



ACADEMY OF LYMPHATIC STUDIES STUDENT APPLICATION FORM

Please complete all sections of this application in full. Under the terms of our course accreditation, we will not be allowed to commence your training until we have received your signed application form and a copy of your professional credentials.

You may also enroll online via our secure website at www.acols.com or call 1-800-863-5935 for more information.

SECTION ONE - COURSE INFORMATION

Course Date: _____ Location: _____

SECTION TWO - STUDENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Cell #: _____ Email: _____

Home #: _____ Occupation: _____

Work #: _____ License #: _____

Preferred contact method: email phone postal mail
(Check all that apply)

Print your name details below exactly as you wish for it to appear on your certificate (e.g. John A. Smith, PT)

Please contact us immediately if any of your contact details change so that we can stay in touch with you.

SECTION THREE - EMPLOYER INFORMATION

Company Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

SECTION FOUR - EDUCATION

We require an official copy of your professional license, diploma or school transcripts.

- Select Preferred Option: Professional license/diploma/transcripts are included
 School is sending a copy of my records

Name on license/diploma/transcript if different from name above: _____

Please provide explanation for difference: _____

Have you previously attended an ACOLS Course? Yes No

Please provide details: _____

SECTION FIVE - EMERGENCY CONTACT

Last Name: _____ First Name: _____ Relationship: _____

Primary Phone #: _____ Secondary Phone #: _____

Please provide details of a second contact in case we are unable to contact the person above.

Last Name: _____ First Name: _____ Relationship: _____

Primary Phone #: _____ Secondary Phone #: _____

SECTION SIX - MEDICAL HISTORY

Manual Lymph Drainage and Complete Decongestive Therapy is a gentle, manual treatment technique. As with any health care modality, some conditions may be contraindicated for and/or aggravated by certain types of manual treatment technique and compression therapy. To support your wellbeing as a student, it is important that we are aware of any health conditions you may have.

Do you have any of the following conditions? Please check all that apply and explain below if necessary:

- | | | |
|---|--|---|
| <input type="checkbox"/> Cardiac/Circulatory Problems | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Herniated Disk |
| <input type="checkbox"/> Vision or Hearing Impairment | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Diabetes or Hypoglycemia | <input type="checkbox"/> Carpal Tunnel Syndrome | |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> CVA (Cerebro-Vascular Accident) | |

 Additional Information: _____

 Have you had any surgeries? If so, please explain: _____

 Have you had, or do you have, any injuries? If so, please explain (include any musculoskeletal injuries and/or repetitive stress injuries): _____

 Do you have any contagious diseases or conditions? If so, please explain: _____

 Please list any medications you are currently taking: _____

 Do you have any serious allergies? If so, please explain: _____

 Do you have any physical or psychological condition(s) for which you are receiving on-going treatment or are considered chronic? If so, please explain: _____

 Do you foresee any complications balancing your educational & personal commitments? If yes, what might these complications be and how might you be able to remedy them? _____

 Are you pregnant or trying to become pregnant? Yes No

SECTION SEVEN - REGISTRATION

Please select the course, tuition payment and Home Study option (if applicable to the selected course):

- | | |
|--|--|
| <input type="checkbox"/> Complete Certification Course (135 hours)
Select pre-course Home Study option:
<input type="checkbox"/> Written Home Study
<input type="checkbox"/> Online Home Study | \$2,850 - See payment options below
Select payment option:
<input type="checkbox"/> Make payment of \$2,850 in full
<input type="checkbox"/> Pay \$850 deposit with application (remaining balance of \$2,000 due 2 weeks before class) |
| <input type="checkbox"/> Upper Extremity Certification Course (86 hours)
Select pre-course Home Study option:
<input type="checkbox"/> Written Home Study
<input type="checkbox"/> Online Home Study | \$1,800 - See payment options below
Select payment option:
<input type="checkbox"/> Make payment of \$1,800 in full
<input type="checkbox"/> Pay \$850 deposit with application (remaining balance of \$950 due 2 weeks before class) |
| <input type="checkbox"/> Attend the last 7 days of the Complete Certification Course - only available to former graduates of the Upper Extremity Course (58 hours) | \$1,100 - Full payment due with application |
| <input type="checkbox"/> Lymphedema Management Seminar (31 hours) | \$895 - Full payment due with application |

