the Card: _____

CANCELLATION FEE: A cancellation fee of $150 is applied from the time of registration until 6 weeks before a course. If cancellation occurs less than 6 weeks before the course, the course fee will be retained but can be applied to a future course.

☐ Liability Release: (Required) I acknowledge that I have read the Liability Release and agree to the statement. It is the responsibility of ALL participants to use the information provided within the scope of their professional license or practice.

☐ Cancellation Policy: (Required) I have read and understand the CANCELLATION POLICY above.

Signature: _____ Date:_____

Please complete and send to:

Email: arausch@sctf.com
or mail to:
Amber Rausch, SCTF c/o AAO
3500 DePauw Blvd., Suite 1100, Indianapolis, IN 46268
Website: sctf.com