Cancer Resource Center of Western Maine

199 Main Street
PO Box 263
Norway, ME 04268

Wellness Provider Application

Thank you for your interest in becoming a wellness provider for CRCWM. As a Wellness Provider we ask you to be familiar with our Vision and Mission Statements, they are stated below.

VISION

We are a healthy community involved in providing, sharing and receiving resources and services that enhance life for individuals and their loved ones facing the challenges of Cancer.

MISSION

We embrace anyone affected by Cancer in a community that offers hope and caring through support, education and concepts in healthy living.

Name _____ Date_____

Mailing address: _____

Email: _____

Landline phone: _____ Cell phone: _____

How do you prefer to be contacted? _____

Former/Current Occupation: _____

Other jobs/positions you have held in the past: _____

Education: (Last year of school completed): _____

Please complete the appropriate section(s) below.

REIKI

1. What level of Reiki training have you attained? _____
2. Who was your teacher(s)? _____
   _____
3. Do you have liability insurance? Circle one: YES NO
4. Do you have experience working with Cancer patients, caregivers or other special populations? Please explain._____
   _____
   _____
   _____
5. Please describe the benefits of Reiki to yourself and others.
   _____
   _____
   _____
   _____
6. Please attach copies of your training and proof of your insurance to this form.

MASSAGE

1. What level of massage training have you attained? _____
2. Do you have a license to practice in Maine? Circle one: YES NO
3. Do you have liability insurance? Circle one: YES NO
4. Have you received specialized training for massage for cancer patients? YES NO

   If YES, please explain:
   _____
   _____
   _____

5. Do you have experience working with Cancer patients, caregivers or other special populations?
   YES NO
   Please explain: _____

6. Please describe the benefits of massage to yourself and others.

7. Please attach copies of your massage license and proof of your insurance to this form.

THERAPEUTIC YOGA

1. Have you completed a 200 hour Yoga Teacher Training? YES NO
2. What additional yoga trainings have you completed that will support you in providing individual session for Cancer patients, survivors, and/or caregivers?_____
3. Are you registered with Yoga Alliance? YES NO
4. What registry(s) do you carry through Yoga Alliance? (Circle all that apply)

   RYT200 E-RYT200 RYT500 E-RYT200 RYT500 E-RYT500
5. Are you a Certified Yoga Therapist with IAYT? (C-IAYT) YES NO
6. Please describe any experience that you have working with individuals, special populations, and restorative yoga. _____
7. Do you have liability insurance? Check one: YES NO

8. Please describe the benefits of yoga to yourself and others:

_____

_____

_____

_____

9. Please attach copies of your 200 hour Yoga Teacher Training certificate, Yoga Alliance Registry, and/or C-IAYT certificate, and proof of your insurance to this form. If you have additional certificates from advanced trainings that you'd like to share with us please also attach those.

OTHER Please name: _____

1. What level of training have you attained? _____

2. Do you have a license to practice in Maine? YES NO

3. Have you received specialized training for cancer patients? YES NO

   If YES, please explain:

_____

_____

_____

_____

4. Do you have experience working with cancer patients? Please explain.

_____

_____

_____

_____

5. Do you have liability insurance? Circle one: YES NO

6. Please describe the benefits of your work/program to yourself and others.

_____

_____

_____

7. Please attach copies of your training and proof of your insurance to this form.

Check YES or NO to the following statements:

1. The Cancer Resource Center of Western Maine has my permission to use my photograph for public relations purposes.	Yes	No
2. Have you ever been convicted in a court of law? If yes, please explain: _____ _____ _____	Yes	No
3. I understand all Cancer Resource Center Wellness Providers may be subject to a background check and by checking YES to this statement I am giving consent for this screening.	Yes	No
4. I am current with my flu shot and can provide proof.	Yes	No
5. Are you interested in providing volunteer services at the center?	Yes	No
6. Are you interested in providing services for pay at the center?	Yes	No
7. Are you interest in providing services in a private setting for pay?	Yes	No

REFRENCES:

Please provide the names, addresses and phone number of **THREE** references not related to you.
At least one of the references listed must be familiar with your work.

1. Name: _____
   Mailing address: _____
   E-Mail address: _____
   Phone number: _____
   How do you know this person? _____

2. Name: _____
   Mailing address: _____
   E-Mail address: _____
   Phone number: _____
   How do you know this person? _____

3. Name: _____
   Mailing address: _____
   E-Mail address: _____
   Phone number: _____
   How do you know this person? _____

Is there anything else you would like to share about yourself? If so, please describe below.

_____

_____

_____

_____

Please attach a business card to be considered part of our Wellness Provider Resource List.

I certify that all answers on this form are correct and answered to the best of my ability.

Signature of Applicant:_____ Date:_____

Please mail completed form to:

Cancer Resource Center of Western Maine
P.O. Box 263
Norway, ME 04268

For CRCWM only:

Date Received: _____