Upledger Institute International
Clinic Affiliate

Clinic Affiliate Application

Instructions: Please complete this application entirely and turn in the items listed below with your application. We are unable to process incomplete applications.

- List of the Diplomate therapists affiliated with your Clinic.
- Photocopies of all current business and staff professional licenses or certificates (documentation/proof of professional qualifications to practice) where applicable.
- Certificates of business and professional liability insurance with IAHE as additionally insured.
- Full disclosure of any past, current or pending litigation for all therapists associated with your Clinic or your Clinic itself.
- Three written patient testimonials testifying to the quality of services provided and respective therapy outcomes achieved.
- Exterior and interior photographs or video of your clinic.
- Advertising and promotional materials, i.e. website address, brochures, YouTube videos, any social media, etc.
- A minimum of two peer references from professionals not affiliated with your Clinic for each therapist performing CranioSacral Therapy attesting to his or her character and professionalism.
- An $850 Application Fee (in U.S. dollars), made payable to Upledger Institute International, Inc. (This fee will be refunded in full should affiliation status not be granted.)

Upon completion please return by fax, email, or mail to:
The Upledger Institute Clinic
11211 Prosperity Farms Road, D-223 Palm Beach Gardens, FL 33410
Phone: 561.622.4706 **Fax**: 561.627.9231 **Email**: clinic@iahe.com

Clinic Name: _____

Address: _____ Suite: _____

City: _____ State: _____ Zip: _____ Country: _____

Phone: _____ Fax: _____

Email: _____ Website: _____

Owner: _____ Contact Person: _____

Professional license no.: _____ Date licensed for business: _____

Instructions: Please supply the following information on all CranioSacral Therapy-trained staff. Clinic owner's signature is required at the bottom of the page.

Therapist Name: ____

Level of CST Training/Certification: _______________ Avg. Hrs/Wk Performing CST: _______________

Have they served as a Preceptor? : ___________________ Visiting Therapist? : ______________________

Therapist Name: ____

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Therapist Name: ____

Level of CST Training/Certification: _______________ Avg. Hrs/Wk Performing CST: _______________

Have they served as a Preceptor? : ___________________ Visiting Therapist? : ______________________

Therapist Name: ____

Level of CST Training/Certification: _______________ Avg. Hrs/Wk Performing CST: _______________

Have they served as a Preceptor? : ___________________ Visiting Therapist? : ______________________

Clinic Owner Signature: ____ **Date**: _________________