
AMERICAN ALTERNATIVE MEDICAL ASSOCIATION

Application for Fellow Certificate

Mail to:

2200 Market Street, Suite 803
Galveston, TX 77550-1532
(888) 764-AADP or Fax (775) 703-5334

EVALUATION APPLICATION

ONLY TYPED OR PRINTED APPLICATIONS ACCEPTED

Whenever additional space is required, please attach additional page.

Name: _____
Last First Middle

Current Home Address: _____

City/State: _____ Zip: _____

Business Address: _____

Home Telephone: () _____ Office: () _____

Birthdate: _____ SS#: _____ Sex: M _____ F _____

Place of Birth: _____
City County State Country

Height: _____ Weight: _____ Color Hair: _____ Color Eyes _____

Citizen or legal resident of what country: _____

State or Country in which you are practicing or plan to practice: _____

EDUCATION

COLLEGE GRANTING DOCTORATE

Name	Address	From/To	Degree(s)	Date
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_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

HOLISTIC EDUCATION/TRAINING

School	Certificate(s)	Date
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_____	_____	_____
_____	_____	_____

Other Certificates: _____