



Postpartum Yoga Teacher Training Application

NAME _____ DATE OF BIRTH _____

Name as you would like it to appear on your certificate.

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

E-MAIL _____

HOME PHONE _____ CELL PHONE _____

OCCUPATION _____

Where did you complete your 200-Hour Teacher Training? _____

Date of Completion: _____ Primary Instructors: _____

Are you currently teaching Yoga at an IY Center? If yes, where? _____

Weekly Class: Yes No - or - At least 2 classes a month: Yes No

Why do you want to take Postpartum Yoga TT? _____

What other training experience have you had since 200-Hour TT? _____

Are you following the yogic lifestyle guidelines? _____

Is there anything else you would like the trainers to know that may affect your participation in this course?

How did you learn about this training?

IYI NY IYI San Francisco IYI Fair Lawn IYCC Princeton Yogaville
 Integral Yoga Teachers Association (IYTA) Yoga Alliance Other _____

Emergency Contact Name _____

Phone _____ E-mail _____

Agreement: *I wish to apply as a Teacher Trainee and I agree to assume full responsibility for any injuries to me that may occur during the training. I am in good health and any physical illnesses or ailments are clearly stated above.*

Signature _____ Date _____

PLEASE SUBMIT COMPLETED APPLICATION TO TEACHERTRAINING@IYINY.ORG

227 West 13th Street, New York, NY 10011 • 212.929.0585 • www.iyiny.org