S T I L L P O I N T

BIODYNAMIC CRANIOSACRAL THERAPY

REGISTRATION INFORMATION FOR INTRO TO CRANIOSACRAL BIODYNAMICS

Please return your completed application to
cfavale@stillpointcst.com or fax to 212-254-0318

To ensure legibility, please print clearly in ink or type.
If any answers need more space, please attach as necessary.

OPTIONAL PHOTO HERE

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)* _____

_____

How did you hear about Stillpoint and this workshop?

_____

_____

_____

What draws you to this work?

_____

_____

_____

What is your experience, if any, with BCST?

What is your experience in the healing modalities?

What is your professional experience, if different?

What do you hope to gain from this weekend workshop?

Signed _____ **Date** _____

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