

Application  
For Colon Hydrotherapy Training

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: Home: ( ) \_\_\_\_\_ Work: ( ) \_\_\_\_\_

Mobile: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

Best times to reach you \_\_\_\_\_

Email Address: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Social Security Number: \_\_\_\_\_  
(Needed for I-ACT Membership)

Date of course you would like to be in: \_\_\_\_\_

Current Profession: \_\_\_\_\_

Previous Profession: \_\_\_\_\_

Education Degrees: \_\_\_\_\_

*Please answer the following questions so that we may best serve you.*

Have you had colon hydrotherapy sessions? Yes No How many? \_\_\_\_\_

Was it a closed system with disposable tubing? Yes No  
\_\_\_\_\_

Do you have a medical condition that requires you to take medications daily?  
\_\_\_\_\_

Please list three of your strengths:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Please list three areas where you'd like to grow:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

What has you interested in participating in this course?  
\_\_\_\_\_  
\_\_\_\_\_

OFFICE USE ONLY

Date received \_\_\_\_\_  
App F Received \_\_\_\_\_  
Processed \_\_\_\_\_  
Responded \_\_\_\_\_  
W. P. Sent \_\_\_\_\_  
Dep. Received \_\_\_\_\_  
Bal. Received \_\_\_\_\_  
Dot ordered \_\_\_\_\_  
Dot received \_\_\_\_\_  
HS Doc. \_\_\_\_\_  
A&P Doc. \_\_\_\_\_  
CPR Doc. \_\_\_\_\_

NOTES \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you in the care of a medical professional? If yes, please explain.

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Are you currently taking any prescription drugs? If yes, please explain.

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Describe your relationship with food and health: \_\_\_\_\_

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What is your personal mission? \_\_\_\_\_

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What are you committed to achieving in your participation in this course?

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**PAYMENT / CANCELLATION POLICY:** A non-refundable deposit of \$ 800.00 must be received five weeks prior to course. Payment balance must be received 3 weeks prior to the beginning of the course. Payment is non refundable. If applicant cancels, payment is *transferable* to another course within one year from original course date. A transfer made less than 3 weeks prior to the course is subject to a \$500 fee.

\_\_\_\_ I have read and fully understand the Cancellation Policy.

\_\_\_\_ I have read and filled out this form accurately.

Sign Name \_\_\_\_\_

Date \_\_\_\_\_

Print Name \_\_\_\_\_

**Please mail application with \$50 non-fundable application fee and copies of:**

- High school diploma, GED (equivalent, please call to clarify)
- Proof of completion of post secondary education A & P (3 semester hours)\*
- Current CPR certificate\*

to:

The Art of Health  
PO Box 363  
Kimberton, Pa 19442

*(Make check payable to The Art of Health)*

*Jeannette Ponder 610-935-0701*

[ponder@theartofhealth.us](mailto:ponder@theartofhealth.us)    [www.theartofhealth.us](http://www.theartofhealth.us)

\* Must have complete and approved within 6 months of course to receive certification.