

The Colonic Network www.colonic.net

ADVERTISEMENT / LISTING FOR OPEN FDA Class II. COLONIC SYSTEMS

PRINT Name/Therapist _____ Business _____

Business Address _____ City _____ State _____ Zip _____

Business Phone Number _____ Province _____ Country _____

Note: For International Listings, Please provide complete dialing info from USA (ie:011).

I-ACT Member ___ Level I. ___ Level II. ___ Level III. ___ Instructor ___ (Send Copy of Certificates)

Open FDA Class II. Device Name; _____ Serial # _____ (Required)

ANNUAL WEB SITE LISTING ADVERTISEMENT: Does Not Include E-mail Option!

Advertisement on Colonic Network Web Site for Twelve (12) Months with Current Prescription!

One Therapist Name per Listing - All Therapists Advertised Must be listed on the Current Prescription.

_____ \$100.00 Fee - Primary Therapist Name, Business Name, Address and Business Phone

_____ \$ 50.00 Fee - Additional Therapist Listing - Same Location and Business Phone

_____ \$ 50.00 Fee - Additional Therapist Listing - Same Location and Business Phone

Additional Therapists; _____, _____

Send Copy of Certificates! (NOTE: Listing cancelled / removed from web when Rx Expires.)

OPTIONAL: ALLOW CLIENTS TO EMAIL YOU - Link to Web site not available!

\$100.00 FEE PER LISTING EMAIL _____

\$100.00 Primary + # _____ Additional @ \$ 50.00 = \$ _____ + # _____ E-mail @ \$100.00 = \$ _____

Total Amount \$ _____ Check # _____ VISA _____ Master Card _____

Card Number _____ Exp. ___/___ 3 digit Security (_____)

PRINT Name of Card Holder _____

Signature of Card Holder **X** _____

Initial

_____ I/we use an FDA Registered Open Class II. Device - Device Name and Serial # is shown above.

_____ I/we only use FDA approved nozzles, flexible tubing and disinfectants per my device manufacturer.
(I/we am aware that use of non-approved Nozzles is against US Federal and International Regulatory Laws and makes my Device considered Adulterated, Illegal and I am subject to fines and lawsuits!)

_____ I/we will always stay in my "Scope of Practice" and follow my Device Manufacturers Guidance.

_____ I/we have never been accused or convicted of a sexual related type felony or misdemeanor.

It is my/our responsibility to provide notice of any changes to the listing in writing.

Should any of this information prove to be false - I/we will immediately be removed with no refund!

I have initialed above, my signature certifies that this information is true and accurate!

Owner Signature X _____ Date ___/___/ 2009

Complete and Sign or Listing will be delayed. We reserve the right to refuse service to anyone!

Colonic.net; 10911 West Avenue • San Antonio, Texas 78213 • Phone 210 308-8888 Fax 210 349-5679

Eff. 1/2/2009

Re: FDA Colonic Irrigation Device and/or Colonic Nozzles

PLEASE PRINT

Device Facility Business Name: _____
Business Address: _____ Phone _____
City _____ State _____ Zip _____
Facility Owned by: _____
Facility Therapist Name: _____
Facility Email Address: (so we can contact if needed:) _____

Colonic Irrigation Device(s):

Device Manufactured By: _____ Device Name _____
First Device Serial # _____ Additional Device Serial # _____
Additional Device Serial # _____ Additional Device Serial # _____

"U.S. Food & Drug Administration (FDA) Requirements"

Colonic Irrigation Devices are FDA (Class II.) Medical Device's for Colon Hydrotherapy. To purchase or use such Device and or Nozzles, a (Doctor/Physician) Medical Health Care Practitioner Licensed by Law in that state, must direct, prescribe or order the use of such device. The LIBBE and LIBBE Nozzles are FDA, ISO 13485: 2003, CE 0086, and Health Canada #78207.

The Below is completed by your Area Physician / Licensed Medical Practitioner.

SAMPLE: OR PRACTITIONER MAY CHOOSE TO WRITE ON PRESCRIPTION PAD.

PLEASE PRINT

Medical Practitioner: _____
Address _____
City _____
State _____ Zip _____
Country _____
Off Phone _____ Cell _____

PLEASE PRINT
Licensed Medical
Practitioner
Name, Address,
Phone, etc:

PRN _____ or Refill: #Boxes _____ (Order Expires 12 Months from below date)
(Note: When **PRN** is marked; it means **P**rescription **R**efilled as **N**eeded.)

Signed: _____ Date: ____/____/2009

X _____ TYPE _____ State Lic.# _____
Licensed Medical Practitioner Signature (MD DC ND) State/Province _____
Country if not US _____

Please mail original to; Tiller MIND BODY, Inc.

10911 West Avenue, San Antonio, Texas 78213

Questions: 210 308-8888 • Fax 210 349-5679

Practitioner Licensed - Sample Ltr. --1/2009