

Co-Creation Catalysts Apprenticeship Program Description and Application

Co-creation Catalysts educational programs have been created to inform, support, and prepare complementary medicine, holistic, allopathic practitioners, life coaches and energy healers to thrive in our local, national, and global environments.

My courses are designed to gently yet radically change your life by the simplest, most powerful means available; teaching you the depth and breadth of the science of co-creation grounded in the understanding that everything is conscious, everything is information, and everything is in relationship.

Self-empowering. Creative. Supportive. Life-affirming. Compassionate. Out of the construct. Bliss Path aligned.

* Introductory Weekend: Workshop Co-Creation Catalysts

- Healing Holodigm: Your Multidimensional Essence and Intelligence
- Continuum of Healing Energies
- DNA and the Embodiment of Love (Core Essence/Living Light)
- Human Electromagnetic Field
- (7 chakra system evolving to 12+ chakra Bliss Path)
- Your Body Portal; Information centers and how to maintain them
- 5D+ Healing/Co-creation Dynamics and New Paradigm Templates

Completion of an Introductory Weekend Workshop is required for application and enrollment into the 2 year Co-creation Catalysts Apprenticeship Program.

My educational programs are all based on trust and nurturing of:

- Autonomy
- Recognizing our needs and highest good through direct knowing
- Joyous companionship
- Balance integration: emotion, sensation, thought, action
- Abundance
- Safe spaces of awareness (energetic, emotional, physical boundaries)
- Loving responsibility to self and others (I/We in Wholeness)

All Public Programs are recorded. Your enrollment and acceptance into the program grants us, the program providers with a blanket waiver to record participants, students and guests (this includes both video and audio recording).

PROGRAM COMPONENTS

This ongoing, two-year certification program grounds practitioners in the challenging transition from an egoic/mind-centered to heart-centered approach to life and the healing holodigm. When we expand our reality base from 3D to 5D, and beyond, our need for egoic control is supplanted by surrender to the mastery of the divine being who resides in every human heart. Our ultimate physical, mental, emotional, spiritual healing begins with our intention to establish trusting relationships with Source and Gaia.

This is how we reclaim our energy fields. Healing the wounds of childhood where separation from our life force and source begins, we open the space where we co-create profound healing of our bodies and lives.

Through lecture, demonstration, and experiential practice, I teach specific technique for consistent, judgment-free clearing while integrating soul fragments into healthy subtle energies.

PERSONAL CLEARING PROCESS: DISSOLUTION OF 3D PARADIGM TEMPLATES

Learn to re-establish connection to your Higher Self/Meta Being by:

1. Bringing loving awareness/attention to the templates embedded in your neurology that keep you locked in duality perception through emotional distress
 - a. Terror of Annihilation, Guilt, Shame, Entrapment, Non-Specific Fear/Anxiety states
2. Shifting your 'reality' perceptual base from ego/mind to heart and higher mind; zero point energy stops duality perception spinning out
3. Understanding choice; psychological defense against vulnerability and closing our hearts to ourselves, Source, and others in our lives
4. Insight into the energy dynamics of codependent relationships and their disruptive emotional patterns and entangling energy cords.

PSYCHODYNAMICS: YOUR ABUSED/WOUNDED INNER CHILD

1. Stages of human growth as mapped through energy field
2. Ego/emotional defense and creation of energetic distortions within your information portals
3. We mirror our wounds: practitioner/client relationships
4. Repatterning and reparenting
5. Mapping your emotional body
6. Inner Dialogue/Out of Projection: Wounded Child, Shadow Self

EXPANDED SENSE PERCEPTION: EMPOWERED EMPATHY

1. Clearing fear/personal power issues that limit multidimensional perception
2. Expand multidimensional sense perception with technique and practice
3. Verification and validation of awareness, perception and direct knowing

4. Accessing and utilizing inner knowing/guidance
5. Teamwork with non-physical healing partners (guides, angels, and more)
6. Learn the art of conscious dialogue and maintaining inner/outer clarity
7. Appropriate use of these skills: permission asked for and granted

ENERGY TECHNIQUE

Over time, I've reduced to steps many of the techniques which I use in hands-on or remote plasma healing. All of these techniques (how to) emerge from being anchored in complete trust and unconditional love.

Stay totally present to the highest awareness and maintain unity with clients. Ask what needs to happen rather than anticipating what needs to be done. Keep the healing sequence in the now, accessing the sea of unlimited, intelligent energy without hindrance from your mind. Planning or anticipating what needs to be "done" ahead of a healing session, whether virtual or in person) signals we are not in total trust and are possibly seeking ego/control. Co-creation catalyst experiences are based in surrender of control while accessing greater charge (information and consciousness in relationship).

