



Healing Warriors Program

Independent Contactor Application

Attn: Human Resources

1044 West Drake Road, Ste 202, Ft. Collins, CO 80526

HR@HealingWarriorsProgram.org | 970-776-8387

First Name _____ Last Name _____

Street Address _____

City _____ State _____ Zip Code _____

Cell Phone _____ Home Phone _____

eMail _____

For which modality are you applying? _____ Acupuncture _____ CranioSacral _____ Healing Touch _____
(check all that apply)

Are you licensed? Yes No

License # _____

How did you hear about this opportunity? _____

Have you ever applied to HWP before? _____

Do you have any friends/relatives working for HWP?
If yes, state name and relationship. _____

ACUPUNCTURE: HWP only contracts state licensed acupuncturists

What School of Acupuncture: _____

What is your license # _____

List your National Provider Identifier number (NPI)
<https://npiregistry.cms.hhs.gov/> _____

CRANIOSACRAL THERAPIST

What CranioSacral school did you attend?

Upledger

Biodynamic

Other, please detail which school



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CRANIOSACRAL THERAPIST (continued)

Please list Certificates of Training: _____

Please list DORA License number: _____

List your National Provider Identifier number (NPI)

<https://npiregistry.cms.hhs.gov/> _____

HEALING TOUCH THERAPY

What is your Healing Touch training?

(HWP) works with practitioners from both certificate programs.

HBB

HTP

Are you Certified?

Yes

No

Expiration Date of your current certification: _____

If your certification is expired, when will you be
renewing your certification? _____

Are you a Nurse?

Yes

No

If yes, list your National Provider Identifier number (NPI)

<https://npiregistry.cms.hhs.gov/> _____

Please attached copies of appropriate licenses and certifications to this application.

EMERGENCY CONTACTS			
Name:		Relationship:	
Phone:		Email:	
Name:		Relationship:	
Phone:		Email:	

PROFESSIONAL REFERENCES (please provide 2)			
Name:		Relationship:	
Phone:		Email:	
Name:		Relationship:	
Phone:		Email:	



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I certify that all information in this Independent Contractor Application is true and complete. I understand that any false information or omission may disqualify me from further consideration for Contractor service and may result in my dismissal if discovered at a later date. I understand that Contractors are evaluated on the merits of their qualifications for positions available, and that Healing Warriors Program does not discriminate on the basis of race, color, religion, national origin, sex, marital status, age, disability, or any other status protected by law or regulation. I understand that all Contractors with Healing Warriors Program are subject to a criminal background check, and that State and county statutes require all persons working with children to undergo this background check. I understand that Contractors are expected to abide by Healing Warriors Program rules and policies.

Signature _____

Date _____

By checking here, I authorize an electronic signature for the name above.

Volunteer Release of Liability and Confidentiality Agreement

I, the undersigned, hereby release and agree to hold harmless Healing Warriors Program, its members, affiliates, and employees or loaned executives of any and all liability that could possibly be incurred as a result of my negligence, intentional or unintentional, during the commission of my responsibilities as a volunteer for Healing Warriors Program. I further release and hold harmless Healing Warriors Program its members, affiliates, and employees or loaned executives of all liability with regard to any physical or emotional harm that I may sustain as a result of my participation as a volunteer, or in any other activity sanctioned by Healing Warriors Program.

I recognize that any and all information shared with me as part of my duties as a volunteer is confidential and shall not be divulged to unauthorized individuals, agencies, or organizations.

I will not disclose or use any client information for any purpose other than for the limited purpose of providing the assigned services.

I have read and understand the above, and by my signature, consent to have the references which I have listed contacted.

Signature _____

Date _____

By checking here, I authorize an electronic signature for the name above.

Please e-mail this completed form to HR@HealingWarriorsProgram.org or print and mail it to:

Healing Warriors Program Attn: Human
Resources
1044 West Drake Road, Ste 202
Ft. Collins, CO 80526 (970) 776-8387

Thank you,
Healing Warriors Program