If you are interested in a membership as therapist or alternative practitioner, please contact HPCM.
Phone: 0031- 457 111 260, email: hpcm@rath-programs.com

EN

APPLICATION TO PARTICIPATE AS A CONSULTANT

in the Partner Program of the Dr. Rath Health Alliance

Personal details of the applicant: Please fill out in block letters.

Surname, first name*

House no, Street*

Town, post code*

Country*

Date of birth

Telephone*

Fax

Email*

Occupation/job

Please transfer my fees to the following account:

Bank*

Swift code (BIC)*

IBAN*

* The Information marked with an asterisk is mandatory.

I hereby apply to join the Partner Program of the Dr. Rath Health Alliance. I have received a copy of the Dr. Rath Health Alliance Guidelines (last status: 16 March 2020) and am in agreement with them – **in particular with data collection and processing as described under point 11.** Participation is voluntary, free of charge and can be terminated at any time.

The Partner Program relies on the information we receive about how new members find us. Please tell us here who invited you to join the Dr. Rath Health Alliance:

☐ **Consultant**

[Name, membership number (if available)] has introduced me to the Partner Program of the Dr. Rath Health Alliance.

If no consultant has referred you, you can tick here if you would like to get in touch with a competent consultant in your area:

☐ **I have become aware of the Partner Program and would like to get in touch with a consultant in my area.**

Date, place

Applicant's signature

Please accept that we can only process fully completed applications. In the case of any changes to your personal data, please send these to us as quickly as possible to ensure that we can calculate and pay your fees smoothly. Please retain a copy of this application, including the guidelines, for your personal documents.

#1844/ 02.210320/UK

Dr. Rath Health Programs B.V. | Postbus 657 | NL - 6400 AR Heerlen | Tel: 0031- 457 111 112 | Fax: 0031- 457 111 119 | Consulting.services@rath-programs.com