

WELLSPRING CHURCH

If you would like to share your testimony, please initial any line that applies. Please also sign and date this form.

Your PRINTED Name _____ Signature _____

Date _____ Phone # _____

_____ I grant permission to Wellspring staff to call me for the details of my testimony.

_____ Wellspring may share my testimony in any way including the Internet, radio and television.

_____ I grant permission to Wellspring to include my name in my testimony.

_____ I grant permission to Wellspring to release my name, phone number and/or e-mail address to outside parties such as Christian or non-Christian journalists or researchers.

_____ I am willing to be contacted occasionally by a person seeking healing of the same disease or injury of which I was healed.

_____ I would be willing to be filmed giving my testimony to be communicated in any way including the Internet, radio and television.

_____ I have medical documentation concerning my previous illness or injury that I would be willing to share.

_____ I have medical documentation concerning my healing that would be willing to share.