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# INSTITUTE OF CLASSICAL HOMOEOPATHY

2325 Third Street, Suite 426 San Francisco CA 94107  
Phone (415) 551-1020 Fax (415) 551-1021  
[ich@classicalhomoeopathy.org](mailto:ich@classicalhomoeopathy.org)

## STUDENT APPLICATION

Please submit to the above address with a \$25 application fee

|                           |                           |
|---------------------------|---------------------------|
| Name _____                | Date of Application _____ |
| Address _____             | Home Phone _____          |
| City, State, Zip _____    | Work Phone _____          |
| Occupation _____          | Cell Phone _____          |
| Place of Employment _____ | FAX _____                 |
| _____                     | Email _____               |

### Please fill out all relevant parts of this form.

How did you find out about the ICH program? \_\_\_\_\_

When did you find out about the ICH program? \_\_\_\_\_

Do you have any health or learning problems that might affect your ability to participate in the program? If Yes, please explain. (Attach relevant documentation.)

\_\_\_\_\_

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### List two current employment or academic references:

Name \_\_\_\_\_ Phone \_\_\_\_\_

Institution/Business \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

Institution/Business \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

*The Institute of Classical Homoeopathy admits students of any race, color, national and ethnic origin, gender or sexual orientation to all the rights, privileges, programs, and activities generally accorded or made available to students at the school. It does not discriminate on the basis of administration of its educational policies, admissions policies, scholarship programs, and other school administered programs.*

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# INSTITUTE OF CLASSICAL HOMOEOPATHY

## Educational Background

School and Location

Dates Attended

Degree/Major

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Have you ever undertaken a formal study of Homoeopathy? If Yes, where, when, and for how long?

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Are you currently enrolled in any other training program? If Yes, what course of study and where?

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Have you completed courses in any of the following? If Yes, please provide names of schools and dates of completion. Credit will not be given until transcripts are provided, except in the care of licensed health care providers.

|                    | <b>School Name</b> | <b>Date Completed</b> |
|--------------------|--------------------|-----------------------|
| Anatomy/Physiology | _____              | _____                 |
| Pathology          | _____              | _____                 |
| Clinical Science   | _____              | _____                 |
| Psychology         | _____              | _____                 |
| First Aid/CPR      | _____              | _____                 |

### Professional Licenses/ Credentials

(Please attach a copy of credentials.)

**Type**

**Agency**

**Expiration Date**

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Are you a member of any professional organizations? If Yes, please list.

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Are you interested in receiving the Certificate of Proficiency?     Yes                     No









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