

Robin's Yoga & Healing Center, LLC

BASIC 200-HOUR 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

Please include deposit of \$500 made payable to Robin's Yoga. This includes a year of Unlimited Yoga classes. Payments of \$200/month by the first of the month to follow.

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:

Personal Yoga Practice for at least 6 months? YES ___ NO ___

of years practicing Hatha Yoga: _____

Regular classes with a certified instructor for at least 6 months? YES ___ NO ___

Teacher'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 YOGA AND INTEREST IN BECOMING AN 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?

Why did you choose the Certification Program of Robin's Yoga & Healing Ctr?

What does Yoga 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: _____