Secretary of State
Office of Professional Regulation

CHIROPRACTOR
Verification of Education

Complete the applicant section of this form and forward to the school where you received your education.

Applicant:

First Name		MI	Last Name & Title (Jr., Sr., II, III, etc.)	Former/Maiden
Mailing Address:	P.O. Box			
	Street/Apt #			
	City/State/Zip			
	Country			

I hereby authorize the_____(name of the school) to furnish to the Vermont Office of Professional Regulation the information requested below.

Signature_____Date:_____

TO BE COMPLETED BY THE INSTITUTION GRANTING DEGREE(S): The school/college must send this form directly to the Board at the address above.

Name of Applicant:			
Name of Institution:			
Address (Street/City/State/Zip):			
Graduation Date:		**Degree Earned:**	
Signature of Authorized Agent		**Date**	/ /
Title		**Phone #**	

(Seal)