CRANIOBIOTIC TECHNIQUE™

Seminar Application

Please mail or fax this form, along with the Workshop Release and Confidentiality Agreement, and your payment to:
Dynamic Health
2065 Riverstone Dr. #102
Coeur d'Alene, ID 83814
Fax: (208) 765-1951 **No phone registrations will be accepted**

Name (type or print)_____

Degree_____ _____

Year Graduated_____

Business Street Address _____

City_____ State _____Zip _____ Country _____

Phone_____ Fax _____ Email_____

Regular Fee: $975
Refresher Fee: $450
Payment Method:

☐ Check (payable to Dynamic Health) ☐ Visa ☐ Mastercard

Credit Card # _____Exp. Date_____ Security Code: _____
(last 3 numbers on back of card)

Billing Address for Credit Card _____ State _____ Zip _____

Name as it appears on Card _____

Signature of Card Holder_____ Date_____
By signing I agree to pay the above total amount according to Card Issuer Agreement (Merchant Agreement if credit voucher)

Seminar you are registering for: Dates: _____ **Location:** _____

CANCELLATION POLICY
1) If you cancel 15 days or more prior to the seminar, your seminar fee will be refunded in full.
2) If you cancel 6 to 14 days prior to the seminar, 75% of your fee will be refunded.
3) If you cancel 2 to 5 days prior to the seminar, 50% of your fee will be refunded.
4) If you cancel within 48 hours of the seminar, 25% of your fee will be refunded.

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Workshop Release Form

During the CranioBiotic Technique seminar, you will be asked to work with another person to practice what you have learned. If you would like to participate, please complete the information below.

Name of Participant _____

Home Phone _____Work Phone _____Cell Phone_____

Home Street Address _____

City_____State_____Zip_____

Date of Birth _____ Marital Status _____

Spouse's Name_____

Emergency Contact _____

Consent to Participate

I _____ give my consent to work with another person in testing and treating each other which is required as part of this training. I agree not to hold anyone responsible for any damages or complications that may result from this training.

Signed_____ **Date**_____

Consent for Treatment Before, During or After the CBT Seminar

I hereby consent, authorize, and request Dr. M. Anthony Smith to administer any treatment deemed advisable and necessary for my condition in accordance with his knowledge and experience. I agree to hold Dr. Smith harmless from any claims for damages or complications that may result from such treatment.

Signed_____ **Date**_____

Witness_____ **Date**_____

CranioBiotic Technique (CBT) Seminar
Confidentiality Agreement

This Agreement sets forth the terms and conditions under which you will be accepted as a participant at the CranioBiotic Seminar. By signing this agreement, you acknowledge that you have read and understand this agreement and accept the terms and conditions specified below. Do not register for the CranioBiotic Seminar if you do not agree with the terms and conditions of this agreement.

M. Anthony Smith, DC has developed a health care system that is based on the manual stimulation of areas on the cranium and upper body in order to direct the brain and immune system to correct a health problem.

The CranioBiotic Technique utilizes principles of anatomy, physiology, and neurophysiology. It also constitutes a unique system of health care that is protected by patent, copyright and trademark laws. CranioBiotic Technique is a patent pending and is a registered trademark, and all content of the CranioBiotic Seminars are the exclusive intellectual property of M. Anthony Smith, DC. All CranioBiotic materials are protected by copyright laws, and none of these materials may be reproduced without written permission of the owner. Furthermore, all information you receive from the CranioBiotic seminar is considered to be confidential and a "Trade Secret" of M. Anthony Smith, DC.

I _____ (Seminar Participant) agree that I have been granted approval to use CranioBiotic Technique procedures in exchange for my CranioBiotic seminar tuition fee. I also agree that this approval does not include teaching CranioBiotic Technique procedures or treatment to any party, except in the usual doctor/patient interaction. I further agree that such disclosure will constitute a breach of this agreement.

In the event that this agreement is violated, I_____ (Seminar Participant) agree to pay M. Anthony Smith, DC for any damages, including reasonable attorney fees incurred while pursuing any legal claim against me, my agents, employees, and/or representatives.

Seminar Participant's Signature_____

Print Name:_____

Date:_____

CRANIOBIOTIC TECHNIQUE SEMINARS
By: M. Anthony Smith, DC

_____

Date_____