

APPLICATION FORM
for Two-year Professional Training
in Craniosacral Therapy

INSTITUTE of
CRANIOSACRAL
STUDIES

Personal Details:

Surname			
First Names			
Address			
Home phone no.		Work phone no.	
Mobile no.		E-mail address	
Date of Birth		Male/Female	

Professional Details:

Profession	
Please give details of all trainings including dates qualified, length of course, qualification received, etc.	
Please give details of any Anatomy and Physiology course.	

Craniosacral Therapy Details:

Please give details of any Craniosacral Therapy course undertaken.	
Please give details of any Craniosacral Therapy treatment received.	

Signed.....

Date.....

**Please include a recent
 passport sized photograph**

For Office Use

<i>Interview details:</i>