

Full Time or Part Time Studies: _____ Start Date: _____

How did you hear of VSBM: _____

PERSONAL INFORMATION

Last Name: _____ First Name: _____

Address: _____

Day telephone: _____ Evening telephone: _____

Email: _____

BACKGROUND

Birth Date: _____ Citizenship: _____

Current occupation: _____

Previous occupation: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Address: _____

Telephone: _____ Cell Phone: _____

APPLICATION QUESTIONS

1. Briefly describe your education, both formal and informal.

2. Detail your prior experience with yoga.

3. Describe your personal and professional goals and how this program can help you achieve them.

4. What qualities, skills, and values do you consider important for a yoga instructor?

HEALTH EVALUATION

This questionnaire will remain strictly confidential and for the sole use of the administrative staff to assess your needs and consult with you appropriately.

1. List any medications taken regularly.

2. Do you have any physical limitations? Describe.

3. Are you presently receiving treatment for any reason? Describe.

4. Do you have any allergies? Describe.

5. Any other illness, surgery, or injury? Describe.

6. Who is your primary health care provider _____

Phone _____

Your signature below indicates that the above information is complete and true to the best of your knowledge.

Signature

Date