

PRIMORDIAL SOUND MEDITATION

APPLICATION FORM

PLEASE PRINT CLEARLY

NAME _____ PHONE _____

ADDRESS _____ FEMALE/MALE _____

AGE _____

OCCUPATION _____

DATE OF BIRTH: Month _____ Day _____ Year _____

PLACE OF BIRTH: City _____ State _____ Country _____

TIME OF BIRTH (Please approximate if necessary): _____ 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 _____

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 that the PSM is not a substitute for treatment of 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 infinite Possibilities Knowledge, 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 this agreement.

Signature _____ Date _____

For Office Use Only: Place of Instruction _____ Date of Instruction _____

Instructor _____ Payment _____