Klose Training
Lymphedema Certification

Klose Training
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STUDENT INFORMATION FORM

BUSINESS INFORMATION (To be shared with your permission):

Business Name: ____

Department: ____

Your Name: ____

Prof. Credentials (please abbreviate, i.e. PT, PTA, OTR/L) : ___________________________________

Biz Street Address (include suite): ____

Biz City, State/Province/Region: ____

Postal Code: ______________ Country: ____

Type of facility (check all that apply as to how a patient can receive treatment for lymphedema at your facility):

- ☐ Home Health Provider
- ☐ Inpatient Facility
- ☐ Outpatient Facility
- ☐ Private Practice
- ☐ Skilled Nursing Facility

Work Phone: ____

PERSONAL INFORMATION (will not be shared):

Cell Phone: ____

Preferred Email: ____

Alternate Email: ____

Home Street Address (include apt/unit): ____

Home City, State/Province/Region: ____

Postal Code: _______________ Country: ____

Please contact Klose Training to update your information if it changes in the future.

CONSENT TO CONTACT

Your privacy is important to us. Klose Training does not share your personal information with outside businesses. On occasion, Klose Training may email you about continuing education opportunities we believe will be of interest to you. If at any time you would like to opt out, please contact Klose Training to make your preferences known. If, starting immediately, you would prefer NOT to receive any further communication from Klose Training, initial the statement below.

*To **DECLINE** all future emails from Klose Training, initial the following:*

__________ *I understand that by initialing this statement, I will NOT receive further emails from Klose Training including notices of new continuing education opportunities and information about future Klose Training Lymphedema Conferences. I understand that I can request to resume receiving Klose Training emails at any time by calling Klose Training at 303-245-0333 or emailing info@klosetraining.com.*

Initials