

Robin's Yoga & Healing Center, LLC

PROFESSIONAL LEVEL 500-HOUR YOGA TEACHER CERTIFICATION PROGRAM APPLICATION

Please print clearly and fill out the entire application.

Return completed application to:

Robin's Yoga & Healing Center, LLC

885 Main Street/Suite 1A

Tewksbury, MA 01876

PROGRAM DATES: One weekend a month for a year. (See 500-hour YTT Agenda)

NAME: _____ AGE: _____

First Middle Last

MAILING ADDRESS: _____

City State Zip

HOME PHONE: () _____ WORK PHONE: () _____

E-MAIL ADDRESS: _____

OCCUPATION: _____

If not currently employed, state your vocation, training, or profession.

PREREQUISITE INFORMATION:

Are you 200-hour Certified? YES ___ NO ___

Date of 200-hour Certification _____

Who were you certified by? _____

What studio/center are they affiliated with? _____

Was this training approved by the Yoga Alliance? YES ___ NO ___

Director's Name: _____ Yoga Style: _____

Other related experience: _____

YOGA TEACHING EXPERIENCE

Are you currently teaching yoga? YES ___ NO ___ # of Classes per week _____

What tradition/style? _____ How long have you been teaching? _____

Do you have any past experience teaching Yoga? (explain) _____

YOUR PERSONAL EXPERIENCE OF BECOMING CERTIFIED AT THE 200-HOUR LEVEL AND INTEREST IN BECOMING A PROFESSIONALLY CERTIFIED INSTRUCTOR: On a separate sheet of paper please answer the following questions. Please be concise, limiting your responses to short paragraphs.

Why do you want to become certified as a Yoga Instructor at the Professional Level?

Why did you choose the Yoga with Robin Certification Program?

What does becoming certified at the Professional Level mean to you?

How has your involvement with Yoga changed and developed over time?

Please describe your perception of what a yoga teacher provides his/her students?

HEALTH INFORMATION

Under medical treatment or supervision for: _____

Pregnant: ____ months at time of program. Comments: _____

Current psychotherapy, counseling or psychiatric treatment for: _____

Hospitalization for psychiatric care: Condition and Dates: _____

Chronic Physical Limitations/Handicaps (e.g. vision, hearing, movement, etc.)

Nature and extent of limitation _____

Serious illness or major surgery within last 5 years (e.g. heart problems, cancer etc.)

Conditions and Dates: _____

Communicable diseases: _____

Drug or alcohol addictions: _____

Prescription medications (indicate dosage and frequency of intake): _____

EMERGENCY CONTACTS: In case of emergency please contact:

Name: _____ Phone: _____

Physician: _____

Phone: _____ Therapist: _____

Phone: _____

DECLARATION OF DISCLOSURE AND ACCEPTANCE OF TERMS

I hereby declare the above information is true to the best of my knowledge. I understand that misrepresentation of this information constitutes grounds for rejecting this application, expulsion from the program, or revocation of certification. I have read the Program Requirements and understand that failure to complete the certification requirements as outlined in these forms will result in my not being certified. I understand that I am entitled to no refunds, credits or adjustments resulting from my failure to complete the certification requirements.

___ I give my permission for my photograph to be used for promotional purposes.

Signature: _____ Date: _____