To drop into this depth of surrender with a single breath, we must be clear, open, honest, vulnerable, and willing to see our 3D templates, energy entanglements, and Shadow distortions. This being understood, the following techniques are shared in throughout the two years of the program.

1. Open to the continuum of multidimensional expression using the One Breath
2. Create and hold space for the Healing Holodigm
3. Energy Field Mastery: beginning with simple fundamentals
4. develop a skill level that differentiates, accesses, repairs, and reintegrates all layers of the energy field simultaneously
5. Co-creating with Angels, 5D surgeons and master healers
6. Access, maintain, and radiate the Silver Violet Ray
7. Auric and Essence Healing
8. Past Life/Alternate Life Healing (clearing karmic cords)
9. Clearing dysfunctional relationship power cords between energy centers
10. Clearing/opening the heart center; assist with formation of tube torus
11. Seeing into the body and visual assessment of the energy field
12. Energy work in the body; soft tissue, muscle, bones, joints, vascular
13. Restructuring, repair, replacement of structured aspects of the energy field
14. Using sound as laser energy
15. Team/Group Healing: healing mass consciousness through the inner net

Practice, evaluation and verification of skills and technique happens in small pods during class sessions

OVERVIEW OF CHINESE MEDICINE, CRANIAL SACRAL, AND TAPPING

Occupation

(check) Fulltime Part time Self-employed Student
 Retired

Emergency Contact

_____ (Name) _____ (Relationship)

Phone: _____

Were you referred to us? By whom? _____

Co-creation Catalyst Apprentice APPLICATION FORM

Part A

Your Spiritual Skills Assessment.

Based on the lists below, circle the category that best describes your skill level.

What are the distinctions between beginner, intermediate, and advanced?

These are general parameters, but based on attending a prerequisite intro or 5 day intensive, Co-creation Catalysts faculty determined where to which group you'll be assigned after personal observation of your skills/dynamics in a live setting.

Beginner

- "awakening" experience or experiences ___
- meditation/prayer practice ___
- gratitude practice ___
- compassion/forgiveness practice ___
- aware of subtle energies ___
- Dowsing using pendulum ___
- Dream recall ___
- Multisensory dreaming ___

Intermediate

- Heart opening and expanding experiences ___
- "awakening" experience or experiences ___
- understanding of core wound ___
- understanding of shadow, negative energy expressions ___
- meditation/prayer practice ___
- gratitude practice ___
- compassion/forgiveness practice ___
- aware of subtle energies ___
- Dowsing ___
- Non-Reiki energy healing (self/others) ___
- past life healings/akashic records ___
- psychic abilities (with boundaries) (remote viewing) ___
- Reiki (yes/no) ___ yes ___ no
- psychic abilities (with boundaries) (remote viewing) ___
- telepathic communication ___
- Bilocation multiple experiences ___

Advanced

- Non-Reiki energy healing (self/others) ___
- Reiki (yes/no) ___ yes ___ no
- past life healings/akashic records ___
- psychic abilities (with boundaries) (remote viewing) ___

- psychic abilities (with boundaries) (remote viewing) __
- telepathic communication __
- Bilocation multiple experiences __
- understanding of core wound (active personal work ongoing) ____
- understanding of shadow, negative energy expressions (active personal work ongoing daily) __
- In communication/cooperation with earth elementals) __
- Sacred Union Journey (with or without 3D partner) __

Part B

Educational History, circle one or more options

- Completed high school
- Attended community college or associate’s program
- University Degree
- Professional license or accreditation
- Masters, Doctorate

Life and Professional Experience (last 5 years)

Part C

Assessment of Personal Strengths and limitations

1. How comfortable are you with your body? (*Please check most applicable*)

1a. Overall appearance

_____1(not at all) _____2(rarely) _____3(some of the time)
 _____4(most of the time) _____5(always)

1b. Weight issues

_____1(not at all) _____2(rarely) _____3(some of the time)

_____4(most of the time) _____5(always)

1c. Agility, coordination, flexibility

_____1(not at all) _____2(rarely) _____3(some of the time)
 _____4(most of the time) _____5(always)

1d. Sensuality, sexual expression, nudity

_____1(not at all) _____2(rarely) _____3(some of the time)
 _____4(most of the time) _____5(always)

1e. Playfulness, youthfulness, fun

_____1(not at all) _____2(rarely) _____3(some of the time)
 _____4(most of the time) _____5(always)

2. In the last month, how often have you felt that you were **unable** to control the important things in your life?

_____1(not at all) _____2(rarely) _____3(some of the time)
 _____4(most of the time) _____5(always)

3. In the last month, how often have you felt confident about your ability to handle your personal problems?

_____1(not at all) _____2(rarely) _____3(some of the time)
 _____4(most of the time) _____5(always)

4. In the last month, please rate your vitality; feelings of joy and hope about life.

_____1(not at all) _____2(rarely) _____3(some of the time)
 _____4(most of the time) _____5(always)

History of Surgeries

Date	Surgery

Medications and Supplements

5. Check each that you currently use:

- Laxatives Pain relievers Antacids
- Cortisone(or other steroids)
- Antibiotics Heart/Blood medication Allergy Medication
- Thyroid medication
- Sleeping pills Anti-depressants Birth Control Pills
- Hormones

