

TAI CHI FROM THE ARTHRITIS FOUNDATION

Instructor Training Workshop Application Level I



General Information			
Name:	Date of Birth:		
Your Mailing Address:	Ethnicity (optional):		
City, State, Zip:	Home Phone:		
E-mail:	Work Phone:		
Facility Information			
Name of Facility:	Name of Program Dir., Exec. Dir. or Supervisor:		
Street Address:	Phone:		
City, State, Zip:	Fax:		
Course Information & Prerequisites			
Date of Course: April 3 & 4, 2009	Location: Dallas, TX		
<p>Cost-\$275.00</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width: 30%; vertical-align: top;"> <p>Minimum Prerequisites for Tai Chi from the Arthritis Foundation:</p> <ol style="list-style-type: none"> 1. Must be at least 18 years of age 2. Must have current CPR certification </td> <td style="vertical-align: top;"> <p>Please answer the following questions completely:</p> <ol style="list-style-type: none"> 1. Do you have arthritis? yes no <li style="padding-left: 20px;">If yes, what type(s)? _____ 2. Why do you want to be a Tai Chi from the Arthritis Foundation instructor? _____ _____ 3. List any health or exercise related training, diplomas, degrees and/or certificates you have received: _____ _____ _____ </td> </tr> </table>		<p>Minimum Prerequisites for Tai Chi from the Arthritis Foundation:</p> <ol style="list-style-type: none"> 1. Must be at least 18 years of age 2. Must have current CPR certification 	<p>Please answer the following questions completely:</p> <ol style="list-style-type: none"> 1. Do you have arthritis? yes no <li style="padding-left: 20px;">If yes, what type(s)? _____ 2. Why do you want to be a Tai Chi from the Arthritis Foundation instructor? _____ _____ 3. List any health or exercise related training, diplomas, degrees and/or certificates you have received: _____ _____ _____
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Please send copies of prerequisite information with your application!			

Participant Signature: _____ **Date:** _____

Arthritis Foundation Representative: _____

Chapter: _____ **Date:** _____

- **Mail** this form with payment to: **Arthritis Foundation**, 4300 MacArthur Ave., Suite 245, Dallas, Texas, 75209 **OR**
- **Fax** this form with credit card (VISA, Master Card, Amex) information to (214) 824-5842:
 Credit Card Number: _____ Expiration Date: _____