

## 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, 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 BELOW

Enclosed is my check for #125.00 payable to The Constellations Group. \_\_\_\_\_

The date of the workshop I plan to attend is \_\_\_\_/\_\_\_\_/\_\_\_\_.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

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Phone: (H) \_\_\_\_\_ (w) \_\_\_\_\_ (M) \_\_\_\_\_

Email: \_\_\_\_\_

I learned about this workshop by/from \_\_\_\_\_

CEU's (6 from NASW): Yes\_\_\_\_ No\_\_\_\_ Certificate of Attendance: Yes\_\_\_\_ No\_\_\_\_

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.