SOTO AUSTRALASIA

SUMMER 2010

EXPRESSION

INSIDE THIS ISSUE:

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The Board of SOTO Australasia wish all our Members a very happy Christmas and a bright, prosperous and safe 2011!

GASTRIC SYNDROME

For those who are joining this series of articles for a first time read: We have been looking at the Bloodless Surgery techniques, which later became CMRT – Chiropractic Manipulative Reflex Technique. DeJarnette developed organ reflex procedure as his discovery of the occipital fibres and their significance was realised from his years of clinical observation in the 1930's and onwards. We have been looking at the writings of Dr. DeJarnette's close friend and colleague, Dr. Mel Rees who developed DeJarnette's 1975 research pilot on the temporal sphenoidal reflex. Dr. Rees' work appeared in the S.O.R.S.I. Despatcher issues from 1972 to 1974 and serve as a valuable source of information, in addition to what you, the student of S.O.T. and CMRT will have attained from your basic seminar series and your reading of the CMRT, 1966 notes. Here now is temporal sphenoidal thoracic five bloodless surgery procedures.

Thoracic 5 TS and CMRT

When your temporal sphenoidal palpatory painful area shows at T5a or T5b, then you are alerted that your patient has abnormal stomach function somewhere from the ante-chamber as it passes through and just under the diaphragm to the pyloric valve just before the small intestine is reached. The utilisation of TS and CMRT procedure provides these hurting patients with a great measure of relief and immediate recall towards relatively healthy gastric function that is only limited by the prior destruction to the stomach lining and the scar tissue formed. Your reflex oesophagitis (pseudo hiatal hernia) patients will swear you are a miracle worker. Your gastritis patient will tell the world of their relief, and send you everybody with a stomach ache. Stomach motility is the answer. A stomach that is not tied down by adhesions can stay healthy. T5 procedures are directed toward correcting this normal stomach mobility. Those delicious substances that our tasters love so much, is many times quite revolting and most uninviting to the hard-working stomach which must churn up these unpleasant, disagreeable foods and convert them into something usable for the small intestine to process. To do this, the stomach must be able to dodge harmful substances that attack its mucous coat as it churns away.

Therefore to remain normal it must have complete mobility. When temporal sphenoidal T5a is active you are warned that the life force that keeps the stomach walls highly agile and sufficiently protected by mucosa, is lacking. This may be a vagus nerve impingement in the cervicals, or it may be a 5th thoracic vertebra dural port problem. When a subluxation of either of these sources of stomach health power occurs, then immediately, the 'turned off' stomach is unable to dodge the obnoxious, harmful-to-the-mucosa, substances that we eat. Put simply, the stomach no longer has the motility to dodge substances which are deleterious to its health. Under these subluxated circumstances, the stomach's normal dodging ability is reduced to fixation.

Next in our discussion is the upper cervical area—in particular, the occiput and atlas.

An area that receives attention in the CMRT seminar for gastric syndrome is the occipital compression and side-slip (for those who have been following these articles for some time, this was the category eight work from 1970, which we wrote about in a previous 'Expression'). Of note to the current stu-

(Continued on page 4)

PRESIDENT'S REPORT

Dear Colleagues,

As the year draws to an end, there is no slowing down in Australia with SOT developments. It is full steam ahead for the Board and SOTO-A on a number of fronts.

Dr Darren Little

As most of you will be aware, SOT education in Australia has been the benchmark internationally, becoming the standard worldwide. We are now undertaking the rebranding of SOTO in Australia which will be reflected in all of the products and materials SOT has to offer. As part of this initiative, the rest of the SOT organisations worldwide are linking in with our redesign and a global brand strategy is underway. The purpose of this idea is to strengthen the image of SOT globally and fit in with the recently completed international standardisation of notes, powerpoints and certification. I hope to unveil this image and brand later in the year and we are all very excited with the impact this will have on the marketing possibilities & global view of SOT.

Our Annual Convention in Melbourne last month was a huge success with our TMD topic proving popular . It was great to see some old faces again and meeting some new people also. DVDs of this event will be made available very soon so preorder your copies with Averil.

