

HEALING ROOMS OF VALPARAISO

1305 Martinal Rd, Valparaiso, IN 46383

(219) 617-2372

HEALING TESTIMONY

Name: _____

Address: _____

Phone: (____) _____ Email: _____

Testimony: _____

(Use the back of this sheet if necessary)

I understand that by signing this testimony, I grant authorization to edit and/or condense as necessary, and I release its use in any form of media including web pages, internet, newspapers, radio, ministry letters, and television.

Signature: _____ Date: _____