IOWA CHIROPRACTIC SOCIETY

District Meeting Continuing Education Attendance Reporting Form

ICS District: _____Date: _____

Location of Meeting: _____

Name of CE Program: _____

Name of Program Presenter: _____

Duration of CE Program: Start: _____ End: _____ Total Minutes: _____

By signing this form, you attest that you have attended this CE program in full. If you came late or plan to leave early, please indicate on form the total number of hours (minutes) you attended.

Name (Please Print Legibly)	**License Number**	**Phone Number**	**Hrs/Min attended**