ORIGINAL HEALING MINISTRIES MHR-TRAINING FORM 2023

APPLICANT INFORMATION		
Legal Name:		Gender: Male Female
Date of birth:		Phone:
Current Address		E-Mail
City:	State:	ZIP Code:

ACADEMIC HISTORY & EXPERIENCE		
How did you find out about this course?		
Do you have experience or training in the original health field?		How long?
What did/do you do?		
Highest educational level	Major:	
Why do you want to pursue this education?		

EMERGENCY CONTACT		
Name of a relative:		
Address:		Phone:
City:	State:	ZIP Code:
Relationship:		

SPOUSE INFORMATION IF JOINT REGISTRATION		
Legal Name:		Gender: Male Female
Date of birth:		Phone:
Current Address		E-Mail

SPOUSE ACADEMIC HISTORY & EXPERIENCE		
How did you find out about this course?		
Do you have experience or training in the original health field?		How long?
What did/do you do?		
Why do you want to pursue this education?		

REFERENCES – NOT REQUIRED		
Name	Address	Phone

APPLICATION FEE PAYMENT INFORMATION		
Card No. Exp Date: CVC#		Type of Card:
Name on Card Billing Zip code:		Single or Joint payment:
Signature of applicant:		Date:
Signature of spouse *(only if for a joint training):*		Date:

Please print your name below, exactly as you wish it to appear on your certificate upon successful completion of this course.

Name _____ Date _____