# YogaX Mental Health Certificate Program Application


Date

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First Name

Last Name

Street Address

Street Address Line 2

City

State

Zip Code

Phone Number

Email Address

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1. Please describe your current yoga practice.

2. What is your prior relevant experience or training? (For example, include your background in yoga, healthcare, allied healthcare, mental healthcare, education or similar work)

3. What are your goals about how to bring to bear your YogaX Mental Health Certificate?

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*Please submit this form to yogaxteam@stanford.edu*

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