Application
For Colon Hydrotherapy Training

OFFICE USE ONLY	
Date received	_____
App F Received	_____
Processed	_____
Responded	_____
W. P. Sent	_____
Dep. Received	_____
Bal. Received	_____
Dot ordered	_____
Dot received	_____
HS Doc.	_____
A&P Doc.	_____
CPR Doc.	_____

*NOTES*_____
_____
_____
_____
_____
_____
_____
_____

Name: _____
Address: _____
City: _____ State: _____ Zip: _____

Phone: Home: ( )_____ Work: ( )_____

Mobile: ( )_____ Fax: ( )_____

Best times to reach you_____

Email Address: _____

Birth Date: _____

Social Security Number: _____
(Needed for I-ACT Membership)

Date of course you would like to be in: _____

Current Profession: _____
Previous Profession: _____
Education Degrees: _____

Please answer the following questions so that we may best serve you.

Have you had colon hydrotherapy sessions? Yes No How many? _____

Was it a closed system with disposable tubing? Yes No
_____

Do you have a medical condition that requires you to take medications daily?
_____

Please list three of your strengths:

1. _____
2. _____
3. _____

Please list three areas where you'd like to grow:

1. _____
2. _____
3. _____

What has you interested in participating in this course?

_____

_____

Are you in the care of a medical professional? If yes, please explain.

_____

Are you currently taking any prescription drugs? If yes, please explain.

_____

Describe your relationship with food and health: _____

_____

_____

_____

What is your personal mission? _____

_____

What are you committed to achieving in your participation in this course?

_____

_____

PAYMENT / CANCELLATION POLICY: Payment is non refundable. If applicant cancels, payment is *transferable* to another course within one year from the start of the original course date. The AOHSCHT reserves the right to retain tuition payment.Transfers made less then thirty days of the start of the original course date are subject to a $1000 fee.

____I have read and fully understand the Cancellation Policy.
____I have read and filled out this form accurately.

Sign Name_____ Date_____

Print Name_____

Please mail application with $50 non-fundable application fee and copies of:

-Check which of the following you are enclosing-

____ High school diploma, GED (equivalent, please call to clarify)
____ Proof of completion of post secondary education A & P (3 semester hours)*
____ Current CPR certificate*

Make check payable to The Art of Health

Or call the office to authorize a credit card debit.

Mail to: THE ART OF HEALTH
PO BOX 363
KIMBERTON, PA 19442

Jeannette Ponder 610-935-0701
vibrant@theartofhealth.us *www.theartofhealth.us*

* Must have complete and approved to receive I-Act certificate, recommended to have complete *no later* than 6 months after completing this course.