

Colon Care Hydrotherapy School of Chicago Course Application:

Training Date you are applying for: _____

Name: _____

Address: _____ (No P.O. Boxes allowed)

Business name: _____

Business address: _____

home ph.: _____

work ph.: _____

cell ph.: _____

fax: _____

e-mail: _____

How do you want your name to appear on your Certificate?:

Membership in organizations and/or associations: _____

Certifications in other modalities: _____

Have you ever had a colonic before?: _____ If yes, when was your last series?: _____ Results?: _____

Do you have an allergy to latex?: _____

Have you had abdominal surgeries and/or hernias in the past year?: _____

What complimentary modalities do you currently use in your practice?:

Highest level of education completed: _____

Do you have any food sensitivities, allergies or restrictions? If yes, please list:

Please provide emergency contact information:

Name: _____ Relationship: _____

Phone: _____ Alternate Phone: _____

