

2011
Reiki Training: Levels 1, 2, 3, Apprenticeship
Registration Forms

Please:

Fill out and sign all forms.
Keep copies of all forms for your personal records.
Return original forms to:

The Awareness Center
2801 E. Foothill Blvd.
Pasadena, CA 91107

If you have questions please contact:
Ravijot Kaur
626.796.1567 ravijot@awarenesscenteryoga.org
www.awarenesscenteryoga.org



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Payment Form

Name: _____

Spiritual Name: _____ Birth Date: _____

Address: _____

City/State/Zip: _____

Home # _____ Work # _____

Cell # _____

Email Address: _____

Referred by: _____

PAYMENT OPTIONS

- Reiki Level 1: \$190.00 pre-registered (2 weeks before weekend), \$240.00 thereafter**
\$25.00 non-refundable deposit included.
- Reiki Level 2: \$330.00**
\$50.00 non-refundable deposit included.
- Reiki Level 3: \$480.00**
\$100.00 non-refundable deposit included.
- Apprenticeship (1 year): \$480.00 (includes 3 private consultations)**
\$100.00 non-refundable deposit included.
- Level 3 & Apprenticeship: \$800.00**
\$100.00 non-refundable deposit included.

Payment type: Cash/Money Order Check Credit Card

TO PAY BY CREDIT CARD PLEASE CALL THE AWARENESS CENTER
TO ARRANGE PAYMENT WITH RAVIJOT KAUR



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**TERMS AND CONDITIONS BETWEEN PARTICIPANTS
AND THE AWARENESS CENTER**

PAYMENT METHODS

Payable by cash, check, money order, or credit card (Visa, Master Card or Discover) .

CANCELLATIONS/WITHDRAWALS

- To withdraw from the training before it begins we must receive your request in writing one week prior to the first day of training. You will be eligible for a refund minus the non-refundable deposit.
- No refunds will be granted for requests received after the training begins.

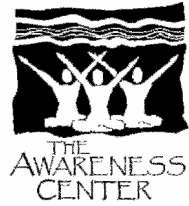
AGREEMENT

By agreeing to these terms, I agree to pay fully for the training. If I miss a session of the training I am still responsible for payment.

I agree to the above terms and conditions for registration and participation in The Awareness Center Reiki Training Program. I understand that details of date, time and location are subject to change.

Signature: _____ Date: _____

Print Name: _____



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Setting Your Intentions

Name: _____

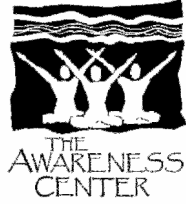
Please set your intentions for personal transformation.

Spiritual:

Mental / Emotional:

Health / Fitness:

Material/Financial:



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Emergency Contact Information

Name of Trainee: _____

Name of Emergency Contact 1: _____

Relationship to Trainee: _____ Home # _____

Cell # _____

Name of Emergency Contact 2: _____

Relationship to Trainee: _____ Home # _____

Cell # _____

Nearest Relative: _____

Relationship to Trainee: _____ Home # _____

Cell # _____

Address: _____

City: _____ State: _____ Zip: _____



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Health History Form

Name _____

In order to provide a safe and effective program it is important that you complete the following Health History. It is crucial that you answer all the questions honestly and to the best of your ability. Please be advised that all the information is kept strictly confidential.

Circle the appropriate response. Read all questions thoroughly.

- | | | |
|---|-----|----|
| 1. Has your doctor ever told you that you have heart problems? | YES | NO |
| 2. Has your doctor ever told you that you have high blood pressure? | YES | NO |
| 3. Have you ever had a stroke or heart attack? | YES | NO |
| 4. Have you ever had pain in your chest? | YES | NO |
| 5. Do you ever feel faint or have dizzy spells? | YES | NO |
| 6. Have you had surgery in the last six months? | YES | NO |

If yes, please explain _____

Circle the appropriate conditions

DIABETES	EPILEPSY	BLOOD PRESSURE	ASTHMA
ARTHRITIS	HEART	HIGH CHOLESTEROL	SEIZURES

Have you injured or have pain in the following areas? Circle the appropriate areas.

NECK	UPPER BACK	SHOULDERS	ELBOWS
KNEES	LOWER BACK	HIPS	WRISTS

If yes, please explain _____

Health History Continued

Are you currently taking any medications? YES NO

If you circled "yes" please list medications, and for what condition.

1. _____

2. _____

3. _____

Are you currently undergoing treatment from any of the following?

Physiotherapist _____ Chiropractor _____ Massage Therapist _____ M.D. _____

Psychotherapist _____ Counselor _____

If yes, why? _____

What is your current exercise level?

None _____ Once per week _____ 2-3 times per week _____ 4-5 times per week _____

What type of exercise? _____

How would you rate your level of stress on a daily basis?

Low _____ Moderate _____ High _____

Estimate how many hours of sleep you get each night. _____

Are there any other reasons/conditions that may affect or limit your participation in the program?

You are encouraged to abstain from alcohol, tobacco and drug use during the program.

Signature _____ Date _____

