



For Office Use Only:	
Date of Application:	/ /200
Received by:	

DECOMPRESSION CAMP
Application for Healers

Personal Information

Full Name:			
	<i>Last</i>	<i>First</i>	<i>M.I.</i>
Address:			
	<i>Street Address</i>		<i>Apartment/Unit #</i>
	<i>City</i>	<i>State</i>	<i>ZIP Code</i>
Phone numbers	Home: Cell:	Birth date:	Month/Day/Year
E-mail Address:			Social Security #

Healing Experience

Primary Therapeutic Approach:			Secondary (if applicable):		
License Number:		Other Training/Certifications:			Years in Practice:
Licensing Institution:					
Describe Your Therapeutic Approach/Technique:				Would you be willing to support a warrior locally or from a distance?	Yes / No
Clients Per Week (avg.)		Cost Per Session:		How many sessions can you comfortably do in a day?	
Are you experienced in PTSD?	Yes / No	If YES, please describe experience			

Personal Care

Do you exercise regularly?	Yes / No	If yes, please circle type of exercises you perform:	Walking • Swimming • Yoga • Running • Biking • Weight Training • Other (please describe):
Amounts you smoke:		Amounts you drink:	
How do you deal with stress?			

Additional Information

What do you feel you can offer the men and women coming back from war?	
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If your room & board and airfare are covered Are you able to donate your services for one week?	Yes / No	If NO, How much would you need to make for the week?	\$	How much advanced notice would you need to participate in a Decompression Camp?	
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References

Please list three references from clients or instructors or attach a Letter of Recommendation to this form:

Full Name:	Relationship:
Email:	Phone: ()
Address:	
Full Name:	Relationship:
Email:	Phone: ()
Address:	
Full Name:	Relationship:
Email:	Phone: ()
Address:	

****Please provide additional information and insights at the bottom of this application.**

I have answered all the above questions as clearly and honestly as I know how.

By signing this form I hereby authorize and request any law enforcement agency to furnish bearer with criminal history and identity check information in their possession regarding me in connection with my services. I am willing that a photocopy of this authorization be accepted with the same authority as the original. I understand this authorization is to be part of the written application which I sign.

Signature

Date

Please email your completed application to:
Healing@HealOurWarriors.org

Or

Submit via mail:
Heal Our Warriors Foundation
PO Box 1651
Frankfort, MI 49635

Or

Submit via fax: (231) 312-6100

For more information visit us on the web: www.HealOurWarriors.org