

CENTER FOR PLANT STUDIES AND HEALING ARTS

PARTICIPATION FORM REQUIRED

Name: _____

Date of Birth: _____

Phone: _____ **Cell Phone:** _____

Email: _____

Mailing Address: _____

Emergency Contact: _____ **Phone:** _____

How did you hear about our program? _____

Please share your experience with flower essences, herbs, or homeopathy and what your interests are in taking our program:

What is your “occupation”?

Hobbies:

Please share your background in personal growth and natural healing:

Are you on any medications? If so, what are they and what are they for?

Do you have any special needs, and if so, please list them:

The Experiential Program requires that you are able to:

*** Walk a minimum of 30 minutes**

***Climb up and down short distances**

***Protect yourself from the elements, wear appropriate clothing, footwear, hat, etc.**

***Carry a small backpack for lunches, water, and class materials, etc.**

Signature Required: _____ **Date:** _____