200-HOUR YTT CERTIFICATION PROGRAM APPLICATION

Please print clearly and fill out the entire application.
Return completed application to:

Robin's Yoga & Healing
1454 Shawsheen Street
Tewksbury, MA 01876

Please include Payment of $2000 in full or Deposit of $250 made payable to Robin Anderson. Deposit is due one week before you begin the training, and payments of $250 are due the 1st of each month TO BE SET UP AS AN AUTOMATIC PAYMENT.

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: _____
Participation in Yoga classes 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: ________________________
____
YOGA TEACHER TRAINING
Are you currently certified as a Yoga Instructor? YES ____ NO _____
What style(s) of yoga are you certified in?
____
Where did you receive your certification?
____
Are currently enrolled in a Yoga Teacher Certification Program? What style(s) of yoga are you certified in?
____
Where did you receive your certification?
____

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?
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 ____
____
List any 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: _______________________