



Bihar Yoga Bharati

Institute of Advanced Studies in Yogic Sciences

Processing No.:

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APPLICATION FORM

This form should be completed in capital letters and sent to:

The Director, Bihar Yoga Bharati, Ganga Darshan, Munger, Bihar 811201, INDIA

PERSONAL INFORMATION

1. Surname (IN CAPITALS): Given names
2. Date of birth: Day Month Year 3. Age
4. Sex: Male Female 5. Marital status: Married Single
6. City/State/Country of birth:
7. Nationality: 8. Passport no:
9. Knowledge of English Fluent Average Poor

Affix a recent
passport size
photograph

ADDRESS

10. Permanent address:
- Pin code:
- Phone: Fax: Email:
11. Postal address (if different):
- Pin code:

COURSE SELECTION (TICK BOX)

12. **Course in Yogic Studies – Four Months**
 English medium (Oct–Jan) Hindi medium (Feb–May) Year:
13. **Course in Yogic Science and Lifestyle – Three Months** Hindi medium (Jun–Aug) Year:
14. Have you applied for any of these courses previously? If yes, give details:
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ACADEMIC QUALIFICATIONS

15. Give details of academic qualifications:
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- a) Special skills/hobbies:

YOGA EXPERIENCE

16. a) Yoga training: i) Institutions:
- ii) Courses: Duration(s)
- b) Yoga teaching i) As Yoga teacher Consultant Therapist Social worker
- ii) Duration:
- iii) Location (city/town/village) Country:

c) Ashram life i) As Sannyasin Karma sannyasin Jignasu sannyasin Visitor/resident

17. Spiritual tradition: i) Tradition: Guru's name:

ii) Spiritual name: Initiation date:

PERSONAL NOTE

18. Mother/Father's name and address:

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19. Name and address of one other contact:

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Relationship:

20. In case of emergency please notify the following person (include name, phone no., email and relationship):

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MEDICAL CERTIFICATE TO BE FILLED IN BY A REGISTERED MEDICAL PRACTITIONER ONLY

I have examined the applicant on and my findings are:

1. Symptoms (if any):

2. Present/past medical history (tick if applicable):

<input type="checkbox"/> Mental disorder	<input type="checkbox"/> Addiction	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Thyroid disease	<input type="checkbox"/> Asthma	<input type="checkbox"/> High BP	<input type="checkbox"/> Allergy
<input type="checkbox"/> Arthritis	<input type="checkbox"/> IHD	<input type="checkbox"/> TB	<input type="checkbox"/> Communicable diseases

3. Vision: Normal Myopia 4. Spine & joints: Normal Deformity

5. Pulse: 6. BP: 7. Respiration:

8. Palpation: i) Abdomen: ii) Lymph nodes:

9. Auscultation i) Heart: ii) Lungs:

10. Current medication: Blood group:

11. In case of a positive medical history please send a copy of supporting medical (diagnostic) document.

Name of medical practitioner:

Address:

Signature: Date: Registration no.: Seal:

ENCLOSURES CERTIFIED COPIES OF CERTIFICATES – NOT ORIGINALS

- Year 10 level mark sheet (required for Four Month Courses: Oct–Jan and Feb–May only)
- Passing certificate
- Proof of date of birth
- Photocopy of passport (first two pages, i.e. photo page, for overseas students)
- Passport-sized photographs

DECLARATION

I, hereby declare that the information given in this application is true and accurate to best of my knowledge. The BYB Institute shall have all the rights to vary and/or reverse any decision made on the basis of incorrect or incomplete information. I further understand that the BYB Institute may, for the purpose of verification, obtain official records from any institute or employer mentioned by me in this application.

Date: Signature of applicant (in full):