HEALING OASIS WELLNESS CENTER
APPLICATION FORM FOR AUDITING
VSMT Modules I - IV

Name: _____

Degree (please circle appropriate one): DC, DVM, VMD, Other: _____

Address: _____

_____

Work phone number: _____ Fax number: _____

Email (required): _____

Emergency / cell phone number (will be kept private): _____

Requesting registration for Module _____ that is scheduled for _____

Admissions requirements:

1. Must comply with the minimum degree required for the SPECIFIC CE seminar that registration is being sent for. For specific requirements see the "Continuing Education Section" on our website – individual CE description.
2. All applicants must also sign the application form attesting to being in good standing with their particular state / provincial / governmental licensing board.
3. Provide a **copy of their current** (not expired) professional license / registration or official state / provincial permit.
4. ALL licensed professionals **must** include a signed letter stating that they understand their state's and or provincial rules and regulations as they apply to the use of "integrative or alternative" health care for animals as set forth by their State Veterinary Licensing & Regulation office for Integrative and / or Alternative Modalities **and** those set forth by **their individual Health Care Licensing Boards.**
5. All applicants **must provide** a copy of the certificate of successful completion of their approved school if it is required (see individual description. If in doubt, please contact our office).
6. Please include a check for the ***total amount of $850.00*** (eight hundred fifty USD, **drawn on a US Bank**). **No foreign checks please**,
7. REFUND criteria:
   a. 75% refund if more than 7 weeks of scheduled date
   b. 50% refund if more than 5 weeks but less than 7 weeks of scheduled date
   c. 25% refund if more than 4 weeks but less than 5 weeks of the scheduled date
   d. NO REFUND if less than 4 weeks of the scheduled date.

   Please note that ***ALL CANCELLATIONS must be done in writing (no messages will be accepted as cancellation). All cancellation notices must be sent via email at CONTACT@HEALINGOASIS.EDU.
   Please note, that a 2.1% charge will be applied to all credit card transactions

Healing Oasis Wellness Center
2555 Wisconsin St
Sturtevant, WI 53177-1825
262-898-1680; 262-886-6460FAX
US Toll Free: 866-203-7584
CONTACT@HEALINGOASIS.EDU OR WWW.HEALINGOASIS.EDU

Signature of Applicant: _____ Date: _____

By signing above, applicant acknowledges that they have read the catalog, are in good standing with their particular licensing board and that they are not currently under investigation for unprofessional conduct.