

Share Your Healing Story *(For use by Reconnective Clients)*

Please complete this form in full and fax to us at 323.960.0011. Attach any additional pages as needed and thank you for sharing your Healing Story with us!

Your personal background:

Details on discovery of your medical situation:

How your situation has affected your life and the lives of those around you:

Healing Sessions:

Dates: _____

Total number of sessions: _____

Your Practitioner's Name _____

Experience during session or seminar:

Results after your session or seminar:

What led you to having a *Reconnective Healing™* session (please note any skepticism, if you had any)

How the healing affected your life:

Your Name _____

Your Town & State _____

Your Phone () _____ Your Email _____

Your Healing Story may be selected for sharing (verbally, in print, on the internet and/or in a future book). Should your story be selected, may we use your real name?

(Please check one) Yes No

By submitting this form, I give my permission for my story to be shared and/or distributed by The Reconnection, LLC without restriction. My real name will only be used if I have checked "YES" above.

Your Signature _____ Today's Date _____