

PROFESSIONAL REFERENCES

Please list the names and contact information of four (4) professional colleagues or peers who are familiar with your work, credentials, and integrity as a practitioner over the last five years. By providing this information you are authorizing permission for OWA to contact for reference. _____ (initial please)

APPLICANT NAME:

Reference # 1: _____

Professional Relationship: _____
(To Applicant)

Profession: _____ Business Name: _____

Business Address: _____
City State Zip

Day Phone: _____ e-mail address: _____

Reference # 2: _____

Professional Relationship: _____
(To Applicant)

Profession: _____ Business Name: _____

Business Address: _____
City State Zip

Day Phone: _____ e-mail address: _____

Reference # 3: _____

Professional Relationship: _____
(To Applicant)

Profession: _____ Business Name: _____

Business Address: _____
City State Zip

Day Phone: _____ e-mail address: _____

Reference # 4: _____

Professional Relationship: _____
(To Applicant)

Profession: _____ Business Name: _____

Business Address: _____
City State Zip

Day Phone: _____ e-mail address: _____

This application is the first step to begin the processing of your membership in Online Wellness Association. If you have any questions, please call the OWA office at (541) 767-6890.

www.onlinewellnessassociation



Online Wellness Association.com

Applicant _____

Attach page 1 & 2 of application for membership

THIRD PARTY BACKGROUND CHECK

Name & Address of Information Source – Please Print or Type:

Relationship to Applicant:

Douglas International
P.O. Box 1524
Veneta, OR 97487

Third Party Agency for
Background Check

I hereby authorize the above named source to release or disclose to Online Wellness Association the following information for the purpose of processing my application for membership as of the date signed below:

I understand that my background check will be completed by a third party company upon receipt of this release including, but now limited to, a criminal background check, and credential check, which is accessing information of public records. All findings of this third party will be kept completely confidential and in the possession of third party. OWA will only receive communication that I have either passed the background check or that the findings require further consideration.

I authorize the use of a telefax or photocopy of this form for the release or disclosure of the information described above.

I understand that this authorization, except for action already taken, may be voided by me at any time. If I do not void this authorization, it will automatically end when a final decision is made on my application for membership.

Signature of Applicant:

Date:

Street Address:

Telephone Number (area code):

City, State, Zip Code:

e-mail address: