Holosyndesis International

UNIVERSITY OF HEALTH AND SPIRITUAL SCIENCES INTL INTGR AUX 20
HOLOSYNDESIS CLINICAL RESEARCH

UHSS American Indian Clinical Research Campus
Holosyndesis Clinical Research
Spiritual Scientific Care/Counseling™ Release form

First name_____ Last name_____

Street Address_____

Town/City _____ State_____ ZIP_____

Email Address_____

Home Phone_____ Cell Phone _____

I recognize that I am coming under Spiritual Scientific Care/Counseling™ research. I hereby consent to receive spiritual scientific care/counseling and enroll in the Institutional Review Board (IRB) of this private trust consortium. I recognize that the counselor in this endeavor is a channel for Divine intervention and, in any consultation of service of or to me, is following the teachings, research and methodologies of Spiritual Scientific Care/Counseling™ research.

I agree to take part in the Spiritual Scientific Care/Counseling research process with knowledge of the above.

Print Name of Party entering into agreement _____

Signed _____ Date of Contract _____

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