The Ola Grimsby Institute, Inc.
International Post Professional Consortium in Orthopedic Manual Therapy
4420 Hotel Circle Ct., Suite 210
San Diego, CA 92108
www.olagrimsby.com
Phone (800) 646-6128 • (619) 298-4116 • Fax (619) 298-4225

Application Fee: $75.00

Post-Entry Level Application For Admissions

____
Application for (City of Interest)

______________________________ ______________________________
Social Security Number Birth Date

____
First Name Middle Name Last Name

____
Address

____
City State Zip

____
Home Phone Work Phone Cell Phone

____
Email Address

Program Applying To (check one):

- ❑ Clinical Certification Program
- ❑ DMT Residency 8 Months Year I (Doctor of Manual Therapy)
  (Completion of CCP Program is required)
- ❑ DMT Independent Study Year I (Doctor of Manual Therapy)
- ❑ DMT On-Site Residency Year I (Doctor of Manual Therapy)
- ❑ Fellowship Program Year II (Completion of Year I Program is required)
- ❑ Ph.D. Program

Check categories that apply (optional):
(The Ola Grimsby Institute does not discriminate on the basis of race, color, creed, sex, sexual orientation, age, religion, physical disability, national origin, or socio-economic background.)

❑ Male	❑ Female	
❑ Hispanic	❑ African-American	❑ Asian-Pacific Islander
❑ Caucasian	❑ Native American	❑ Other_______

Education:
(In order to apply, you must have a physical therapy degree. Please submit written confirmation that you successfully passed the National Physical Therapy exam. Please request transcripts to be sent from all colleges that you attended that are listed below. Use additional paper if necessary.)

____
Name of high school | City | State

____
Degree | Date of graduation

____
Name of college/university | City | State

____
Degree | Date of graduation

____
Name of college/university | City | State

____
Degree | Date of graduation

____
Name of college/university | City | State

____
Degree | Date of graduation

Professional Education:

Post Graduate:

____
Description | Training Center | Dates | Designation

Certificate:

____
Description | Training Center | Dates | Designation

Workshops:

____
Description | Training Center | Dates | Designation

Specialties:

____
Description | Training Center | Dates | Designation

Certifications and State Licenses:
(Please attach copies.)

Document State Date Number

Document State Date Number

Document State Date Number

Document State Date Number

Document State Date Number

Professional Work History:
(Begin with current employer. Use additional paper if necessary.)

Employer Start Date End Date Supervisor

Title and Work Description:

Address

City, State Zip Phone Fax

Employer Start Date End Date Supervisor

Title and Work Description:

Address

City, State | Zip | Phone | Fax

Employer | Start Date | End Date | Supervisor

Title and Work Description:

Address

City, State | Zip | Phone | Fax

Additional Information Required:
(not required for Clinical Certification applicants)

- ❑ On separate paper, please provide a handwritten autobiographical statement. Include your personal and professional goals, the reasons you are interested in the programs, and the qualities you feel you possess in order to be successful.
- ❑ Please include a recent photograph of yourself.
- ❑ References from two employers or professional associates.
- ❑ Official transcripts from prior school(s) or universities.
- ❑ Copy of your current Physical Therapy License.

The above information is true and accurate to the best of my knowledge:

Student Signature **Date of Application**