

2012 200 HOUR YOGA ALLIANCE CERTIFIED TEACHER TRAINING

Application Form



Please return completed form, medical questionnaire and payment (or \$500 deposit) by February 15th, 2012 to: The Treehouse at Cornerstone, 419 South York Rd., New Hope, PA 18938 (215.862.2200). All responses are strictly confidential.

Name: _____

Address: _____

Phone Number: Primary # _____ Secondary # _____

Date of Birth: _____ Email: _____

Emergency Contact: _____ Phone #: _____

How did you hear about this program? _____

Why are you interested in the teacher training program?

Tell us about your yoga practice:

How long have you been practicing yoga?

Which type of yoga do you practice?

Who have been your main teachers or sources of information?

Describe your current spiritual and physical practice.

What is your educational and professional background outside of yoga?

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Medical Information Form



All responses are confidential. We use this information only to better assist you during the program, not to screen participants (unless participation would be medically inadvisable). Attach additional sheets if necessary.

1. Briefly describe your overall health.

2. Describe any history (include dates) of back/spine/neck problems and indicate whether they still give you problems. *Please be specific.*

3. Describe any history (include dates) of joint problems (knee, hip, shoulder, wrist, ankle, etc) including joint repair/replacement surgeries. *Please be specific.*

4. Blood pressure (circle one): **HIGH / LOW / NORMAL** When was it last checked? _____

5. Describe any history of cardiovascular problems. If you don't have any cardiovascular problems but are considered to be "at risk", then please indicate this as well.

6. Circle any of the following difficulties you have had (or have) and explain the relevant specifics:
Diabetes Osteoporosis-Osteopenia Chronic Headaches Ulcers Stroke Seizures Allergies
Asthma Cancer Frequent Dizziness Other: _____

7. Women: are you pregnant? **YES / NO** If so, when is your baby due? _____

8. Do you have any other limitations/dietary restrictions, or health conditions? **YES / NO** If yes, what conditions?

9. Are you currently seeing a physician or a therapist for any physical conditions? **YES / NO** If yes, what conditions?

10. Are you taking medication for any physical or psychological conditions? **YES / NO** If yes, what medications are taken for what conditions and at what frequency?

11. If you have any learning disabilities or other special physical or psychological circumstance, please explain below so we can better serve you during the program.

I hereby certify that the above information is correct to the best of my knowledge.

_____ Date

_____ Participant's Name (print)

_____ Participant's Signature