

IFNH Professional Membership Application

Name: _____
(Print exactly as you want on your membership certificate; include your degree if desired)

Clinic: _____

Address: _____

City: _____ State: _____ Zip: _____

Type of Practice: _____ Retired

Phone: _____ Fax: _____

E-Mail Address: _____ Website: _____

I give permission to send IFNH related material to my E-mail Please don't use my E-Mail

What schools did you attend? _____

Type & Date of Degree(s): _____

How long have you been in practice? _____

How long have you been using nutrition in your practice? N/A _____

How long have you been using natural remedies in your practice? N/A _____

How long have you been using Homeopathy in your practice? N/A _____

Do you use any of the following clinical tools in your practice?

- | | |
|--|--|
| <input type="checkbox"/> Symptom Survey Software | <input type="checkbox"/> Specter Vision |
| <input type="checkbox"/> The Nutritional Exam | <input type="checkbox"/> Blood Analysis |
| <input type="checkbox"/> Acoustic Cardiograph | <input type="checkbox"/> In Office Lab (urine, blood, etc) |
| <input type="checkbox"/> Heart Rate Variability | <input type="checkbox"/> Hair Analysis |
| <input type="checkbox"/> Bio Meridian Testing | <input type="checkbox"/> Saliva Testing |
| <input type="checkbox"/> Page Measurements | <input type="checkbox"/> Digestive Assessments |

List any other clinical tools: _____

On a scale of 1-10, how comfortable are you using the Nutritional Exam? _____

Have you taken the Foundations of Nutritional Therapy Course (FNT)? _____ If yes, when? _____

Have you taken any other courses from any of the following people?

- | | |
|---|--|
| <input type="checkbox"/> Jeremy E. Kaslow, MD, FACP | <input type="checkbox"/> Robert J. Peshek, DDS |
| <input type="checkbox"/> Michael Dobbins, DC | <input type="checkbox"/> Ray Bisesi, DC |
| <input type="checkbox"/> Jay R. Robbins, DC | <input type="checkbox"/> Fred Ulan, DC |
| <input type="checkbox"/> James Murphy, DO | <input type="checkbox"/> Janet Lang, DC |
| <input type="checkbox"/> Ernest Caldwell, DC | <input type="checkbox"/> Holly Carling OMD Lac |

If yes please name and approximate date of the courses you've taken. _____

If you have taken other courses, please describe and note their impact: _____

Did you get certified? _____ How many hours were required for certification? _____

Circle the type of muscle testing in your practice: None – CRA – NET – AK – ART – NRT – other

Circle any specific certification in nutrition: DACBN – CCN – CNC – NTT – Other _____

Do you have any certifications that you use in your practice that were not listed? _____

Are you interested in a certification in whole food nutrition? _____

How many staff members are in your practice? _____ How many are used clinically? _____

What are their credentials? _____

How many staff members are involved in your clinical nutrition practice? _____

Would your staff be interested in becoming a Certified Whole Food Nutrition Technician? _____

List the types of patient education programs you use? _____

What points do you emphasize? _____

What information would you find most supportive for a patient education program? _____

For an educational and/or certification program, circle the time structure(s) you would prefer:
(All Day - Saturday - Saturday & Sunday - 1 ½ hour - 2 ½ hour - Thursday - distant learning program)

Would you prefer a phone conference lecture accompanied by real time PowerPoint and Notes? You would receive a CD for use in your home or office computer while you are listening to lecture. _____

JOIN TODAY – First 250 to sign up for Professional Membership will be Charter members and will receive 3 free *original “Applied Trophology” articles* from the series.

SELECT A PAYMENT PLAN FOR THE ANNUAL MEMBERSHIP OF \$360.00

- One Payment Plan* of \$295, includes a \$65 discount
- Monthly Payment Plan* \$100 initial payment and \$28 per month for 10 months (Each payment includes a \$2 processing fee for a total of \$380)

Check

3-Digit Code: _____

Visa MasterCard # _____

EXP: _____

IFNH reserves the right to resuse membership to those who do not meet the criteria of the review board.

FAX (858)-488-2566 or MAIL: IFNH 3963 Mission Blvd. San Diego, CA 92109