



# INTERNATIONAL HOLISTIC TOUCH INITIATIVE

(Managed by Fourthway ManHo Center, Reg. No.: JM 0349891-H)  
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## Trainer Form (Holistic Health Practice Program)

### Trainer Form

Name of Associate/Trainer/Master:

\_\_\_\_\_

Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Nationality: \_\_\_\_\_

Identity Card No./Passport: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Tel: \_\_\_\_\_ Fax: \_\_\_\_\_ HP: \_\_\_\_\_

E-mail \_\_\_\_\_

Highest education level: \_\_\_\_\_

Main work experience, occupation and/or number of years:

\_\_\_\_\_  
\_\_\_\_\_

Please indicate training fields/skills (and other expertise):

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

## Memorandum of Understanding (MOU)

1. I wish to be an IHTI Holistic Health Practice Program Associate/Trainer/Master Partner.
2. I understand that this associate-ship opens up training/other assignment opportunities to me by IHTI.
3. I understand that training/other fee/sharing ratio will be negotiable for any training/other assignments made available by IHTI and that either party will work together for success, mutual benefit and in the spirit of cooperation.
4. Either party can withdraw the associate-ship by written request for the withdrawal and upon giving each other sufficient time for the transition process in the interest of the program participants.

Signature: \_\_\_\_\_ Signature : \_\_\_\_\_

Name: \_\_\_\_\_ Name : \_\_\_\_\_

\_\_\_\_\_ Designation : \_\_\_\_\_

Date of Application: \_\_\_\_\_

Date of Approval : \_\_\_\_\_

**Note:**

**Copy of Resume/CV, certificates, diplomas, degrees, transcripts and others are required for official record purposes.**

If in doubt, please contact Professor Dr. Tan Man Ho for confirmation and verification

**Mobile: +6012-245 5127**