AROMATICA

Centre for Natural Therapies & Holistic Study

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226-229-0241
www.aromatica.ca

STUDENT REGISTRATION FORM

Please print clearly and complete all sections.

Please print your name how you would like it to appear on your certificate

_____

PROGRAM / WORKSHOP INFORMATION

Program / Workshop Enrolling In:

_____

Start Date: _____

Tuition: $ _____

Deposit: $ _____

Balance Owing: $ _____

Résumé Attached: Yes _____ No _____

IMPORTANT NOTE

A deposit is required to reserve your seat.

Payment plans are available.

Please ensure all information is accurate.

PERSONAL INFORMATION

Full Legal Name: _____ Preferred Name: _____

Date of Birth (YYYY/MM/DD): _____ Email: _____

Mailing Address: _____ Apt / Unit: _____

City: _____ Province: _____ Postal Code: _____

Phone (Cell): _____ Phone (Home): _____

EMERGENCY CONTACT

Full Name: _____ Relationship: _____

Phone (Cell): _____ Phone (Home): _____

LANGUAGE REQUIREMENT

Students must be able to read, write and comprehend English.

Yes _____ No _____

MEDICAL & HEALTH INFORMATION

Do you have any medical conditions we should be aware of? None _____ Yes _____ If yes, please explain: _____

Do you have any allergies? None _____ Yes _____ If yes, please explain: _____

Are you currently under the care of a healthcare professional? None _____ Yes _____ If yes, please explain: _____

Please note: You are responsible for informing the school of any changes to your health that may affect your participation in training or clinical practice.

DECLARATION

I certify that the information provided on this form is true and complete. I understand that withholding information may affect my ability to participate in the program.

Signature: _____ **Date** (YYYY/MM/DD): _____

OFFICE USE ONLY

Date Received: _____ Deposit Received: _____ Amount: $ _____ Method: _____

Application Reviewed By: _____ Approved: Yes _____ No _____

Notes: _____