Quantum Lightweaving® Fellowship Of Lightweavers
Disclaimer and Agreement Form

I, (Print) _____,
being of sound mind, body and spirit, do agree to be fully responsible for my experience in any of the Quantum Lightweaving®/Fellowship Of Lightweavers events and personal sessions by Kenji Kumara and his staff of teaching assistants. I agree to waiver my right to hold Quantum Lightweaving, Fellowship Of Lightweavers, Kenji Kumara and any of his training assistants responsible for any and all effects from the work on any level of consciousness and physical body.

I agree that I am physically, emotionally, mentally, spiritually and socially adjusted and balanced to attend and participate in the Intensive, Intro, Audience Work, FOL Ordinations and/or personal sessions. I agree to submit in writing my medical doctor's permission to attend any Quantum Lightweaving® events in the event I have a medical condition that requires monitoring such as mental, emotional, and physical handicaps or limitations and/or any mental or psychiatric conditions that require the use of medications or natural remedies.

I understand that Quantum Lightweaving® and the Fellowship Of Lightweavers promotes a safe, comfortable, nurturing and protective atmosphere and environment for rapid, gentle and lasting transformations and changes within the consciousness.

I agree to be filmed, video and/or audio taped in any of the Quantum Lightweaving® event and for my photograph and/or testimonial to be used anonymously regarding attendee feedback or on www.QuantumLightweaving.com website.

I agree that my attendance in any event is of my own free will and choice, and I am ready to experience the heart of healing and transformation that is best for my body, mind, soul and spirit. I understand that QL is not a replacement for medical therapies, procedures and consultations but may act as a powerful complimentary adjunct and support for existing psychiatric, medical and physical therapy treatments. I understand that QL does not diagnose or treat medical and mental health conditions. We refer you to consult with your licensed physician, psychiatrist, psychologist, minister and therapist.

NAME (print clearly):
PHONE:
EMAIL (print clearly):
DATE:
SIGNATURE:

( ) Check box if you want to schedule an appointment
( ) Check box if you are interested in the next training.
( ) Check box if you want to apply for the Apprenticeship Program.