Healing Warriors Program

Independent Contactor Application
Attn: Human Resources
1044 West Drake Road, Ste 202, Ft. Collins, CO 80526
HR@HealingWarriorsProgram.org | 970-776-8387

First Name _____ Last Name _____

Street Address _____

City _____ State _____ Zip Code _____

Cell Phone _____ Home Phone _____

eMail _____

For which modality are you applying? (check all that apply) ☐ Acupuncture ☐ CranioSacral ☐ Healing Touch

Are you licensed? ☐ Yes ☐ No License No. _____

Practitioners working with Healing Warriors Program are 1099 Independent Contractors. In accordance with State of Colorado requirements, 1099 contractors must have an independent business providing the same professional services for which they are being contracted.

Do you have an independent business providing the same professional services? ☐ Yes ☐ No

How did you hear about this opportunity? _____

Have you ever applied to HWP before? _____

Do you have any friends/relatives working for HWP? If yes, state name and relationship. _____

HIPAA: Do you have a current HIPAA certificate? ☐ Yes ☐ No

ACUPUNCTURE: HWP only contracts state licensed acupuncturists

What School of Acupuncture: _____

What is your license # _____

List your National Provider Identifier number **(NPI)** https://npiregistry.cms.hhs.gov/ _____

List your **CAQH** # https://www.caqh.org/about/contact _____

Are you currently a VA Provider? ☐ Yes ☐ No

CRANIOSACRAL THERAPIST

What CranioSacral school did you attend?

☐ Upledger
☐ Biodynamic
☐ Other, please detail which school _____

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CRANIOSACRAL THERAPIST (continued)

Please list Certificates of Training:

Please list DORA License number:

List your National Provider Identifier number (NPI)
https://npiregistry.cms.hhs.gov/

List your CAQH # https://www.caqh.org/about/contact

HEALING TOUCH THERAPIST

What is your Healing Touch training? ☐ HBB ☐ HTP
(HWP) works with practitioners from both certificate programs.

Are you Certified? ☐ Yes ☐ No

Expiration Date of your current certification:

If your certification is expired, when will you be renewing your certification?

Are you a Nurse? ☐ Yes ☐ No

If yes, list your National Provider Identifier number (NPI)
https://npiregistry.cms.hhs.gov/

Please attached copies of appropriate licenses and certifications to this application.

EMERGENCY CONTACTS			
Name:		**Relationship:**	
Phone:		**Email:**	
Name:		**Relationship:**	
Phone:		**Email:**	

PROFESSIONAL REFERENCES (please provide 2)			
Name:		**Relationship:**	
Phone:		**Email:**	
Name:		**Relationship:**	
Phone:		**Email:**	

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I certify that all information in this Independent Contractor Application is true and complete. I understand that any false information or omission may disqualify me from further consideration for Contractor service and may result in my dismissal if discovered at a later date. I understand that Contractors are evaluated on the merits of their qualifications for positions available, and that Healing Warriors Program does not discriminate on the basis of race, color, religion, national origin, sex, marital status, age, disability, or any other status protected by law or regulation. I understand that all Contractors with Healing Warriors Program are subject to a criminal background check, and that State and county statutes require all persons working with children to undergo this background check. I understand that Contractors are expected to abide by Healing Warriors Program rules and policies.

Signature _____

Date _____

☐ By checking here, I authorize an electronic signature for the name above.

Volunteer Release of Liability and Confidentiality Agreement

I, the undersigned, hereby release and agree to hold harmless Healing Warriors Program, its members, affiliates, and employees or loaned executives of any and all liability that could possibly be incurred as a result of my negligence, intentional or unintentional, during the commission of my responsibilities as a volunteer for Healing Warriors Program. I further release and hold harmless Healing Warriors Program its members, affiliates, and employees or loaned executives of all liability with regard to any physical or emotional harm that I may sustain as a result of my participation as a volunteer, or in any other activity sanctioned by Healing Warriors Program.

I recognize that any and all information shared with me as part of my duties as a volunteer is confidential and shall not be divulged to unauthorized individuals, agencies, or organizations.

I will not disclose or use any client information for any purpose other than for the limited purpose of providing the assigned services.

I have read and understand the above, and by my signature, consent to have the references which I have listed contacted.

Signature _____

Date _____

☐ By checking here, I authorize an electronic signature for the name above.

Please e-mail this completed form to HR@HealingWarriorsProgram.org or print and mail it to:

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(970) 776-8387

Thank you,
Healing Warriors Program