I would like to give a special thanks to Rebecca Bowring and Andrew Paul who have stepped down off the Board at our AGM. Both Bec and Andrew have been integral parts of our organisation for many years. Their contribution to the running of SOTO-A has been enormous and we would not have been in the position we are now without their valuable input. Bec has been tireless in revising the certification process and material and her standard of quality control will be hard to match. Andrew's experience and wisdom has enabled me to grow as part of our team and learn the ropes over my years on the Board . I wish them all the best for the coming year and I hope they enjoy not having to think about all things SOT for a while. We welcome two new Board members this year, Mary Bourke returns after many years, and Kate Stewart offers a fresh passion for SOT and a recent involvement in the certification and examining process. I look forward to working with them both in the coming year. Thankyou for the opportunity to serve you again as President for another year. Some of the initial tasks we have undertaken are part of a five year plan and I am pleased that the other members of the Board will be able to continue working with me toward this common vision and goal. We are way ahead of schedule, thanks to Sandy Clark, Sam Culley, Gerald Vargas and Jim Whittle. I thank them for their continued dedication to serving SOT.

Have a healthy and relaxing Christmas and I hope that SOTO-A can help you achieve your SOT goals in the coming year.

Cheers

Darren Little
President

Aqualizers!

For those of you who attended the Annual Convention, we have ordered the Aqualizers and will have them as a stock item.

Prices are $35.00 ea or $300 for 10.

Contact Averil to pre-order now for delivery early in 2011.

FROM THE EDITOR'S PEN

Dr Samantha Culley

Hello to All,

Welcome to our Summer edition of Expression. Yet again we have two amazing articles for you to peruse and learn. As you may have noticed the advanced CMRT is very well researched and recorded. So for those that may be being a little left in the dark, make sure you attend our seminar series next year. (our dates are set out below).

Many congratulations to all those who passed their certification. (page 5).

For those who are needing to have a holiday after a busy year, check out the locums page. There are an array of fantastic Chiropractors who are all very capable at looking after and loving your people.

So here's to wishing you all Merry Christmas and a fantastic New Year.

Enjoy reading.

Sam Culley

Editor

Membership subscriptions

Due 1st January, 2011

The best of all gifts around a Christmas Tree is the presence of a happy family all wrapped up in each other.

SOTO Australasia—Events 2011

Month	Dates	Categories	CMRT	Cranial	Advanced Module / Annual Convention
April	16 & 17	Melbourne			
	30 May 1	Sydney			
May	21 & 22		Melbourne		
June	4 & 5	Perth			
	11 & 12		Sydney		
	25 & 26	New Zealand			
July	9 & 10			Melbourne	
	16 & 17	Adelaide			
	23 & 24			Sydney	
	30 & 31		Perth		
August	4 - 8				Fiji
	20 & 21		Adelaide		
September	3 & 4		New Zealand		
	17 & 18			Perth	
	29 & 30			Adelaide	
October	8 & 9			New Zealand	
November	12 & 13				Adelaide

GASTRIC SYNDROME (CONT.)

(Continued from page 1)

dents of CMRT is that this finding, occipital side slip, produces three fibre bands which will be contracted on the side of the long leg. (These being below the level of the three occipital fibre lines.) DeJarnette said of the occipitoatlantal side slip compression problem that if you should be restricted to one upper cervical technique, this is the one you would chose after seeing its accomplishments, the adjustment being the one described in the 1970 notes.

The fifth thoracic subluxation presents in various ways. The thoracic five dorsal port problem to the stomach has occurred when a buttock sign indicator points to the upper thoracics. When you have an anterior fifth thoracic then the entire stomach is involved in the subluxation complex. When the left transverse of the 5th thoracic is involved in the occipital three, line two subluxation complex, then the doctor is alerted to a greater curvature of the stomach abnormality where the symptoms of gastritis occur immediately upon eating and following a meal. When the right transverse of the 5th thoracic in the occipital three line two subluxation complex, then the doctor is alerted to a lesser curvature of the stomach abnormality or a pyloric valve abnormality.

(The Greek word, pylorus, means the 'gate-keeper' which is a good description of this region.)

