

Coursework in Auriculotherapy Training form (CAT)

Name: _____ Degree or License: _____

1. Course, Seminar, Workshop, or Conference

Title of Course: _____

Organization offering Training: _____

Faculty Name(s): _____

Date(s): _____ Location: _____

Training Objectives: _____

2. Course, Seminar, Workshop, or Conference

Title of Course: _____

Organization offering Training: _____

Faculty Name(s): _____

Date(s): _____ Location: _____

Training Objectives: _____

3. Course, Seminar, Workshop, or Conference

Title of Course: _____

Organization offering Training: _____

Faculty Name(s): _____

Date(s): _____ Location: _____

Training Objectives: _____

I have successfully completed the auriculotherapy training listed above.

(Signature)

(Date)