Please note: Tuition on the following courses does not include the textbook for 'Lymphedema Management' authored by Joachim Zuther

- | | |
|--|---|
| <input type="checkbox"/> Wound Management Strategies (16 hours) | \$595 - Full payment due with application |
| <input type="checkbox"/> LANA® Exam Preparation (16 hours) | \$320 - Full payment due with application |
| <input type="checkbox"/> Billing and Documentation (8 hours) | \$275 - Full payment due with application |
| <input type="checkbox"/> 'Lymphedema Management' Textbook | \$50 - Full payment due with application |

SECTION EIGHT - PAYMENT INFORMATION

- | | |
|---|---|
| <input type="checkbox"/> Pay by Purchase Order | P.O. #: _____ |
| <input type="checkbox"/> Pay by Check | Check #: _____
(check payable to: ACOLS) |
| <input type="checkbox"/> Bill my organization | Card #: _____ - _____ - _____ |
| <input type="checkbox"/> Pay by Credit Card
(Visa, MasterCard or Discover) | Expiry: _____ / _____ |
| | Security 'V' Code: _____ (last 3 numbers on signature line) |
| | Name on Card: _____ |

SECTION NINE - BILLING ADDRESS

Last Name: _____ First Name: _____ Middle Initial: _____

Company Name (if applicable): _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Email: _____

SECTION TEN - ATTESTATION

Lymphedema Therapy is a demanding profession. The training provided by the Academy of Lymphatic Studies (ACOLS) involves giving and receiving manual treatment and compression therapy on each day during the course that may create physical and emotional demands. While our curriculum allows each student to adapt to a variety of techniques while developing stamina, we ask you to consider your overall fitness before committing to this training.

By signing below, I verify that I have considered my health and my ability to complete a program in Manual Lymph Drainage (MLD) and Complete Decongestive Therapy (CDT) at ACOLS and will not hold ACOLS liable for any pre-existing conditions that may limit my ability to perform MLD and CDT.

I understand that all student records are strictly confidential and are kept permanently on file in the school administrative offices. Student records are only available to the individual student, ACOLS' administrative and teaching staff, and Department of Education officials.

Print Name: _____ Signature: _____ Date: _____

By signing below, I confirm that I understand that during the course I will perform and receive MLD and CDT with other students for practice purposes. I release those students, ACOLS and ACOLS' Instructors and staff from any responsibility for my health. I also understand that the physical requirements of this course could trigger or inflame existing physical or physiological conditions.

Print Name: _____ Signature: _____ Date: _____

BY SIGNING BELOW, I AGREE THAT I WILL NOT HOLD ACOLS, ACOLS' INSTRUCTORS AND STAFF OR ACOLS' FACILITY PROVIDERS LIABLE FOR ANY MEDICAL CONDITIONS WHICH HAVE OR HAVE NOT BEEN REPORTED ON THIS FORM OR ANY CONDITIONS THAT ARISE DURING OR AFTER THE COURSE. I HAVE COMPLETED THIS APPLICATION TO THE BEST OF MY KNOWLEDGE AND I STATE THAT THE INFORMATION PROVIDED IS TRUE AND CORRECT.

Print Name: _____ Signature: _____ Date: _____

Thank you for choosing ACOLS as your preferred training provider!

FINAL CHECKLIST

Under the terms of our course accreditation, we will not be allowed to commence your training until we have received your signed application form and a copy of your professional credentials.

Please use the following checklist to ensure that your application is complete.

- Sections One to Ten completed in full
- Signed and dated Section Ten in 3 places
- Enclosed an official copy of your professional license, diploma or school transcripts
- Smile because you've just chosen the premier school for your Lymphedema Management training!

Please return your completed application form to ACOLS by fax or to the following address:

ACOLS, 11632 High Street, Sebastian, Florida 32958