

I YOU WE ONE

## GOOD MEDICINE DIRECTORY

### Membership application

#### PERSONAL

Name \_\_\_\_\_

Home Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Cell \_\_\_\_\_

Birthdate \_\_\_\_\_ Age \_\_\_\_\_

Office Address/ Location  
\_\_\_\_\_

Web site \_\_\_\_\_

E-mail address \_\_\_\_\_

#### PRACTICE

Professional Title \_\_\_\_\_

License Number \_\_\_\_\_

Certifications \_\_\_\_\_

Modalities \_\_\_\_\_

Specialties \_\_\_\_\_  
\_\_\_\_\_

#### SEVA

Service work you are currently involved with \_\_\_\_\_  
\_\_\_\_\_

Service work you would like to bring to I YOU WE ONE and Good Medicine Practitioners  
\_\_\_\_\_  
\_\_\_\_\_

Please send completed application and Signed Healer's Oath to:  
I YOU WE ONE PO box 381 2801 Ocean Park Blvd. Santa Monica, Ca 90504