MILNE INSTITUTE INC.

VISIONARY CRANIOSACRAL WORK™ CERTIFICATION PROGRAM

APPLICATION FORM

Please type or print clearly. If you need additional space use a separate piece of paper.

Name _____ Age _____ Gender _____

Name as you would like it to appear on the Practitioner's Certificate (if different from above)

_____

Home Address _____

City _____ State _____ ZIP _____

Office Address _____

City _____ State _____ ZIP _____

Phone Numbers: Home _____ Office _____

Fax _____ email _____

Preferred address & phone number for mail list & referrals:

_____

_____

Schools Attended Since High School	Dates Attended	Area of Study	Degree	Date Received

Professional Experience: _____

_____

_____

Present Occupation:_____

_____

Previous Study of Other Healing Arts:_____

_____

List Current Licenses and/or Certificates in the Healing Arts from State, Federal or Other Agencies:

License	Issuing Agency	License Number	Issue Date	Exp. Date

List Craniosacral Workshop Experience:

Name of Program	Dates-Mo./Yr.	Location	# of Hours	Instructor

Craniosacral Clinical Experience: _____

_____

_____

_____

Number of years using craniosacral work: _____ Estimated total number of treatments given: _____ Current number of treatments given per week: _____ Average length of time per session: _____ Do you do relatively pure Craniosacral work ? _____ What percent of your practice is pure Craniosacral work ? _____ Have you incorporated Craniosacral principles into another system?

_____

_____

Location of most of your Craniosacral sessions: _____

_____

Personal Experience with Craniosacral Work (number of treatments received, comments on your experience)_____

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_____ _____

Signed Date of Application