

SPIRIT 2 SPIRIT

Healing

Name: _____

Date: _____

Training Application

PLEASE FILL OUT APPLICATION IN ITS ENTIRETY AND
RETURN WITH ALL REQUIRED SUPPORTING DOCUMENTATION

TO: SPIRIT2SPIRIT ATTN: KAT CROSS

Fax # 575.613.7167

PLEASE DO NOT MAIL THIS PACKET TO FL, FAX or SCAN IT.

Email: Kat@s2trauma.com

This Form Must Be Filled Out In Its Entirety and Turned In With All Required Supporting Documentation Prior To Beginning Any Module of the CTT® or CTP® Certification Programs.

If any of the questions are not applicable, please answer N/A for that question.

Training Application

Select one: Certified Trauma Therapist (CTT®) Certified Trauma Professional (CTP®)

Contact Information

Full Name: _____

Credentials: _____ SSN: _____ DOB: _____

Home Street Address: _____

City: _____ State: _____ Zip: _____

Company Name: _____

Business Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Fax: _____

Email Address: _____

Education: Current Level of Education:

Bachelor's Degree Master's Degree MD PhD Other _____

Dietary Restriction/Food allergies: _____

| Academic Institution | Date of Graduation | Degree Earned |
|----------------------|--------------------|---------------|
| | | |
| | | |

Certifications (Professional & Job Related) Certifications Turned Into Spirit2Spirit for Certification Purposes Must Be Current:

| Certifications Held | Date of Certification |
|---------------------|-----------------------|
| | |
| | |

Licenses: Licenses Turned Into Spirit2Spirit for Certification Purposes Must Be Current

| License Held | State | License Number |
|--------------|-------|----------------|
| | | |
| | | |

Department Of Law Enforcement: (Police Academy, EMT/EMS, Firefighters Certificate, Etc)

| Certification Held | Date of Completion |
|--------------------|--------------------|
| | |
| | |

Supervision

If You Currently Receive Any Form Of Job Related Professional Supervision Please Fill Out Information Below

Supervisors Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____

Email: _____

Ethical Violations/Malpractice Claims

Have ANY Malpractice Claims Been Brought Against You? _____ Yes _____ No _____ N/A

Have ANY Professional, Legal or Ethical Hearings Been Brought Against You? _____ Yes _____ No

If Yes Please Attach A Summary Of The Details Including Past and Pending Actions Against You As Well As Copies of All Relevant Information, Including Judgments, Pertaining To The Claims.

REFUND POLICY

In the event that you are unable to attend the retreat, Spirit2Spirit Healing will give you a refund as long as you provide two weeks-notice. If cancellation is due to an emergency, you will be refunded. In either case Spirit2Spirit Healing reserves the right to hold your deposit and apply it towards a future retreat. I fully understand that if canceling, I will be financially responsible for any fees incurred by Spirit2Spirit Healing, due to payment method chosen and acknowledge that Spirit2Spirit Healing does not offer refunds for treatment rendered.

Required Documentation

The Following Documents Must Be Submitted In Order To Process Your Application

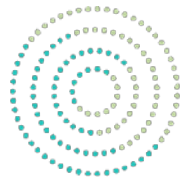
- Completed Application With Payment
- Copies of Diplomas/Certifications/Licenses
- Copies Of Current Resume/Curriculum Vitae
- Copy of Malpractice Insurance (CTT® Only)
- Letter of Recommendation From Immediate Supervisor (Non-Degree CTP® Only)

By Signing This Application, I hereby certify, that to the best of my knowledge and understanding, the information provided on this form is true and accurate.

Signature

Date

Print Name



SPIRIT 2 SPIRIT
Healing

Personal Information

Dates of Program: _____ Location: _____

Full Name: _____ Date of Birth: _____ Age: _____

Female: _____ Male: _____ Trans: _____ Other: _____

Dietary Restrictions: (Food Allergies, Etc.) _____

Treatment History

Are you currently under the care of a therapist/psychiatrist/psychologist/counselor/life coach? Yes _____ No _____

Are you currently taking part in any 12 step programs? If so, please list all: _____

Are you currently under the care of a Physician for any major medical conditions? _____ Yes _____ No

If Yes: Dr's Name: _____ Phone: _____ Fax: _____

Email: _____ Illness: _____

Circle all types of Therapy and Treatments have you participated in (PHP, IOP, Residential, Psychotherapy, EMDR, DBT, SE, other/
name: _____

Are you currently on any medication? If yes, please list below: _____

Please let us know a little about what you hope to get out of this experience: _____

What was the first trauma or perceived trauma that you experienced? _____

_____ Age? _____

Did you experience other traumatic events? If yes please describe: _____

