HEALTHCARE PROFESSIONAL PROGRAM APPLICATION

Thank you for your interest in our Healthcare Professional Program! Please complete this form and submit to us along with a copy of your healthcare professional license/certificate/diploma.

Fax: (520) 395-9491 • Email: ericka@icahealth.com

PRACTITIONER INFORMATION

Name: ______________________________

Position/Title: ______________________________

Practice/Business Name: ______________________________

Nature of Practice/Business:

Medical doctor | Naturopathic Doctor | Nurse/Nurse Practitioner
Chiropractor | Pharmacist/Pharmacy | Compounding Pharmacy
Health Food Store | Healthcare Provider | Other: __________

Specialty: ______________________________

Phone Number: ______________ **Fax Number:** ______________

Email Address: ______________ **Website:** ______________

How Did You Hear About Us?

Conference | Professional Colleague | Patient
Dr. Wilson's Adrenal Book | Internet | Other: __________

Do You Sell Products Online?

YES NO Business website: ______________

Shopping Service e.g. Amazon.com Other: ______________

Billing Address: Street: ______________ Suite or Building Number: __________

City: __________ State: ______ Zip/Postal Code: ________ Country: __________

Shipping Address: Street: ______________ Suite or Building Number: __________

☐ Same as Billing City: __________ State: ______ Zip/Postal Code: ________ Country: __________

Optional Website Referral Program

adrenalfatigue.org

If you would like to be included in our Website Referral Program on adrenalfatigue.org, please fill out all information as you would like it to appear on our websites. Any information you would not like to include, please leave blank. If you prefer not to be listed, you may skip the following portion of the application.

Practice/Business Information ☐ Same as Billing Address above ☐ Same as Shipping Address above

Street: ______________________________ **Suite or Building Number:** __________

City: __________ **State:** __________ **Zip/Postal Code:** ______ **Country:** ________

Phone Number: ______________ **Fax Number:** ______________

Email Address: ______________ **Website:** ______________

I give ICA Health, LLC permission to list the above information on their websites.

Sign: ______________________________ **Date:** __________

Position/Title: ______________________________