Ananda Institute of Living Yoga

"Where Yoga Comes to Life"

LEVEL 2 YOGA TEACHER TRAINING (AYTT-2) APPLICATION

Please complete this form and the medical questionnaire and e-mail to: michelle@anandaseattle.org; or fax to (425) 806-3788; or mail to the address at the bottom of the page; or drop it at the temple reception. ATTN: Michelle Marshall (AYTT-2 Application)

All responses are strictly confidential.

PERSONAL INFORMATION

Name

Nickname

Name as you would like it to appear on Certificate of Completion

Address

Email
Note: email address is required for program participation

Phone: Day/Evening

Please provide an emergency contact name and phone number for

(a) Personal

(b) Medical

INSTITUTE OF LIVING YOGA APPLICATION FEE (NON-REFUNDABLE)*

Please attach a check for $50 (payable to Ananda Seattle) or call the Ananda Meditation Temple (425-806-3700) to pay with a credit card.

*This is a one-time fee. If you have previously paid it in conjunction with another program, please indicate that.

PLEASE TELL US ABOUT YOUR YOGA PRACTICE

Where did you complete your RYT-200 training? _____

How long have you been practicing hatha yoga? _____

Which tradition(s) or style(s)? _____

Currently, how many days per week do you practice, and for how long each day?

_____

How many months/years have you been practicing this much? _____

_____

Have you practiced Ananda Yoga? **Yes / No**

If Yes, how much? _____

Do you practice meditation regularly? **Yes / No**

If Yes, how long do you practice? _____

WHAT DO YOU EXPECT OUT OF THE PROGRAM?

Please describe what you hope to gain from AYTT-2. When possible, please be specific in your description. This will help us serve you better during the program.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

MEDICAL INFORMATION

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.

Name _____ Date of Birth _____

1. Briefly describe your current 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 concerns? If so, please explain.

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

10. Are you taking medication for any physical or psychological conditions? **Yes / No.** If Yes, then what medications are taken for which 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	PARTICIPANT'S SIGNATURE