



LEARNER EDUCATION

120 S. Spalding Drive • Suite 400 • Beverly Hills, CA 90212  
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**ACUPUNCTURE ORTHOPEDICS OBSERVATION RECORD**

TYPE OF FACILITY

- |   |   |                                     |
|---|---|-------------------------------------|
| <input type="checkbox"/> CHIROPRACTIC     | <input type="checkbox"/> NEUROLOGY            | <input type="checkbox"/> ORTHOPEDIC |
| <input type="checkbox"/> OSTEOPATHY       | <input type="checkbox"/> PHYSIATRY            | <input type="checkbox"/> RADIOLOGY  |
| <input type="checkbox"/> RHEUMATOLOGY     | <input type="checkbox"/> DENTISTRY            | <input type="checkbox"/> PODIATRY   |
| <input type="checkbox"/> ANAESTHESIOLOGY  | <input type="checkbox"/> OCCUPATIONAL THERAPY |                                     |
| <input type="checkbox"/> PHYSICAL THERAPY | OTHER: _____                                  |                                     |

NAME OF **CLINICIAN/FACILITY**: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE: ( ) \_\_\_\_\_ FAX: ( ) \_\_\_\_\_

NAME OF **OBSERVER/STUDENT**: \_\_\_\_\_

DATE ATTENDED THIS FACILITY: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ # OF HOURS: \_\_\_\_\_

**TO BE COMPLETED BY CLINICIAN:**

I hereby certify that the above-named Acupuncture Orthopedics student has observed the above number of hours in my facility today.

Signed: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

If you have any questions, please contact Fred N. Lerner, D.C., Ph.D., F.A.C.O. at (800) 838-8584.