Visionary Craniosacral Work® LLC Milne Institute

Milne Institute
Visionary Craniosacral Work®™

Certification Program

APPLICATION FORM

Please type or print clearly. If you need additional space use a separate piece of paper.

Name _____
Age _____
Gender M/F/Non-binary/ Prefer not to respond. _____

Name as you would like it to appear on the Practitioner's Certificate (if different from above)

Home Address

_____

City _____State _____ ZIP _____

Office Address

_____

City _____State _____ ZIP _____

Phone Numbers:
Home _____
Office _____

Email _____

Preferred address & phone number for mail list & referrals:

_____

_____

Schools Attended Since High School	Dates Attended	Area of Study	Degree	Date Received

Professional Experience:

_____

_____

Present Occupation: _____

_____

Other Studies, Trades or Skills

_____

List Current Licenses and/or Certificates in the Healing Arts from State, Federal or Other Agencies:

License	Issuing Agency	License Number	Issue Date	Exp. Date

List Craniosacral Workshop Experience:

Name of Program	Day Mo Year	Location	# of Hours	Instructor

Craniosacral Clinical Experience:

_____

_____

_____

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_____

Number of years using craniosacral work: _____ Estimated total number of treatments given: _____ Current number of treatments given per week: _____ Average length of time per session: _____ Do you do relatively pure Craniosacral work? _____ What percent of your practice is pure Craniosacral work? _____ Have you incorporated Craniosacral principles into another system?

Location of most of your Craniosacral sessions:

_____

_____

Personal Experience of craniosacral work, given and received:

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Signed _____

Date of Application_____

Visionary Craniosacral Work® Milne Institute

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