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"The Essence of Excellence."

www.whitedovehealing.com

Practitioner Registration Form

Name: _____ Company Name: _____ Date: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Shipping Address: (if different) _____

City: _____ State: _____ Zip: _____

Business Residential Phone: _____ Fax: _____

Email Address: _____

Degree: (highlight, then underline)

MD DO DDS DVM NO PhD DC OMD Lac RN PA MA DNBHE DHANP

Other: _____

Please list Professional Licenses, Registrations, and Certifications (include numbers): _____

Clinical Experience Relating to Homeopathy/Nutritional Therapy: _____

Signature: _____	Completed by: _____	Date: _____
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For Colorado Businesses Only:

State Sales Tax License Number: _____

City, County and/or Local Sales Tax License Numbers: _____

Please attach a current Business Card or Letterhead to complete this portion of the Registration Form process.

White Dove Healing Arts, Ltd.
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