



Clinical Acupressure Certification Program Enrollment Form

November 2019

Welcome to the application process for Clinical Acupressure Certification. You are about to embark on a wonderful journey!

Please read the program requirements thoroughly before completing this application form. (They are found in the CA Certification Program Overview document on SLI website under CA Certification.)

This program is for professional health and/or psychological practitioners who wish to label themselves or advertise as Clinical Acupressure practitioners.

Note: You may use extra pages where needed. Please PRINT legibly.

Name: _____ **Age:** _____ **Gender:** _____

Home Address:

City: _____ **State:** _____ **Country:** _____ **Zip:** _____

Home Phone: _____ **Cell:** _____

Home E-mail: _____

Office Address (if applicable):

City: _____ **State:** _____ **Country:** _____ **Zip:** _____

Phone: _____

Professional E-mail: _____

Please indicate your preferred address, email and phone number for SLI records, including mailing list and referrals:

_____ Home Address OR _____ Office Address

_____ Home Phone OR _____ Cell Phone OR _____ Office Phone

_____ Personal Email OR _____ Professional Email

What attracts you to this program?

Education:

<u>Schools Attended</u> <u>Since High School</u>	<u>Dates Attended</u>	<u>Area of</u> <u>Study</u>	<u>Degree</u>	<u>Date</u> <u>Received</u>
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Present Occupation & Credentials:

Previous Professional Experience: (for the last 10 years)

Previous Study of Other Healing Arts: (Indicate significant programs & length of study)

Is your involvement in the “healing world” ___ Full Time; ___ Part Time; ___ Other.

If other, please briefly explain.

List current licenses or certificates (including PA), in the Healing Arts from State, Federal or other agencies:

<u>Title</u>	<u>Issuing Agency</u>	<u>License Number</u>	<u>Issuing Date</u>	<u>Expiration Date</u>
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Clinical Acupressure Clinical Experience

Number of years using either CA or PA:

Estimate total number of treatments given:

Current number of treatments per week:

Length of time required to give a typical CA session:

Do you combine CA with other modalities in your practice? ___ No; ___ Yes. If yes, please describe.

If yes, what percentage of “Pure” CA do you do in your practice?

Please describe your personal experience receiving CA and PA:

Location of most of your CA treatments: ___ Office; ___ Home; ___ Out-Call; ___ Other. If other, please briefly describe.

Is there a particular person you would like to request as your mentor?

Please note that the list of CA Mentors is on the SLI website under CA Certification. Whenever possible, we will honor your request. You will receive confirmation of your mentor when you receive your Acceptance Letter.

Your anticipated date of completion of Certification program:

(Typically 1 to 2 years – but 4 years are allowed)

Please note that when you are completing your Completion of Requirements form, you may request your student class transcript from the Certification Director, and it will be emailed to you. (certification@soullighting.com)

Soul Lightening International

CA Certification Program Statements of Understanding

___ I understand that I am applying for entrance into the Clinical Acupressure Certification program.

___ I have read and understood the requirements of the program and am ready to embark on this journey. (CA Certification Overview Doc is on SLI website under CA Certification)

___ As part of the enrollment process, I agree to the policy of not teaching Clinical Acupressure without formal teacher training and certification from SLI.

___ I understand that the program is for professional health and/or psychological practitioners who wish to label themselves or advertise as Clinical Acupressure practitioners and that I may not advertise or list myself as a Clinical Acupressure Practitioner until I am certified.

___ I understand that Clinical Acupressure certification does not represent a legal status to practice.

___ I understand that it is my responsibility to satisfy any state or local requirements to practice hands-on professional work.

___ I understand that my Certification program does not start until the Director of Certification has accepted my enrollment form, I have been assigned a mentor and my certification fee has been paid. (The certification fee is included in the CA Certification Value Plan.)

Please read and then initial each of the above statements. Then date & sign this enrollment form and mail it, along with your check for the certification fee (\$150.00) to:

Soul Lightening International, P.O. Box 339, Greensboro, MD 21639

Please make your check payable to: Soul Lightening International

Date: _____

Signature: _____

Acceptance by Director of Certification

Date: _____

Signature: _____