

OFFICE USE ONLY

Date of Deposit: _____ Payment: _____ Balance Due: _____



yoga study application

Class applying for: Weekend Intensive: _____ Fall 2010 _____ Spring 2011

Name: _____

Street address: _____

City: _____ State: _____ Zip: _____

Email address: _____

Home phone: _____ Work phone: _____

Emergency contact information

Name: _____ Phone: _____

Current yoga practice (taking classes, home practice, videos): _____

How long have you been studying and practicing yoga? (Please mention any teachers or workshops)

Please share your motivation for wanting to teach yoga: _____

What training or experience in your background might you draw on as a yoga teacher (university or medical degree, massage background, teaching experience, fitness or dance instructor, etc.)? _____

Check the area of most interest to you in this training:

- | | |
|--|--|
| <input type="checkbox"/> Learning asanas (alignment, etc.) | <input type="checkbox"/> Anatomy/physiology |
| <input type="checkbox"/> Meditation techniques | <input type="checkbox"/> Yoga history, philosophy |
| <input type="checkbox"/> Pranayama (breath work) | <input type="checkbox"/> Learning to work with a group |
| <input type="checkbox"/> Business (liability insurance, marketing) | <input type="checkbox"/> Increase general knowledge |

I understand that participation in this activity is completely voluntary. I hereby waive and release Sun Moon Studios, its employees and instructors of any liability in case of an accident. I know as part of Sun Moon teacher training I may be photographed. I give my consent to use these photos for Sun Moon promotional purposes. I have filled out and signed the health history form on the back.

Signature: _____ Date: _____

Name: _____

Sex: _____ M _____ F

Are you taking any medications or drugs? Yes _____ No _____ If Yes, what? _____

Does your physician know you are participating in this teacher training? Yes _____ No _____

Describe your current physical yoga practice (e.g. inversions, headstands, back bend): _____

Do you now, or have you had in the past:

	YES	NO
1. History of heart problems, chest pain or stroke.	_____	_____
2. Increased blood pressure.	_____	_____
3. Any chronic illness or condition.	_____	_____
4. Difficulty with physical exercise.	_____	_____
5. Advice from physician not to exercise.	_____	_____
6. Recent surgery (last 12 months).	_____	_____
7. Pregnancy (now or within last 3 months).	_____	_____
8. History of breathing or lung problems.	_____	_____
9. Muscle, joint, or back disorder.	_____	_____
10. Diabetes or thyroid condition.	_____	_____
11. Cigarette smoking habit.	_____	_____
12. Obesity (more than 20 percent over ideal body weight).	_____	_____
13. Increased blood cholesterol.	_____	_____
14. History of heart problems in immediate family.	_____	_____
15. Hernia, or a condition that might be aggravated by weights.	_____	_____

If you responded yes to any of the above questions, please list the number of the question and explain below:

Signature: _____

Date: _____