# School of Metaphysics® Healing Projection Request

Full Name

Mailing Address

City/State/Zip

Phone No.

Location 7:30 (CT) p.m. Sundays

Physical Description: Sex Age Height Weight

Coloring Hair Eyes Other

Description of Disorders

Signature of person requesting healing ______________________ Date

**For School use only**

Dates of Projection/Group/Leader:

Proj. 1 Proj. 2 Proj. 3

Follow up letter by Date