A right transverse is the one you hope you don't see too often, because most of these patients, when you get to them, have already eaten through the mucous protection and have a raw ulcer in the lesser curvature or pyloric valve that you have to contend with; or they have been the route of an ulcer diet plus drugs and stomach-coating digestant stopping substances, things that make matters worse until the stomach's 'life force' is turned back on.

If the stomach problem has regressed to a trapezius major and a right pedicle is hot, then you have a real problem on your hands with the greater curvature of the stomach walls deteriorated to a mass of scar tissue and resultant lack of secreting cells.

These are your pernicious anaemia patients. You hope this patient has not gone to the point of no return and a life of blood transfusions.

If the stomach problem has regressed to a trapezius major and a left pedicle is hot, then you must start thinking in terms of malignancy of the stomach. (Check for line three.)

The other TS point is 5b, thus 5a and 5b – they are next to each other (and remember, in modern SOT, you can verify the finding with joint lock phenomenon via an arm fossa test or mind language).

5b is concerned with the diaphragm and its effect on the 'gastric antrum' producing reflux. Drug companies have recently given this the new name of GORD (gastro-oesophageal reflux disorder) – so you can 'see your doctor' and get a new prescription, along with your others. Since the 1970s, in SOT, we have termed this a pseudo hiatal hernia and mark it on our patient files as PHH, and work on this area would have already commenced if your patient presented as a Category II.

Next is our procedure for checking indicators followed by the step-by-step corrective technique. A good suggestion for you, our 'Expression" reader, is to have your copy of the CMRT seminar notes and your copy of CMRT, 1966 open at the T5 / gastric pages.

Gastric Syndrome Indicators

1. The basic gastric reflex is a box extending horizontally across the mid gastric area and is intensely painful when an ulcer is present. Mark this area with a skin pencil.
2. The rim of the left shoulder is painful in gastritis hyperacidity. Mark this with a skin pencil.
3. The T5 to T9 areas, posteriorly, will be tender to palpation in the gastric patient. The posterior reflex for ulcers lies left of the fifth and sixth dorsal vertebrae. Mark this with a skin pencil.
4. Another gastritis reflex lies on the left lateral margin of the 9th rib – and may actually simulate a kidney stone attack. Mark this area with a skin pencil, if present.
5. The previously mentioned anterior 4 – 5 – 6 dorsal will cause whole stomach nerve interference.
6. Steps 6 and 7 have been discussed in a previous 'Expression' article – The Category Eight. DeJarnette observed an occipital compression and other side sideslip (thus, for example the left side occiput compression, with the right side, side slipped). Step 6 is the compression which will be on the side of the short leg in a supine leg check.
7. As mentioned in the previous Category Eight article from DeJarnette's 1970 SOT notes, occipital side slip is pretty important territory. Three muscle bundles will be found to be taut and tender. These are to be found below the three occipital fibre lines.
8. In our SOTO Australasia CMRT seminar notes, points 5, 6 and 7 above are grouped with this one Cervicals 3, 4 and 5 under the heading "The following subluxations can be involved and must be corrected if present". Here is our chance to discuss with you, in some more detail, the cervical spine, at least from an SOT perspective. For simplicity in description there are three motor units – Occ – C_1 – C_2; second motor unit is C_3 – C_4 – C_5 and third motor unit is C_6 – C_7 – T_1. The correction process for these areas, as related to the dorsal 5 syndrome is a simple muscle adjustment. Meaning, you have utilised cervical step procedure, figure eight, occipital compression, side slip and/or R plus C depending on your categorisation and now have arrived at this point in time in your Category One, occipital line two area three assessment. You are seated at the head of the supine patient for this technique. When the muscles in the first motor unit are painful to palpation one side, then the cervicals on that side are posterior. You lift them towards the ceiling on that side – the pain intensity will ease. The second motor unit which is really the area of concern we are addressing here has an opposing listing. When the muscles of the second motor unit are painful on one side, then the cervicals in that area are anterior and you lift the opposite side muscles toward the ceiling and the pain vanishes. When the third motor unit muscles are tender on one side then the cervicals on that side are posterior, thus you would lift the same side muscles.
9. The left thumb – index finger web will be painful in a stomach syndrome. Mark this with your skin pencil.
10. The space between 5th and 6th ribs on the left anterior rib cage is a gastric reflex. Palpate for this starting from the sternum and working laterally. Mark the tender area. Medial means a cardiac orifice problem, lateral means a pyloric valve lesion.
11. Pectoralis reflex at the sternal portion of the 5th and 6th rib interspace moving up to the left shoulder. Mark it with a skin pencil, if present. Pain along the pectoralis muscle is an indicator of diaphragmatic fixation.

