CONFIDENTIAL

Life Mastery Intensive

Transformation to Self-Empowerment through Life Mastery

Application

Shamanic Passage LLC
636-748-0177

By completing this form, it is understood that you will be considered for the program. It is not under our obligation to approve everyone at this time. We want to ensure you are completely ready for this transformational process. This is an intensive system and there may be changes that need to be made prior to beginning. Please answer all questions.

Name:
Date:
Dates in which you are applying for:
What is your personal goal for attending?

Please describe briefly any experience you have had in the areas of therapy, the healing arts, meditation, channeling or divination.

It is helpful for us to know in advance about whatever health problems you may have so that we can adjust for any physical limitations or dietary needs required during your stay. Do you have any allergies, physical disabilities, limitations or medical problems?

Because this intensive is designed to work in your depths, we ask that you answer the following questions:

Have you had head trauma, epileptic states or neuro issues?
Have you ever been diagnosed with a psychiatric condition?
If yes, please elaborate.

Have you been in psychotherapy in the past 2 years?
Are you currently in psychotherapy?
Have you ever been hospitalized for mental health reasons?
Have you ever tried to commit suicide?

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We ask that you complete this form and provide a deposit of $375 which will be cashed only upon approval and the homeopathic consult appointment is made.

Remit to:
Amy Page, Shamanic Passage
6717 Martha Drive
Cedar Hill, MO 63016

I understand that my physical, mental and emotional well-being are my own responsibility. Shamanic Passage LLC and collaborators are not intended to substitute for therapy and that by signing this form, I affirm that I am physically, mentally and emotionally capable of undertaking the rigors of the 5-month intensive at this time. I am seeking and will continue to seek, medical or therapeutic treatment for any conditions that I may have. I have related all pertinent information in this document.

Signature:

Date:

Legibly Printed Name:

State of Residence:

Contact Number:

Email Address: