POWERS OF THE HEALING ARTS
THERAPY AND TRAINING CENTER

Course Registration Form

Name of Course:_____

Participant Name: _____DOB: ____/____/_____

Mailing Address: _____

Telephone: Home:_____ Work:_____ Cell: _____

Ok, to leave message? **Yes**___ **No**___

Email Address:_____

Emergency Contact Name:_____

Emergency Contact Telephone: Home:_____ Work:_____Cell: _____

Accommodations needed:_____

Fax completed form to: Julie M. Powers-Candelmo, LSCW, CCS
207-221-1679

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