

**STUDENT REGISTRATION FORM**

New  Review

Workshop Dates: \_\_\_\_\_

Instructor: \_\_\_\_\_

Name: Mr./Ms./Mrs. \_\_\_\_\_  
(PRINT NAME as you want to appear on the certificate)

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Tel: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ E-Mail: \_\_\_\_\_

Occupation: \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

How did you hear about Pranic Healing? \_\_\_\_\_ Referred by: \_\_\_\_\_

Course Taking:  Basic Pranic Healing Level I - \$400  Advanced Pranic Healing Level II - \$500  Pranic Psychotherapy Level III - \$400  
 Pranic Crystal Healing Level IV - \$400  Psychic Self-Defense - \$400

**CONFIDENTIAL STUDENT DATA**

For your safety, please answer the following questions:

1) Do you smoke?	<input type="checkbox"/> Yes	<input type="checkbox"/> Rarely	<input type="checkbox"/> No
2) Do you take drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> Rarely	<input type="checkbox"/> No
3) Do you drink alcoholic beverages?	<input type="checkbox"/> Yes	<input type="checkbox"/> Rarely	<input type="checkbox"/> No
4) What is your diet?	<input type="checkbox"/> Vegetarian	<input type="checkbox"/> Non-Vegetarian	<input type="checkbox"/> Vegan
5) Have you been diagnosed or had history of contagious diseases or other illnesses?	<input type="checkbox"/> Yes	<input type="checkbox"/> Suspect	<input type="checkbox"/> No
6) Do you have history or present serious physical or psychological disorders?	<input type="checkbox"/> Yes	<input type="checkbox"/> Undiagnosed	<input type="checkbox"/> No

Please Specify: \_\_\_\_\_

**WAIVER:**

**I promise that I will not give, teach or divulge the techniques and teachings derived from the workshops to anyone without Master Choa Kok Sui's written approval. I also promise not to misuse the knowledge that I derived from the workshops. I also acknowledge that the courses developed by Master Choa Kok Sui are copyrighted and are not to be reproduced in any way without his written approval.**

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**PAYMENT DETAILS:**

Please make checks or money orders payable to: \_\_\_\_\_ and PayPal to: [paypal.me/lightlovepower](https://paypal.me/lightlovepower)

PayPal/Cash Amount \$ \_\_\_\_\_  Check Amount \$ \_\_\_\_\_ Check# \_\_\_\_\_

American Express \$ \_\_\_\_\_  Visa \$ \_\_\_\_\_  Mastercard \$ \_\_\_\_\_

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

Name: \_\_\_\_\_ Signature: \_\_\_\_\_  
(As it appears on your credit card) (For credit card payments only)

Internal Use Only:  
Balance Due: \$ \_\_\_\_\_  
PP: \_\_\_\_\_  
PN: \_\_\_\_\_  
Initial: \_\_\_\_\_  
Cert. issued: \_\_\_\_\_