



**ACADEMY FOR GUIDED IMAGERY  
PROFESSIONAL CERTIFICATION TRAINING**

**CERTIFICATION ENROLLMENT FORM**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Country: \_\_\_\_\_

Day Phone: \_\_\_\_\_ Website: \_\_\_\_\_

Primary Email: \_\_\_\_\_ Secondary Email: \_\_\_\_\_

Occupation: \_\_\_\_\_

Educational Degrees: \_\_\_\_\_

Professional Licenses & States: If you are licensed by your state to diagnose and treat, please list your license(s) and the state(s) that grant them: \_\_\_\_\_

\_\_\_\_\_

Professional Specialty: What particular therapeutic approaches do you utilize and/or what special problems do you treat: \_\_\_\_\_

\_\_\_\_\_

Professional Affiliations: List any hospital, academic, institutional, governmental organizations with which you are affiliated: \_\_\_\_\_

\_\_\_\_\_

Your Intentions: How and in what capacity do you intend to use your training in IGI<sup>SM</sup>: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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