



**Connecticut Society of Acupuncture and Oriental Medicine
2010 Application Form**

Name _____
Address _____
City _____ State _____ Zip _____
Home Phone _____ Cell _____
E-Mail _____

Office Information:

Business Name _____
Address _____
City _____ State _____ Zip _____
Phone () _____ Fax () _____
E-Mail _____
Website _____
School Graduated _____
Year of Graduation _____
NCCAOM Certificate # _____ Year exp _____
Certifications/licenses _____

CT License # _____ Expiration date _____

Please indicate any above information you do not want published
outside of the CSAOM association. **(DNP)**

Dues: Practitioners \$100.00 *** Student \$40.00

Payable to **CSAOM** -Send with a **COPY OF YOUR LICENSE** to:

Christine Rizzo
8 Elm Street #3
Deep River CT 06417

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PAID
WEBSITE