

S T I L L P O I N T

BIODYNAMIC CRANIOSACRAL THERAPY

APPLICATION FOR FOUNDATION TRAINING IN CRANIOSACRAL BIODYNAMICS

Please fax your completed application to 212-254-0318

To ensure legibility, please print clearly in ink or type.

If any answers need more space, please attach as necessary.



Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Work Phone _____

E-mail Address _____

Occupation _____

Age _____ Date of Birth _____ M/F _____

Family/relationships: *(married/partner, children)* _____

FORMAL EDUCATION AND TRAININGS:

Degrees and Certificates

DEGREES / CERTIFICATES

COMPLETION DATE

LENGTH OF TRAINING
(Hours / months / years)

DEGREES / CERTIFICATES	COMPLETION DATE	LENGTH OF TRAINING <i>(Hours / months / years)</i>

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Training in Anatomy and Physiology

COURSE	LENGTH OF COURSE	HOURS OF TUITION

Previous Craniosacral Therapy Training

COURSE	LENGTH OF COURSE	HOURS OF TUITION

PROFESSIONAL CAREER

Professional Qualifications/Credentials (e.g., association registration, etc.)

Clinical Practice (Years in practice, number of clients per week, specialties etc.)

MEDICAL HISTORY

Current and Past Medication Prescribed and recreational drugs, including alcohol, amount per week

Physical Physical illnesses, accidents, falls, etc.

Psycho-emotional Psychiatric, psychological processes that affected your functioning or well being

Hospitalizations, Surgery For physical or psychological reasons

Birth History and Childhood Any known details, any relevant history

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Cranial Experience

Your experience as a client to date, approximate number of sessions taken, any experience of Biodynamic Craniosacral Therapy? etc.

Any Past Criminal Record:

Any other relevant information:

Any other information to support your application:

Signed _____ Date _____

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