



HBOT for Adults

Complete the application below and sign the Code of Conduct form at the end of the packet. Submit the application with a copy of Medical documentation stating diagnosis. Mail completed application to Chambers for Hope at address above or email to info@chambersforhope.org.

PERSONAL HISTORY

Last Name: _____ First Name: _____

Mailing Address: _____

Date of Birth: _____ Gender: M F

Email Address: _____

Telephone #: _____ Alternate #: _____

How did you hear about the HBOT program?

Have you ever had HBOT treatments? YES NO

If yes, when did you receive HBOT treatment and at what clinic?

Are you currently under a physician's care? YES NO

What is your current diagnosis? _____

What medications do you take currently? _____

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Are you currently receiving or participating in any other treatment programs, i.e., Chiropractic Care, Massage Therapy, Acupuncture, etc? YES NO

If Yes, please indicate modality: _____

PERSONAL BIOGRAPHY

We would like to understand why you would like to be considered for the HBOT program. Please explain your situation. You can use the following bullets as a guide.

A. How did you obtain your diagnosis? Include information about injury if applicable.

B. Why would you like to be considered for the HBOT program?



C. Describe your symptoms and the impact they have had on: 1) your life; 2) school/work; 3) family.

D. Provide a short description of your goals for treatment.



E. Provide a short biography from your significant other (if applicable) explaining the impact of your diagnosis/injury on him/her and family life.



The CFH “Pay It Forward” Program allows recipients of HBOT funding an opportunity to help the next person in line. All “Pay It Forward” funds will be allocated to the Chambers for Hope Maintenance Fund for individuals needing additional HBOT treatments.

Are you interested in participating in the “Pay It Forward” Program? YES NO

If Yes: Donation Amount \$ _____

CODE OF CONDUCT

The HBOT program was developed because there is a great and unfulfilled need for safe and effective treatment for TBI and PTS as well as other conditions noted on the List of Internationally Treated Conditions. We want to help fill that gap in service and provide as many individuals access to services that assist in the healing process. In order to be accepted into the program, it is imperative that candidates agree to the following Code of Conduct.

Please read the following. If you agree, date and sign the bottom. If accepted into the HBOT program and medically cleared for treatment, I agree to:

1. Attend the prescribed number of HBOT treatments, on a weekly basis – no less than 4x/week.
2. Honestly and accurately describe my experiences and results as observed.
3. Provide written or video testimonials describing my experience and results that can be used to acquire donations via personal interactions, the Web or other media. (this can be anonymous)
4. To keep confident all personal information that I may acquire during treatments or interaction with other HBOT program members
5. To be courteous and respectful of other HBOT program members and staff in the treatment facility
6. Abstain from drinking alcohol and using tobacco on the days of treatment

Print Name: _____

Date: _____

Signature: _____