ILLINOIS PRAIRIE STATE CHIROPRACTIC ASSOCIATION

Chiropractic Assistants

Radiographic Technician Program

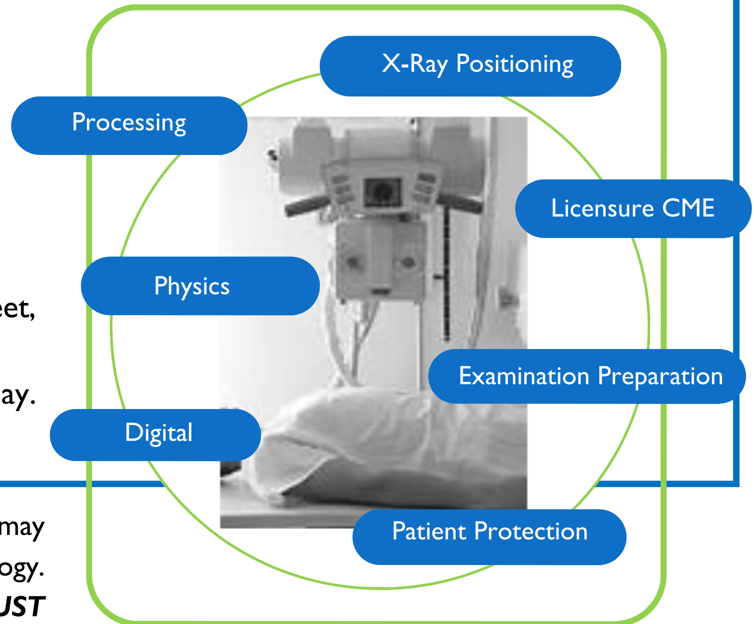
Spinal X-Ray Procedures, Positioning, Safety, & Licensure Preparation

March 23-24, 2019
April 27-28, 2019
June 22-23, 2019

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

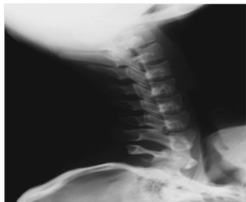
Location: IPSCA Central Office, 4330 11th Street, Rock Island IL 61201 309-732-3233

Lodging: Holiday Inn (closest), 1-888-holiday. Various other hotels within minutes of site.



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	$200	$265
DC CME	$250	$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".

Register online or 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 Online registration: www.illinoischiropractors.org

Cancellation Policy: Registration fees will be refunded less a $50 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): ______________________