



ICTA Cupping Workshop Registration Form

Full Name	Mailing Address	Telephone Number(s)
Email Address (important)	Current Medical Licensure: (RN, LMT/RMT, MD, LAc, PT, ND, etc)	
Dates/Location of Workshop	State/Province of Issue and License # -	
How you wish your name to appear on your certificate – (name only please)		
How did you hear about this workshop? <input type="checkbox"/> ABMP <input type="checkbox"/> AMTA <input type="checkbox"/> Acupuncture Today <input type="checkbox"/> Massage Today <input type="checkbox"/> Massage Magazine <input type="checkbox"/> Google or other online search engine <input type="checkbox"/> Friend or Professional Colleague <input type="checkbox"/> Other <input type="text"/>	Reason for taking the Cupping workshop: <div style="border: 2px solid black; padding: 10px; background-color: #e0e0e0;"> <p align="center">Please Check One:</p> <p>NCBTMB CE Hours _____</p> <p>NCCAOM PDA Points _____</p> <p>_____</p> <p>Report to CE Broker? _____</p> </div>	
Emergency Contact Name and Telephone Number –		

International Cupping Therapy Association

info@cuppingtherapy.org

425.999.2225

