



APPLICATION FORM
FOR TRAINING IN DR. VODDER'S
MANUAL LYMPH DRAINAGE

(Please print clearly)

NAME: _____
(as I would like it to appear on my certificate)

ADDRESS:
PO Box/Street: _____
City: _____
State: _____
Post Code: _____
Home Phone: (____) _____ Business: (____) _____
Fax : (____) _____ Email: _____

OCCUPATION: _____
EDUCATION
Highest Level: _____
Year taken and location: _____
Training background for this course: _____

(Copies of certificates, registrations, diplomas, degrees etc. required to accompany this application)

COURSE APPLIED FOR: BASIC MLD THERAPY I THERAPY II & III (Circle one)

DATE: _____ LOCATION: Healing Hands Seminars
110 N Federal Hwy, Suite 204
Hallandale Beach, FL 33009

I hereby state that the above information is true and correct in all aspects. I am aware of the Student Agreement that I will b required to sign before receiving my certificate of course completion.

Signed: _____ Date: _____