CERTIFIED GAPS PRACTITIONER REGISTRATION FORM

First Name:

Last Name:

Practice/Business Name:

Business Address:

Street/Number

Town/City

State/County

Zip Code/Post Code

Country

Business Phone:

Business Fax:

e-mail:

Web Site:

Professional Qualifications:

(Languages you speak, consultations in person and/or virtual, and/or do you see clients 1:1, run groups, or retreats?)

Areas of Special Interest:

Do you specialize in an area of holistic or medical healthcare? Please be specific.

Are you in active practice and ready to receive GAPS clients now?

Username for Log In:
(minimum 8, maximum 12 characters.
At least one alpha and at least one numeric. No symbols)

Password for Log In:
(minimum 8, maximum 12 characters.
At least one alpha and at least one numeric. No symbols)

Once complete please return this form to gaps@gapstraining.com

THIS SERVICE IS ONLY AVAILABLE TO PRACTITIONERS WHO HAVE COMPLETED THE CERTIFIED GAPS PRACTITIONEER TRAINING COURSE