



**2012**  
**Kundalini Yoga Teacher Training, Level I**  
**Registration Forms**

**Please:**

- ✓ Fill out and sign all forms.
- ✓ Keep copies of all forms for your personal records.
- ✓ Return original forms with payment by payment option deadline:

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

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



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**Registration & Payment Information**

Name: \_\_\_\_\_

Spiritual Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Home # \_\_\_\_\_ Work # \_\_\_\_\_

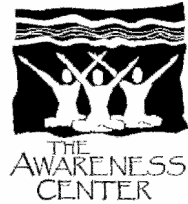
Cell # \_\_\_\_\_

Email Address: \_\_\_\_\_

Referred by: \_\_\_\_\_

**PAYMENT OPTIONS: Please check one option**

- Early Registration Discount by September 21, 2011: \$3000**  
Pay in full with cash, check or credit card by September 21, 2011.  
\$800.00 non-refundable deposit.
  
- Early Registration Discount by November 9, 2011: \$3200**  
Pay in full with cash, check or credit card by November 9, 2011.  
\$800.00 non-refundable deposit.
  
- Pay in full with cash, check or credit card: \$3400**  
\$800.00 non-refundable deposit due by January 9, 2012.  
Balance of \$2600.00 on/before January 20, 2012.
  
- Payment Plan with credit card: \$3700**  
\$800.00 non-refundable deposit due by January 9, 2012.  
Balance of \$2900.00 paid in 7 monthly auto-payments of \$414.29.  
Auto Payments on 3<sup>rd</sup> Friday of each month: February 17, March 16, April 20, May 18,  
June 15, July 20, August 17



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**Auto-Payment Information**

**If you have chosen the Payment Plan please fill out the following information completely.**

Name on Credit Card: \_\_\_\_\_ Credit Card Type: \_\_\_\_\_

Credit Card #: \_\_\_\_\_ Exp. Date \_\_\_\_\_

Billing Address: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Signature: \_\_\_\_\_



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**Payment Agreement**

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

**PAYMENT METHODS**

Payable by cash, check, money order, or credit card (Visa, Master Card and Discover).  
Payment plan "auto-payments" by credit card only.

**DEPOSIT**

There is a non-refundable deposit of \$800.00 for all participants.

**AUTO PAYMENT DATES**

There are seven (7) auto payment dates for participants who chose the payment plan:  
February 17, March 16, April 20, May 18, June 15, July 20, August 17

**CANCELLATIONS/WITHDRAWALS**

- To withdraw from the course before it begins we must receive your request in writing before January 20, 2012. You will be eligible for a refund minus the non-refundable deposit of \$800.00.
- To withdraw from the course after it begins we must receive your request in writing before February 24, 2012. Once the course begins you will be eligible for a refund minus the non-refundable deposit of \$800.00 and a pro-rated amount of the course.
- No refunds will be granted for requests received after February 24, 2012.

**AGREEMENT**

By agreeing to these terms, the participant agrees to pay fully for the course according to the agreed upon plan you have selected. If you miss a session of the course you are still responsible for all installments. If you miss a payment, you will not be allowed to participate in the following weekend until the payment has been made.

I agree to the above terms and conditions for registration and participation in The Awareness Center Yoga Teachers Training Course.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_



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**Setting Your Intentions**

Name: \_\_\_\_\_

**Please list/set your intentions for personal transformation .**

Spiritual Growth:

Mental / Emotional

Health / Fitness



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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 # \_\_\_\_\_

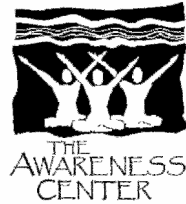
Nearest Relative: \_\_\_\_\_

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 fell faint or have dizzy spells?                     | YES | NO |
| 6. Have you had surgery in the last six months?                     | YES | NO |

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. \_\_\_\_\_

4. \_\_\_\_\_

Are you currently undergoing treatment from any of the following?

Physiotherapist \_\_\_\_\_ Chiropractor \_\_\_\_\_ Massage Therapist \_\_\_\_\_ M.D. \_\_\_\_\_

If yes, why? \_\_\_\_\_

What is your current exercise level?

None \_\_\_\_\_ 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 \_\_\_\_\_