The Systemic Constellations Group, LLC
FAMILY CONSTELLATIONS WORKSHOP
Registration and Release Form

This demonstration workshop is designed as an educational experience, not as a substitute for professional/medical consultation or therapy.

I understand that this workshop may bring up issues of a personal nature that may invoke physical and/or emotional responses.

I confirm that I do not currently suffer from any emotional or medical condition that might make it inadvisable for me to attend this workshop.

I agree to respect the confidentiality of any disclosure made within the course of this workshop.

I will not discuss any details about someone else's work outside the meeting space.

By signing this document below, I willingly agree to hold harmless and release from all liability the organizers, facilitators, and participants in this workshop.

Powerful healing is possible for every participant: as a client, a representative, or an observer. However, I understand that not all who attend the workshop will have the chance to set up their own constellation.

Signature _____ Date ____/_____/_____

COMPLETE ALL SPACES IN THE FORM BELOW

_____ Enclosed is my check for $135 payable to The Constellations Group.

The date of the workshop I plan to attend is _____/_____/_____

Name: _____

Address: _____

_____

Phone: (H) _____ (W) _____

Email: _____

I learned about this workshop by/from _____

Mail completed form and check to: The Constellations Group, 4000 Cathedral Avenue NW #250B, Washington DC 20016. Call (202) 253-1954 or (202) 257-8300 for more info.