the Zero Balancing Association

ZERO BALANCING CERTIFICATION PROGRAMME

APPLICATION FORM

(Please type or write in capital letters)

Name _____

Date of Birth _____

Home Address _____

Work Address _____

Email _____

Website _____

Phone h w c _____

List any healthcare licenses and certificates Issue date

_____ _____

_____ _____

_____ _____

List additional training in the healing arts Length of training

_____ _____

_____ _____

_____ _____

You may be asked to supply further details or transcripts of your prior training

Is your involvement as a Health Care Practitioner

Full Time ☐ Part Time ☐ Just beginning ☐

If you have an existing health-care practice, how long have you been in practice?
months/years _____

List all ZB training you have participated in

Title	Date	Location
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Zero Balancing Clinical Experience

Number of years practicing ZB _____
Estimated total number of sessions given _____
Current average number of sessions given each week _____

Have you incorporated ZB principles into another system? Yes No
If yes which other system(s)?

Personal Experience with Zero Balancing, (sessions received, other pertinent comments)
_____
_____
_____

What attracts you to the Zero Balancing Programme?
(*Please type statement or write legibly on a separate page*)

Please indicate how you would like your name to appear
1. In the Membership File _____
2. On your Practitioner's Certificate _____

Date of Application _____ Signed _____