Name : First name :

Date of birth : Profession : N°SIRET :

Address :

City :  Postal code : Country :

Tel. : Mail :

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| *I register for :* |  | staff |  | professional | Name of the structure : |

**Title of internship :** **Date :** **Internship location :**

Training courses completed (prerequisites for the internship) :

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Normal course fee (excluding accommodation costs) *:* | | |  | | | | | |
| *How did you hear about the school ?* |  | Internet | |  | Vidéos |  | Recommendation | Others : |

**What are your motivations for taking this course? (multiple answers possible) :**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Discovery |  | Personal renewal |  | Stress management |  | UHTS Certification Program |
|  | Other details to be specified : | | | | | | |

What are your expectations at the end of the internship? (multiple answers possible):

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Acquire new professional skills | | |  | Access a UHTS Certification Course | | |
|  | Consolidating a personal practice |  | Recharge my batteries | | |  | Managing stress |

Other details to be specified :

**Any special circumstances to report? (disability, sciatica, neck pain, circulatory problems, respiratory problems)**

|  |  |  |  |
| --- | --- | --- | --- |
|  | NO |  | YES, to be specified\* : |

\* For health issues that require special attention, please provide us with a medical certificate.

**I certify that I have received and accepted the terms of the following information and documents :**

|  |  |
| --- | --- |
|  | Consideration of needs analysis. |
|  | Internal regulations of the School of Tao of Vitality® and roadmap relating to the internship location. |
|  | Complete training program including duration, terms and conditions, and prerequisites for enrollment. |
|  | I agree to complete the post-course questionnaire available in my personal space 10 days after the end of the course. |
|  | My course completion certificate will be issued automatically once the post-course questionnaire has been completed. |
|  | I authorize the Soulimet Association to film, photograph, or record me for the purpose of promoting its activities. |
|  | I am responsible for my physical, emotional, and spiritual health. I release the Soulimet Association and its facilitators from all liability and waive all recourse in the event of an accident or damage occurring during the activities. |
|  | By registering for this course, I automatically become a member of the Soulimet Association. |

Done at on

|  |  |  |  |
| --- | --- | --- | --- |
| LAST NAME/FIRST NAME |  |  | *Read and approved* |