Now, that we have our regions mapped we can proceed with the step – by – step technique for a thoracic five major.

Step-By-Step Technique

"These patients need first, the post-ganglionic reflex technique to calm their nerves" was DeJarnette's statement from the June 1966 CMRT

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Bulletin.

Of course, the pattern you have seen working in the Rees procedure is to commence with a touch and hold TS pain control so that post ganglionic and the following procedures could be more readily acceptable to the patient's sensory nerve system.

Step 1:

As soon as the patient is turned from prone to supine, you apply the TS pain control so that the patient can more readily receive the post- ganglionic vibratory technique. Doctors left hand holds light contact over the most painful TS D5 area as the right flat hand holds light contact over the receptor block area above the umbilicus for two minutes.

Step 2:

Maintaining your TS 5 contact with the left hand, move your right finger tips so as to create a vibratory action to this area for one minute. This tends to normalise the stomach post-ganglionics, which are governors of visceral sensation and sensation demand factors which have gone wild in this tied down stomach situation. With this step made, your sensory problem is cleared. Now you can use your anatomical reflexes.

Step 3:

Pass your left hand under patient and contact the painful left or right transverse area. With your right hand, you work the stomach. This is a variation of contacts to the regular CMRT post-ganglionic. As you work this area for a minute, you will feel the soft tissue loosen up.

Step 4:

For you 'CMRTers' we are now in familiar territory. This is the left thumb web reflex and the mid gastric reflex area. You hold the abdominal reflex area, left hand and you contact the left thumb web. You can work the thumb web but a good alternative is to have the patient open and close their hand ten times. This brings circulation up to near normal in the stomach area by arterial dilation. Now nutrition and elimination is accomplished.

Step 5:

Free the cervical muscle pulls described in point 8 above.

Step 6:

You now turn your attention to gastric reflux. Various methods for the PHH have been discussed in a previous 'Expression' article.

Step 7:

Now it's time to turn your attention to the occipital side slip. For those of you who like the history and development of DeJarnette technique this one goes way back to the early 1930's in the DeJarnette catalogue. A good description is given on pages 40 – 44 of the 1961 SOT Convention notes and of course, the 1970 SOT notes have the Category Eight, as we have previously noted.

(Contact Dr. David Roseboom at the Rose Ertler Memorial library www.dejarnettelibrary.com, chiron@rozeboom.com. Dr. Roseboom is a keen DeJarnette historian and has made the library available to SOTO Australasia members!)

Step 8:

If all marked painful areas are now neutralised, restart your reflex arcs with the pre-ganglionic technique.

Well, there you have some information to look at over summer. CMRT work helps you to help more people you see. The TS work offers some variations from Dr. Rees. We also find his notes contained some good explanations of reflexes and physiological actions that may not receive a mention elsewhere. We look forward to next issue and welcome your comments or questions.

We remain,

John S. Kyneur
Haberfield, NSW

Peter J. Kyneur
Toronto, NSW

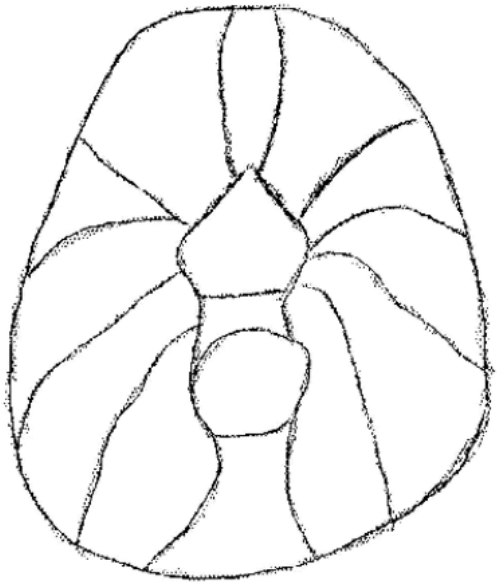
CONGRATULATIONS!

