THE MASTERS INSTITUTE

200-HOUR HATHA YOGA TEACHER TRAINING APPLICATION

Please take a moment to fill out the form below to begin your application process. Once we receive your application a representative should be in contact with you within 24-hours. Please note that all information submitted via this application is considered private and confidential and will not be shared with ANY third party individuals or vendors.

CONTACT INFORMATION

NAME: _____ DATE: _____

ADDRESS: _____

ADDRESS 2: _____ CITY: _____

STATE: _____ ZIP: _____ COUNTRY: _____

HOME PHONE: _____ EMAIL: _____

CELL PHONE: _____

EMERGENCY CONTACT NAME: _____ RELATIONSHIP: _____

BIRTH DATE: _____ BIRTH TIME: _____ BIRTH PLACE: _____

Again, thank you for your interest in the Masters Path 200-Hour Yoga Teacher Training Certification. The following questions will assist us in learning a little bit more about who you are, where you heard about our program, your intention for taking this training and how we can best serve you during this part of your journey.

1. How / where did you hear about our program?

_____

_____

2. What is your experience with Yoga? How long have you been practicing? Please specify both ***Āsana*** and ***other practices*** separately:

_____

_____

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3. Is this your first teacher training? If No, please list the other trainings completed along with hours and dates.

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4. List the three primary reasons you would like to attend this particular training:

1._____

_____

2._____

_____

3._____

_____

5. Is it your intention to teach Yoga after the training? If ***YES***, please be specific as to the why or intention behind the desire. If ***NO***, please share with us why so that we can ultimately support your intention to learn this practice.

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6. Please list any physical or mental injuries or conditions that ***could*** impact your teacher training experience:

_____

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7. Please let us know about any special dietary needs you may have (gluten free, vegetarian, etc.):

_____

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OVERALL HEALTH INTAKE

Please take a few moments to fill out the following questions to better assist us in determining how we can best serve you during this training:

8. Please list major past illness, surgery or injuries:

9. Please list any hereditary illnesses that your family may have:

Father:

Mother:

Siblings:

10. Please list any health concerns you may have, major or otherwise:

DIETARY HABITS

11. Please list how many times a week you consume the following foods (1 = Once per week, 7 = Daily):

Vegetables _____	Red Meat / Fish / Poultry / Eggs _____	Fruit _____
Crackers and / or Chips _____	Oils _____	Grains / Breads (Gluten Based) _____
Coffee / Tea / Soda _____	Alcohol _____	Grains / Breads (Gluten Free) _____
Dairy Products _____	Raw Foods _____	Spicy Foods _____
Sweets _____	Salty Foods _____	Nuts / Legumes _____

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OVERALL HEALTH INTAKE CONT.

12. Please describe your past or present use of the following.

Pharmaceutical / Recreational Drugs:

Smoking (Tobacco / Marijuana):

Alcohol:

Caffeine / Stimulants

Food:

13. Please check if you experience any of the following emotions on a ***regular*** basis:

Stress ☐ Anxiety ☐ Fear ☐ Depression ☐ Frustration ☐ Anger ☐ Hopelessness ☐

If so, how do you normally cope with the above emotions?:

SLEEP HYGIENE

14. On average how many hours a night do you sleep?: Regular time to bed: Regular time to wake:

15. Circle how rested you normally feel when you wake up: 1 - - - - - - - - - - - - - - 5 - - - - - - - - - - - - - - 10

(1 = Not Rested At All / 10 = Very Rested)

16. Please describe the quality of your dream state (Vivid or don't remember):

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PLEASE NOTE:

This training is highly experiential. You will be working deeply with yourself, closely with other individuals and your class group. You will experience a range of different teaching and learning styles, some of which you may be unaccustomed to. While issues can sometimes arise, participants need to be able to effectively process, express and contain these experiences appropriately. If you are currently undergoing psychiatric or psychotherapy treatment for experiences which are still very traumatic or triggering for you, we highly recommend discussing the possibility of attending this training with your therapist or health care professional.

17. Please list all medications you are taking (including vitamins):

_____

_____

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_____

18. Please list your expectations upon completing this training? What would you like to accomplish? Be specific (use the backside of this page if necessary):

_____

_____

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I hereby declare the information in this application is true and complete. I understand that providing false information is grounds for rejection of this application and potential dismissal from the training. I have read and understand all of the policies with respect to the training including program requirements, cancellation and refund policy.

SIGNTURE: _____ **DATE:** _____

PRINTED NAME: _____

CERTIFICATION REPRESENTATIVE SIGNATURE: _____

DATE: _____ ☐ **APPLICATION DEPOSIT - $500.00**