Please list what medications (prescribed or over the counter), herbs, vitamins, supplements, etc. you are taking:

Family History

6. Please complete the following table, to the best of your knowledge

	Mother	Father	Sisters	Brothers	Children	Maternal Grandparents	Paternal Grandparents
Ages (if living)							
Current Health: Good/Poor							

Age at Death							
Cause of Death							
Age you were when they died							

Indicate if there have been any of the following diseases have affected you, your parents, grandparents, brothers, sisters, or children.

Cancer _____

Diabetes _____

Heart Disease _____

High Blood Pressure _____

Anemia _____

Kidney Disease _____

Allergies _____

Asthma _____

Arthritis _____

Tuberculosis _____

Epilepsy _____

Stroke _____

Glaucoma _____

Mental Illness Diagnosis _____

Alzheimer's/dementia _____

Sexually transmitted disease_____

Lifestyle/Habits

7. ___Y ___ N Have a religious/spiritual/meditation practice

8. ___Y ___N Practice yoga/exercise

9. ___Y ___N Receive regular bodywork (massage, craniosacral, rolfing, etc.)

10. ___Y ___ N Average 6-8 hrs. of sleep

11. ___Y ___ N Have a supportive relationship

12. ___Y ___ N Use recreational drugs

Substance_____ Amt/day_____

13. ___Y ___ N Treated for drug dependence

14. ___Y ___ N Use alcoholic beverages How much?

_____#/day _____#/week _____#/month

15. ___Y ___ N Treated for alcoholism

16. ___Y ___ N Use tobacco currently

17. ___Y ___ N Used tobacco in the past? How many years?

_____How many packs per day?_____

18. ___Y ___N Prescribed medication for mental health reasons? Explain

19. ___Y ___N Hospitalized for mental health reasons? Explain

Birth Information

20. Location of birth(city/state/country)_____

21. Place of birth: _____At home _____Small/rural hospital
 _____Large/teaching hospital _____Birthing center

22. What is your birth order? _____

23. Please relate any other information you know concerning your conception, your parents' attitude toward having you (planned, unplanned, wanted, confused, unwanted). If unwanted, did they consider or attempt abortion?

24. What do you know about your life in the womb including physical effects (maternal or paternal smoking, drinking, drugs, mom's diet), and emotional effects including absence or presence of father during pregnancy or birth, parents' relationship with each other during your pregnancy, siblings' attitude toward your birth? If you are adopted, give information about transition in hospital and new family as well as any birth history known.

25. Have you lost a child to miscarriage, abortion, stillbirth or death? If yes, please explain circumstances and dates and how this affects you today.

26. Please check what you know or think applies to your birth history.

_____ Home birth:

_____ Unmedicated vaginal birth at home

_____ Started at home and transported to hospital

Hospital birth:

_____ Unmedicated vaginal birth in the hospital

_____ Anesthesia used during birth

_____ Mother was induced: _____ Pitocin IV _____ Pitocin vaginally

_____ Water broken to speed labor

_____ Forceps used

_____ Cranial suction used

_____ Fetal Heart Monitor used

_____ C-section: _____ Emergency _____ Planned

_____ Breech birth

_____ Other _____

_____ Post-natal diagnosis of chronic condition _____

_____ If yes, what is the condition _____

Is this condition resolved, or an ongoing challenge? _____

27. _____ Are you a twin (or multiple)?

28. Please check what you know or think applies to your prenatal and birth history.
 _____ I was conceived by Artificial Insemination(AI) or In Vitro Fertilization (IVF)

_____ I had a twin that did not live.

If yes, at what point in the pregnancy or postnatal time did (do you sense your twin left? _____

Please add any other information you may know that you would like to add:

_____ I was premature. How many weeks? _____

_____ I was in a Neonatal Intensive Care Unit.

Please state how long. _____

_____ I was incubated. How long? _____

_____ **I was circumcised**

_____ Mother underwent complications or surgery at birth or within the first few days after birth describe

_____ **Did your mother die of complications due to your birth? At birth? Soon after?**

29. Where was your father during your birth? _____

30. Were you separated from you mother at birth (sent to a nursery)?

31. Were you breast-fed? If yes, how long?

_____ 1(not at all) _____ 2(<3 months) _____ 3 (<6 months)

_____ 4(1 year) _____ 5(2+ years)

_____ Unknown

32. Please note any interventions shortly after birth such as hospitalization for illness or high jaundice, operations, illnesses as an infant (6 months old or younger.)

