Preferred Patient Referral Program

(Please fill this out and then mail it back to us in the self-addressed stamped envelope.)

Your Name: _____

At Lighthouse Health, we have many programs available such as:

Breakthrough Weight Loss	Diabetes/Blood Sugar Issues	Skin Care Programs
Kids Weight Loss	Candida	Body Wraps
Teen Weight Loss	Fibromyalgia	Saunas
Family Weight Loss	Pain Relief	Detoxification Programs
Personal Training	Hormone Balancing	Maintenance

We would love to send out some literature on some of these programs to your friends, family, co-workers, or any other acquaintance you can think of who might benefit from this information. Please list people you know you might have an interest in any of this information. Please use an additional sheet if needed.

Name _____

Address _____

City, State, Zip Code _____

Information to Send (Optional) _____

Name _____

Address _____

City, State, Zip Code _____

Information to Send (Optional) _____

Name _____

Address _____

City, State, Zip Code _____

Information to Send (Optional) _____

Name _____

Address _____

City, State, Zip Code _____

Information to Send (Optional) _____