Successful Certification candidates for 2010 from left, Bill Stathoulis, Fiona Haughie, Trudi Bellis, Tanya Christofas, Emma Kavenagh, Janine Kinahan, Sarah McLinden, Michelle Dickinson, Melanie Unsworth, Naomi Gale, Jason Glynn and Steve Doig who received their Certificates from Darren Little, President of SOTOA

Twelve candidates were successful this year at the 2010 Certification Examinations held over the Annual Convention & AGM weekend in Melbourne. Congratulations go to the following doctors who achieved Basic and Advanced levels of SOT Certification:

Trudi Bellis, Yarraville, Vic—Basic and Advanced
Tanya Christofas, Box Hill South, Vic—Basic and Advanced
Michelle Dickinson, Kingsland, New Zealand—Basic and Advanced
Steve Doig, Locum—Advanced
Naomi Gale, East Launceston, TAS—Advanced
Jason Glynn, East Launceston, TAS—Advanced
Fiona Haughie, Napier, New Zealand—Basic and Advanced
Emma Kavenagh, Brighton, SA—Basic and Advanced
Janine Kinahan, Katherine, NT—Basic and Advanced
Sarah McLinden, Bendigo, Vic—Basic and Advanced
Bill Stathoulis, North Sydney, NSW—Basic
Melanie Unsworth, Castle Hill, NSW—Basic and Advanced

THE COUGH TEST, CRANIAL TECHNIQUE 1976, MAJOR BERTRAND DEJARNETTE, D.C.



The prone cough test is the only specific test we have at this time to determine the physical state of the internal cranial mechanics and the responsive condition of the meningeal systems of the brain and spinal cord.

The cough test is not a test to determine the position of the sacral base as such would be measured at Ferguson's angle.

The dural insertions involve the first three sacral foramina. Those insertions are the basic elastic stretch control mechanism for the dura.

Cranial Technique Teaches:

There is a primary respiratory function performed by all living tissues. This is a movement of fluids, not air or gases. Cerebrospinal fluid serves to excite and control the volume of nerve or neural impulse flow… Strong, medium, light or absent.

Motion is essential to life. Synchronized motion is normal. Motion out of step with companion motion is disease, and disease is immobility.

Costal respiration is not in ration to the primary respiratory motion of fluid movement, but such can be synchronized at will… Note pressure on the eyeballs… into the ear canals… on top of the skull…over the aorta…Conscious control of 10 to 60 cycles per minute.

Flexion and Extension

These are terms used to define the function of the dural membrane in controlling the intracranial, intraneural and intrasacral pressures. Basically, the point of all intracranial flexion or extension localizes at the sphenobasilar symphysis. This articulation, like a cocked shotgun hammer, is always in slight flexion, but can go into extension when the demand is present and in extension to evacuate the pituitary gland.

Flexion or extension is normal motion when describing the dural arcs either as normal or abnormal. The only specific test known today to determine which is present is the Sacro Occipital Technic S.B. plus or minus cough test.

The dural arc is in flexion when the dollar sign fails to restore itself to normal tension. It is in extension when the dollar sign is normal.

The cranial movement produced by inspiration or respiratory flexion produces general changes in the contour of the skull with a general convexity occurring when the occiput is fixed in flexion and a concavity when the occiput is fixed in extension.

The Sphenoid Bone

The position of the sphenoid is denoted by the forehead, orbit and mouth. When the sphenoid is distorted, those members are distorted as you will observe. A general rule of thumb to quickly determine sphenoid position is to place your finger tips tightly into a patient's ear canals and then have him say “hello.” You should feel pressure equally against both finger tips if the sphenoid is going through its normal range. If you feel excessive pressure in one ear and little or no pressure in the other ear, the sphenoid is not flexing and extending, but rotating on its central axis. This will create a whole field of skull distortions. In doing this little ear test, you are actually feeling or not feeling the temporals moving the occiput and the sphenobasilar moving the dural membranes through the pole attachments.

