



Primordial Sound Meditation Application Form

Name _____ Phone (____) _____

Address _____

Email Address _____

Female/Male _____ Age _____ Occupation _____

Date of Birth Month (Spell it out) _____ Day _____ Year _____

Place of Birth City _____

Province _____ Country _____

Time of Birth _____ AM, PM

Have you ever been instructed in a mantra meditation technique? Yes _____ No _____

If yes, which one? _____

Date Instructed _____ Do you still practice it? _____

How is your health? Mental _____

Physical _____

Please list any medication you are taking _____

Emergency Contact Name and Number _____

My decision to learn Primordial Sound Meditation (PSM) is a personal decision. I have not been made any promises or warranties that I will receive any benefits or specific results. I understand the PSM is not a substitute for treatment or services ordinarily provided by health care professionals for physiological or psychological complaints. I further understand that any instruction given to me during the PSM is for me personally and may not be appropriate for others. In consideration for teaching the PSM, I hereby agree to hold Chopra Center, LLC, and their officers, agents, and employees harmless in any claims brought by me, or on my behalf, which contradict the above.

My Signature below constitutes my acceptance of the conditions expressed in the agreement.

Signature _____ Date _____

Please mail your completed form and your deposit (\$100.00 cheque to Integrative Medicine Consultants Inc.) to 3067 Balmoral Ave, Burlington, L7N 1E5. The balance of the payment \$295, is due on the first evening.