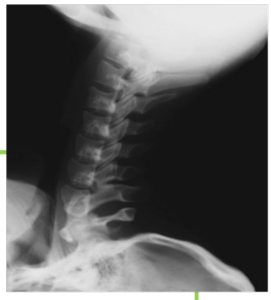
ILLINOIS PRAIRIE STATE CHIROPRACTIC ASSOCIATION

Chiropractic Assistant's

Radiographic Technician Program

with Patty Litwiler-Britt, ARRT

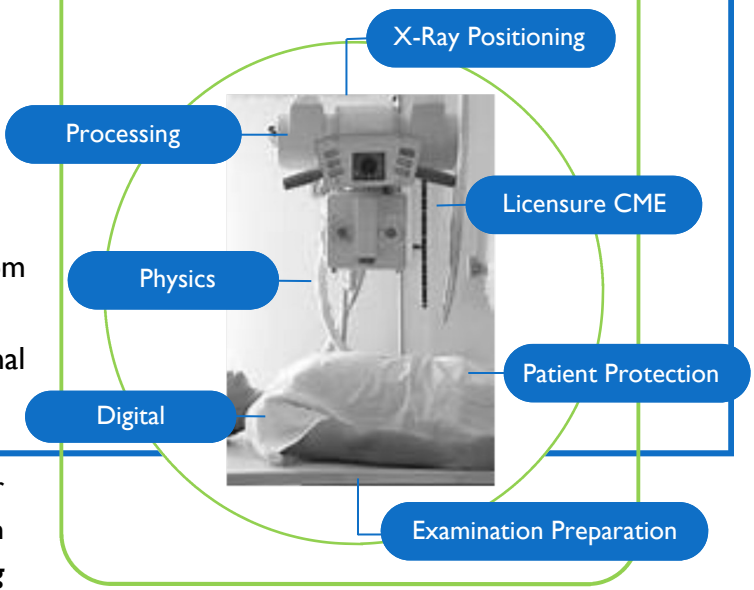


The Illinois Prairie State Chiropractic Association presents a 42 hour course to train chiropractic assistants in the skill of taking spinal x-rays.

March 25-26, 2017
April 29-30, 2017
June 10-11 2017

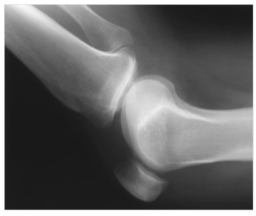
Times:
Saturday 9:00 am - 6:00 pm Sunday 9:00 am - 2:00 pm

Location:
Stout Chiropractic Office, 208 Parkinson Street, Normal IL 61761



Under the Illinois Radiation Act, a licensed Chiropractor may register an assistant as a "Student-In-Training" in radiology. ***(Any person in a chiropractors office taking x-rays MUST be licensed/certified by the state of Illinois.)***

The student is to be trained over 16 months in which he/she is able to take x-rays under the doctor's license.



Cost:	***Members***	***Non***
All Sessions	$450	$635
CA CME	$225	$265
DC CME	$265	$350

Within 8 months of **application to the state of Illinois** the student must take a state exam in radiation physics and patient protection followed by an examination in a specialty selected.

Upon successful completion of the state examination the student will be certified by the Illinois Department of Nuclear Safety as a "Limited Radiographic Technician".

IPSCA Illinois Prairie State Chiropractic Association

Complete & Return Registration Form To: IPSCA, PO Box 4174, Rock Island IL 61204
Phone: 309-732-3233 Fax: 309-732-3227 email: jreyes@illinoischiropractors.org

Cancellation Policy: Registration fees will be refunded less a $35 processing fee for cancellations **POSTMARKED 5 BUSINESS DAYS PRIOR** to program. A request for refunds received after the 5 day deadline **WILL NOT** be refunded.

Name: _____ CA/DC Sessions: __ All Sessions or Single Session Date: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Fax: _____ Email: _____

Method of Payment: __ Check __ Discover __ MasterCard __ Visa Amount Paid: _____

Credit Card #: _____ - _____ - _____ - _____ Expir. Date: _____ CVS: _____

Authorized Signature: _____ Date: _____

Billing Address (If different): _____