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 ☐ AMEX

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**_____