

Please PRINT this Document, complete, sign and forward to the ACADEMY of HIRUDOTHERAPY, via e-mail attachment or fax. The original registration, along with the copies of all original documents shall be forward to the Academy via registered mail, to the address provided below.

REGISTRATION and APLICATION FORM

ACADEMY of HIRUDOTHERAPY INTERNATIONAL

2612 Breakers Creek Drive, Las Vegas, NV 89134

Phone: (347) 981-6171

Fax : (888) 825-0793

E-mail: office@academyofhirudotherapy.org

www.academyofhirudotherapy.org

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

COUNTRY _____

HOME PHONE _____ WORK _____

FAX _____ CELL _____ E-MAIL _____

CURRENT PROFESSION _____

HOW LONG? _____ PREVIOUSLY? _____

LIST ALL EDUCATIONAL DEGREES EARNED (copies are required)

PROFESSIONAL LICENSE NUMBER, if applicable _____

PROOF OF CITIZENSHIP OR PERMANENT RESIDENCY IN the USA:

SOCIAL SECURITY NUMBER (copy is required)

PASSPORT NUMBER (copy required)

PROOF OF **CANADIAN** CITIZENSHIP (copy is required)

DRIVER LICENSE NUMBER or STATE ID NUMBER (**USA & Canada**) (copy is required)

ADDITIONAL INFORMATION

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In order to have some idea of your learning style, **please answer the following questions** to the best of your ability, so we may serve you better:

1. Do you absorb information better as a reader or a listener or by experience?
2. Does writing notes immediately make it easier to remember ideas?
3. Are you a loner or do you work better as part of a team?
4. Are you best in a structured, predictable environment?
5. Do you care for your eating habits? Please describe.
6. Do you consider yourself to be a patient person?
7. Do you practice a contemplative discipline? If so, describe.
8. Have you ever had any Hirudotherapy Treatments? When and why?
9. Was it helpful?
10. Do you have credits in ANATOMY & PHYSIOLOGY? If not, are you willing and able to take it?
11. Are you able to study independently and travel to various locations of ALA-MED for clinical study?
12. Are you under the care of a doctor or health professional? If yes, explain.
13. Do you have a medical condition that requires you to take prescription medications daily? If so, Please explain.
14. Do you actively and officially involved in practicing other alternative therapies or modality?

15. Please list your 3 top strengths:

- 1.
- 2.
- 3.

16. List 3 areas where you want to improve:

- 1.
- 2.
- 3.

17. Have you ever been convicted of a misdemeanor or felony? If yes, explain:

18. What health-related books have you read, reading?

19. Do you consider yourself to be a compassionate person?

20. What is your personal mission?

21. Did you have any treatment for mental or emotional challenges?

22. Please tell us why you are interested in this program?

23. **COURSE TYPE: Professional HT Training, Theoretical & Practical, Module I, II, III & DIPLOMA in HT**

Start Date: _____ **2015** or _____ **2016**

24. **The Registration Deposit Fee of \$ 4,000 has to be paid along with an Application.**

25. **The remaining balance of \$ 6,000 must be paid-in-full, not later than one (1) day after the approval to the Academy of Hirudotherapy.**

26. **The \$ 500 tuition discount fee can be adjusted if the Candidate pays the tuition balance in full and cannot be combining with installments or any other discounts.**

27. **Please contact the Academy of Hirudotherapy regarding other tuition payment options.**

28. **What is the best phone number or Skype nick to contact you?**

Note:

The Certificates and Diploma in Hirudotherapy will be issued after: completed Anatomy & Physiology credits, all tuition fees are paid-in-full, successful HT course completion, documented prof of open/closed client's file, Show Case Presentation and the final Exam.

CANCELLATION POLICY:

If the applicant cancels within 15 days before the first day of class and after all payments have been submitted to the **ACADEMY OF HIRUDOTHERAPY**, the applicant has the right to transfer tuition toward another course in a later date within **6 months of the application.**

The ACADEMY OF HIRUDOTHERAPY will retain all tuition payments, less a \$ 100 transfer fee that will be deducted on the day of the notice given. (This \$ 100 will need to be paid before beginning of the next course).

By signing this form, I understand and agree to the following:

1. I have read and fully understand the Cancellation Policy. The ACADEMY OF HIRUDOTHERAPY has my permission to keep all documents/ copies submitted by me. I also understand that entrance to and dismissal from this program may be based on objective and subjective criteria.

2. All course lectures and materials will be delivered in English. If English is not your primary language, please let the Academy know. You may be required to bring a translator at your own expense. However, we do provide materials in the Polish and Russian languages upon request.

3. FORMS AND APPLICATION must be forwarded to the ACADEMY OF HIRUDOTHERAPY via fax or e-mail with the signature of the applicant. The original Registration should be mailed to the Academy address or presented at the first class meeting.

4. All the lecture materials, written materials, pictures and photographs, videos & presentations given by the Academy of Hirudotherapy Educators and Instructors, are classified as Intellectual Properties of the Academy of Hirudotherapy, USA.

LIABILITY WAIVER:

I understand that by signing this application, I hereby waive any and all liabilities, now and/or in the future, against the ACADEMY OF HIRUDOTHERAPY, ALA-MED HIRUDOTHERAPY ALTERNATIVE, their owners, associates, employees and volunteers.

SIGNATURE OF APPLICANT _____ DATE _____

The content of this Registration Form has been provided for educational and informational purposes only and is not intended to be a substitute for any Medical and /or Legal advice.

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