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

***HEALER COMMUNITY NETWORK***

**Application for Healers**

**Personal Information**

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

**Healing Experience**

| Primary Therapeutic Approach: | | Secondary (if applicable): | | | |
|---|---|---|---|---|---|
| License Number:<br><br>Licensing Institution: | | Other Training/ Certifications: | | Years in Practice: | |
| 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 | | | |

**Additional Information**

| What do you feel you can offer the men and women coming back from war? | | | | | |
|---|---|---|---|---|---|
| Would you be willing to donate session(s) to a Warrior? | Yes / No | If YES, how many: | ____ per week<br>____ per month<br>Other:_________ | Would you be willing to see Warriors for discounted rates? | Yes / No |

## References

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

Full Name: Relationship:

Email: Phone: ( )

Address:

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Full Name: Relationship:

Email: Phone: ( )

Address:

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Full Name: Relationship:

Email: Phone: ( )

Address:

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***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