I have oftentimes told my classes that the sphenoid is a key bone, moving all facial bones except the mandible. This could seem very strange to the uninitiated doctor. The sphenoid bone has twenty-six articular surfaces and if you doubt this, count them yourself. This is like the key stone that holds the arch together in masonry.

The wings of the sphenoid bone have such a wide range of motion, and in association with the occipital bone, can change the total skull by simple axis upon axis of movement, and all motion is included… flexion-extension, internal and external rotation. The miracle of the whole is that this motion can be used to correct by directing the membranes to draw the offending structures back into position. The dura is the medium for axis correction. You can rotate the sacrum and flex or extend the sphenoid and occiput. This will in turn affect the facial bones.

A point worth mentioning here .and elaborated on elsewhere is that tension applied to the heel bones does more to alter the position of the sphenoid and the occiput than can be accomplished by all other contacts put together. This perhaps explains why painful heels are associated with occipital-sphenoid subluxations. (Emphasis added)

(Article provided by Dr. Joe Unger, USA)

2010 Annual Convention Review

Last month, SOTO-A held our Annual Convention and AGM in Melbourne. Dr Bob Walker was our guest speaker on the topic of co- treating TMD cases.

Dr Walker covered a huge amount of content ranging from postural assessment of ascending and descending patterns to TMJ click diagnosis and dental appliance applications. For those already utilising the work of Dr Walker, the weekend proved to be a showcasing of the latest developments of Bob's new work and understanding, and those less familiar with his work it was a unique opportunity to get a "best of SOT TMJ" in one jam-packed weekend. SOTO-A has decided to make available the "aqualizers" that were demonstrated at the seminar for everyday use with patients in the office and pre orders can be made with Averil as we await the first shipment from the US.

DVDs of the weekend will also be available for purchase soon, for those who were unable to attend or those people who would like to review the material again at their leisure.

Our next Annual Convention and AGM will be held in the Barossa Valley with a host of International speakers presenting a variety of Paediatric specialty techniques. This is going to be a huge event and it will be a chance for us to showcase our great country and mingle with some of the best in SOT. Be sure to be there.

DVD sets of the 2010 Annual Convention

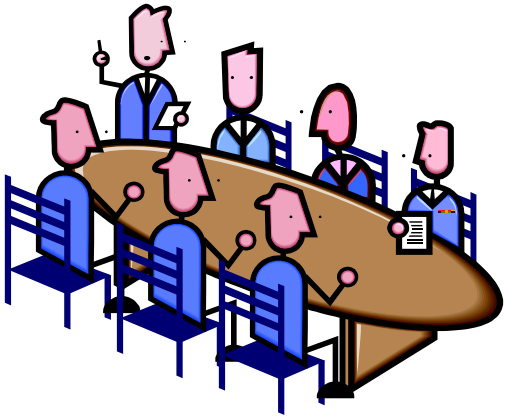
'The Chiropractic Dental Patient: A Combined TMD Approach'

will be available early in the New Year.

Call Averil to order your set NOW!

Your Board Members for 2011!

Congratulations go to Gerald Vargas, Sam Culley, Mary Bourke and Kate Stewart, who were voted by the membership at our Annual General Meeting on 13 November to represent SOTOA Members! Congratulations also to Darren Little who was voted again as President. Your 2011 Board representatives are:



Darren Little, President

Sandy Clark, Vice-President

Sam Culley, Secretary & Newsletter Editor

Gerald Vargas, Treasurer & Research Representative

Jim Whittle, Board Member, Student Liaison & Certification Committee

Mary Bourke, Board Member

Kate Stewart, Board Member

These are *your* representatives so if you have any questions or issues, they are only too happy to help.