33. Did either or both of your parents, step-parents, or their partners lose another child to miscarriage, abortion, stillbirth, or childhood death?

_____Yes _____No

34. If yes, are you aware of how this affected you? Give dates and circumstances.

35. Were you raised by a single parent? _____Yes _____No

36. Were you raised by your biological parents?

37. If your parents separated/divorced, how old were you?

38. Did you have other major primary care givers like grandparents, aunt and uncles, older siblings, nannies, guardians or adoptive parents? _____Yes _____No

Childhood Memories

39. Please rate the level of childhood memories you possess at this time:

_____1(none) _____2(a few) _____3(average) _____4(many)
 _____5(everything) **Age of earliest memory** _____

40. How often did you change houses as a child?

41. When you moved to a new home, please include information on these areas:

Did you fit in? _____

Did you find it easy to make friends? _____

Were you bullied, outcast, ostracized? _____

Frequently Unsupervised? _____

Were you happy or lonely? _____

42. Did you have any serious childhood illnesses (after age 6 months) or

hospitalizations? (please list):

43. Please rate the level of positive maternal support you received as a child:

_____1(none) _____2(rarely) _____3(some of the time)
 _____4(most of the time) _____5(always)

44. Please rate the level of positive paternal support you received as a child:

_____1(none) _____2(rarely) _____3(some of the time)
 _____4(most of the time) _____5(always)

45. Please rate the level of positive childhood friendships you had (*quality, not necessarily quantity*)

_____1(none) _____2(rarely) _____3(some of the time)
 _____4(most of the time) _____5(always)

46. Was there someone outside of your immediate family (neighbor, teacher) who gave you support, encouragement, or guidance as a child?

47. Did a parent or other adult in the household often or very often... Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?

_____Yes _____No

48. Did a parent or other adult in the household often or very often...Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?

_____Yes _____No

49. Did an adult or person at least 5 years older than you ever (check if yes)
 _____ Touch or fondle you or have you touch their body in a sexual
 way?
 _____ Attempt or actually have oral, anal, or vaginal intercourse
 with you?
 _____ **Ask you to touch, fondle or perform oral sex on them or
 another person?**

50. Did you often or very often feel that...No one in your family loved you or thought you
 were important or special? or Your family didn't look out for each other, feel close to
 each other, or support each other?
 _____ Yes _____ No

51. Did your family look out for each other, feel close to each other, and support each
 other:
 _____ Yes _____ No

52. Did you often or very often feel that you were neglected as a child: You didn't have
 enough to eat, had to wear dirty clothes, and had no one to protect you? or Your
 parents were too drunk or high to take care of you or take you to the doctor if you
 needed it?
 _____ Yes _____ No

53. Was a biological parent lost to you through divorce, abandonment, or other reason?
 _____ Yes _____ No

54. Was your mother, stepmother, father, stepfather, sibling (check all that apply):
 _____ often or very often pushed, grabbed, slapped or had something thrown at
 her?
 _____ sometimes, often, or very often kicked, bitten, hit with a fist or hit something
 hard?
 _____ repeatedly hit over at least a few minutes or threatened with a weapon?

55. Did you live with anyone who was a problem drinker or alcoholic or used street drugs?

_____Yes _____No

56. Was a household member depressed or mentally ill, or did a household member attempt suicide?

_____Yes _____No

57. Did a household member go to prison for an extended period of time?

_____Yes _____No

58. Please rate how any past trauma still affects you today:

_____1(not at all) _____2(occasionally)
_____3(situationally) _____4 (often)
_____5 (daily)

59. What is your relationship to recreational or therapeutic use of water?

60. What aspect of your early and/or present life would you like to explore for healing and personal transformation?

61. With any body-centered therapy, emotions occasionally surface that may be uncomfortable or surprising. Do you have access to follow-up therapy in the event this occurs?

_____Yes _____No

62. Do we have permission to contact your therapist?

Name of therapist: _____

Contact info: _____

Please print out this document, fill it out and include a self-addressed, stamped envelope. Submit your application BY MAIL to:

**Co-creation Catalysts Apprenticeship Program
Program Director
Anais Salles
261 W. Walnut Lane
Philadelphia, PA 19144**

Check here if you've been invited to enroll

I agree to the following *(please initial and sign at the bottom)*:

Tuition paid in full for one year term
 in a single payment in the amount of _____
 Multi-payment Tuition option of _____ x _____

I agree to be responsible for my well-being during each class session.

Signature: _____ Date: _____

_____/_____
(Print) First Name (Print) Last Name