



FRANCHISE APPLICATION

*Interested in a
UCHC Office Conversion*

*Interested in a
New Office Franchise*

*Interested in a
New Office Trial Franchise*

What Upper Cervical Technique do you use? _____

Are you certified in this technique? _____ By who? _____ When? _____

What other techniques do you use in your office? _____

Do you adjust anything below Axis? _____ What levels? _____

Do you use Physical Therapy in your office? _____ If so, what kind? _____

Do you take X-rays? _____ Do you use instrumentation? _____ If so, what kind? _____

Name: _____ Male Female

Home address: _____

City, state, zip: _____ Country: _____

Country: _____

Practice name (if applicable): _____

City, state, zip: _____ Country: _____

Home telephone: _____ Business phone: _____ Fax number: _____

Email address: _____

Social security number: _____

Date of birth: _____

Citizenship: _____ How long have you lived in the United States? _____

Are you married? Yes No If yes, spouses name: _____

Do you own your current practice? Yes No

Are you an associate doctor? Yes No

Are you an independent contractor? Yes No

Will you have other owners/partners? Yes No

If yes, who are they? _____ (Each of these individuals must submit a separate, completed application.)

HAVE YOU EVER:	Y	N
Filed bankruptcy	—	—
Had a real estate loan foreclosed	—	—
Been reported to your local chiropractic board	—	—
Had legal action taken against you	—	—
Been convicted of an indictable offense	—	—
If yes, please explain: _____		

EMPLOYMENT: (Begin with current status)
Practice name: _____
City: _____
Position: _____
Employed from/to: _____
Practice name: _____
City: _____
Position: _____
Employed from/to: _____
Practice name: _____
City: _____
Position: _____
Employed from/to: _____

EDUCATION: (Post-secondary only)
DC college name: _____
Major: _____
Degree: _____
Year completed: _____
University name: _____
Degree: _____
Year completed: _____

ASSETS:	Amount
1. Checking account(s) balance (include verification)	
2. Saving(s) account(s) balance (include verification)	
3. U.S. Government securities (include verification)	
4. Listed securities (include verification)	
5. Unlisted securities (include verification)	
6. Accounts and notes receivable good	
7. Accounts and notes receivable doubtful	
8. Real estate owned (home)	
9. Real estate owned (other)	
10. Real estate mortgages receivable	
11. Automobiles and other personal property	
12. Accumulated bonus net of taxes (include verification)	
13. Income tax refund due	
14. Other assets (readily convertible to cash-list)	
15. 401(k) pension plan	
TOTAL ASSETS:	
LIABILITIES:	Amount
1. Charge account(s)/credit card(s) balance	
2. Notes payable to banks, secured	
3. Notes payable to banks, unsecured	
4. Notes payable to relatives	
5. Notes payable to others	
6. Accounts and bills due	
7. Unpaid income tax	
8. Other unpaid taxes and interest	
9. Real estate mortgages payable (home)	
10. Real estate mortgages payable (others)	
11. Other debts (itemized)	
12. _____	
13. Margin Accounts	
TOTAL LIABILITIES:	
NET WORTH:	

Upper Cervical Health Centers®, LLC, (UCHC), does not guarantee the financial performance of any health center or franchised operation. The decision to become an *Upper Cervical Health Centers®*, LLC, franchisee must be based on the applicant's independent research and analysis. I hereby certify that all information contained herein is current and within 30 days and accurate to the best of my knowledge. I further give *Upper Cervical Health Centers®*, LLC, permission to obtain credit reports which will be used in the health center opening approval process.

Signature: _____ Date: _____

EVERYTHING THAT I HAVE STATED IN THIS APPLICATION IS TRUE AND ACCURATE, AND I UNDERSTAND THAT THE INFORMATION PROVIDED BY ME WILL BE RELIED UPON BY THE FRANCHISOR [UPPER CERVICAL HEALTH CENTERS, LLC. ("UCHC")]. I understand that the granting of a Franchise is at the sole discretion of the Franchisor UCHC and that acceptance of this Application is not a granting of a franchise. Franchises are granted only by execution of a written Franchise Agreement.

I understand that any information I received from the Franchisor UCHC or from any employee, agent, or franchisee of the Franchisor is highly confidential ("Confidential Information"), has been developed with a great deal of effort and expense to the Franchisor UCHC, and is being made available to me solely because of this Application. I agree that I shall treat and maintain all Confidential Information as confidential, and I shall not, at any time, without the express written consent of the Franchisor UCHC, disclose, publish, or divulge any Confidential Information to any person, firm, corporation or entity, or use any Confidential Information, directly, for my own benefit or the benefit of any person, firm, corporation or other entity, other than for the benefit of the Franchisor UCHC.

I authorize the release of any information deemed necessary by the Franchisor UCHC to verify any and all of the information contained herein. This authorization for release of information includes but is not limited to matters of opinion relating to my background, mode of living, credit worthiness, character, ability, reputation and past performance. I understand that I have a right upon written request to the franchiser UCHC to provide information regarding the nature and scope of such investigation. I authorize all persons, schools, companies, corporation, credit bureaus, and law enforcement agencies to release such information without restriction or qualification to investigatory parties selected by the Franchisor UCHC, any of its officers, agents, employees and servants. I voluntarily waive all recourse and release them from liability for complying with this authorization. This authorization and release shall apply to this as well as any future information request. I authorize that a photocopy or facsimile of this authorization and release be considered as valid as the original.

DATE

PRINT NAME (FIRST MIDDLE INITIAL AND LAST)

SIGNATURE IN INK

Office Photographs Needed:

As part of the application process, we require photographs of your current office. Please provide photographs of the following:
Exterior signage, reception area, front desk, resting area, exam room, X-Ray room, & bathrooms.
You may also email the photographs in .JPG format to marketing@uchca.com.

Return this application & photographs of your current office to:

Upper Cervical Health Centers
10816 Black Dog Lane, Suite 120, Charlotte, NC 28214
(704) 394-5007 Fax: (704) 394-5009

REFERENCES

Please provide a list of references below, include a contact phone number and/or email address

Reference 1

Reference 2

Reference 3

Reference 4

Reference 5
