Kentucky Association of Chiropractors

2027 LB Payne Insurance Seminar

Saturday, January 23 & Sunday, January 24, 2027

Marriott East • 1903 Embassy Square Blvd, Louisville, KY 40299

More info: thekac.org/LBP

Doctor Registration Form

MAIL • FAX • EMAIL

DOCTOR INFORMATION

First Name | Last Name | Credentials (e.g., DC)

KY Chiropractic License # | Email | Phone

Office / Mailing Address | City | State | ZIP

REGISTRATION TYPE & DATES

CHECK ONE	FULL WEEKEND (12 CEs)	ONE DAY (SAT 7 / SUN 5 CEs)
KAC Ultimate Member	☐ $0 included in membership	☐ $0 included
Enhanced Member, using Enhanced CE hours	☐ 12 hours ($0)	☐ 7 hrs Sat / 5 hrs Sun ($0)
KAC Member*	☐ $250	☐ $159
Nonmember	☐ $399	☐ $329

*Enhanced, General, 1st/2nd/3rd Year, Life & Out-of-State members. All registrations include exhibit hall access and up to 2 staff; additional staff are $50 each.

Enhanced Members receive 18 CE hours per year. KAC can advance your 2027 Enhanced member hours for this seminar; hours used will be deducted from the hours you receive in 2027. Prefer not to use your hours? Register at the Member rate instead.

I WILL ATTEND: ☐ Both days (12 CEs) ☐ Saturday only (7 CEs) ☐ Sunday only (5 CEs)

No. of Staff | Staff Name #1 (included) | Staff Name #2 (included) | Additional Staff Names ($50 each)

CREDIT OPTIONS

Do you need Peer Review credit? ☐ Yes ☐ No Up to 8 hours applied for (pending); a maximum of 6 will be applied to your license.

☐ **I need a PACE continuing education certificate for another state** **+ $25.00**

Do NOT check if you ONLY have a Kentucky chiropractic license. Check with your state board before requesting.

State(s) needing PACE | License # in that state

☐ **Opt OUT of sharing my contact info with Exhibitors** We share name, office address, phone & school only. WE NEVER SHARE EMAILS.

PAYMENT

Registration $ _____ + PACE ($25) $ _____ + Add'l staff ($50 each) $ _____ = **TOTAL $** _____

☐ Check enclosed, payable to KAC (mail with form) ☐ Credit card (Visa, MasterCard, AmEx, Discover)

Card Number | Exp. (MM/YY) | CVV | Name on Card

☐ **Billing address is the same as the mailing address above**

Billing Address (if different) | City | State | ZIP

Cardholder Signature | Date

RETURN THIS FORM TO KAC

Please return by Thursday, January 21, 2027

Email: kac@thekac.org Fax: (855) 813-5300

Paying by card? Please fax or mail rather than email.

Mail: Kentucky Association of Chiropractors, PO Box 8320, Lexington, KY 40533-8320

KAC office use: Received_____ Entered in CE21_____ Initials_____