CFR SEMINAR REGISTRATIONFORM

STOP: This Is Mandatory Before Proceeding With The Registration
Please provide a copy of your of DC license or College Graduation Certificate.

NAME: _____
(As you want it to appear on our website and your CFR graduation certificate)

OFFICE NAME: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

CELL PHONE:_____**WK PHONE**: _____

E-MAIL: _____

WEBSITE: _____

DC LICENSE NO.:_____ **STATE** _____
(Please provide a copy of your current license)

CFR ADVANCED SEMINAR

Feb 27, 2027

Saturday: 9 AM - 6 PM

LOCATION:

TBD
Spokane WA.

FREE REGISTRATION FOR:
CFR Elite Members and CFR Dr's only

Billed to: Chiropractic Rocks, LLC

PAYMENT METHOD_____VISA_____MC_____AMEX_____ DISCOVER

CREDIT CARD NO. _____

Exp Date:_____ **3 or 4 digit Security Code:**_____ **Billing Zip Code** _____

A 3.5% Service Charge Will Be Added to Registration to Cover Credit Card Processing Fees.

SIGNATURE_____ **DATE** _____

Return completed form to:
dr.adam@cranialfacialrelease.com
U.S. Tel: (818) 427-1312
Thank you!

Deposits and registration fees are non-refundable, but can be applied to future seminars.