CLASSIFIEDS

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Locums Available

Practicing for 13 years (RMIT graduate). Techniques—SOT, Diversified, Some Drop Piece. Availability—Brisbane/Gold Coast and Melbourne. Available for short and extended periods. Contact Dr. Domna Lovatt, domnalovatt@hotmail.com - 0423 777 224

Kate Stewart. Experienced Full Time Locum throughout Australia. Advanced Certified in SOT. Webster Certified. Currently completing Certification with International Chiropractic Pediatric Association (ICPA). Passionate about wellness chiropractic care for the whole family. Committed in providing excellent care for your practice while you are away. Excellent references available. katemcraestewart@gmail.com or 0402 423 212.

Dr. Steve Doig. Willing to travel nation-wide. S.O.T. Basic Certified (undertaking Advanced level in Nov, 2010). N.E.T. Certified. References Available. *Contact* Steve Doig 0401 012 873 hdoige@hotmail.com. *Note to correct email on printed directory!*

Experienced Wellness SOT Locums available. Sam Lowe & Catherine Metcalf available for locum cover in South-East Queensland from start of February 2010. 13 years locum and practice experience throughout Australia & England. Please email & we will be happy to contact you to discuss your needs. Email: sam.cath@mac.com

S.O.T. Locum Available. Dr. Troy Miles. SOT Advanced Certification. Available Australia chirotroy@yahoo.com.au

Wayne Jennings Locum Service. Commencing January 2011. 29 years private practice. SOT Certified / Diplomate. 0457 931 377.

Dr. Ali Postles. Passion. Integrity. Commitment. Techniques SOT, NET. References. Available Now! Contact alipostles@gmail.com. 0420 233 577.

Associates / Locums Available

Looking for Associate/Locum position in Sydney or surrounds starting Mid Feb 2011. Currently working in busy practice in country SA and re-locating to Sydney. SOT Advanced rating and Activator proficiency rating. Presently studying post-graduate Chiropractic Neurology program with Carrick Inst. Have your patients cared for as you would. Ref available on request. Reply to Bryan Hornby—central_connectivity@hotmail.com or call 0422 289 948 after 630pm.

Associates / Locums Required

A Motivated Associate / Practice Partner / Sydney 2011. We are looking for you to join the Handson group practice if you love to educate and empower your client to their optimum level of health. As a well adjusted 6 chiropractor team practice with 3 locations in Sydney and nearly 30 years of established reputation in delivering wholistic wellbeing, you will have all you need here at Handson for you to be a productive and happy chiropractor. Please check our website www.handsonsydney.com.au The practice has well established programs of care and regular re-examinations and education; excellent support staff and practice management software to help you build a huge client base. If you are a highly charged chiropractor ready to 'go for gold' you will succeed with us. Please contact sem@handsonsydney.com.au to express your level of interest and experience.

Do you want to adjust 130 – 140 patients per 4.5 day week with good remuneration, in an SOT practice that sees many families and babies? Are you enthusiastic, dedicated, compassionate, punctual and friendly and want to join a friendly dedicated team in a healthy, easy going lifestyle? Are you a good communicator of wellness care? Then we would love to hear from you, we are looking for an associate to replace our current associate, who is leaving to travel. Contact Liana on 08 87256291 after hour 6pm Tuesday to Sunday.

Sunshine Coast. A fantastic opportunity exists for an associate in a family wellness care practice to take over from busy associate going overseas in Feb 2011. Must have a passion for wellness care and love working with families & young children. Several years of experience with low force techniques (SOT/AK) is a prerequisite and some experience with NET will be looked upon favourably. The successful applicant will become a valuable team member, be supported in their professional development and be inspired towards excellence. Please contact Gabriella on g_palomares@optusnet.com.au or 0409637737.

An opportunity exists for an associate in beautiful Peregian Beach on Queensland's Sunshine Coast! Must enjoy working with families in particular pregnancy and babies, SOT and NET preferred with an interest in kinesiology. Wonderful opportunity for a 'people' person to work in a supportive beach community with a growing team of professionals. Opportunity to work in beautiful Peregian Beach. Call Jodi 0404007899 Jodichiro1@bigpond.com

For Sale

Martin 3 Drop Piece Table. Newly recovered, very good condition, $1380. (Gold coast area). Call 0412 963 106