Client Name: _____

Address: _____

_____

Cell Number: _____

Email Address: _____

I understand that close contact with people can increase the risk of infection from COVID-19 and other communicable diseases. By signing this form, I acknowledge that I am aware of the risk and give consent to receive Sessions and/or take classes/workshops.

I understand that my name and contact information may be shared with the state health department in the event a client, student or practitioner at this facility tests positive for COVID-19. My contact details will ONLY be shared if pertinent based on suspected exposure date, and only for appropriate follow up by the health department.

In the last 14 days, to the best of my knowledge, I have not tested positive for Covid 19, been asked to self-quarantine, exhibited cold/flu like symptoms or been in close contact with anyone who has.

Client Signature:

_____

Practitioner Signature:

_____

(Maureen M. Aruta)

Date: _____

HEALING
with Mo