

Describe any other skills, work experience, or formal training that you would like us to know about.

Please provide three references from the categories listed below. References from the first two categories are preferred. Please provide names, phone numbers and email addresses for these references.

- Meditation Teacher
- Someone who has supervised you at work
- Other professional reference

1. Name _____ Work Relationship _____
 Phone _____ Email _____
 Name _____ Work Relationship _____
 Phone _____ Email _____
 Name _____ Work Relationship _____
 Phone _____ Email _____

During your participation in the IMS Working Guest program you will be expected to follow the following five training precepts:

- to refrain from harming living beings,
- to refrain from taking what is not freely given,
- to refrain from sexual misconduct,
- to refrain from lying, gossiping, or using harsh language,
- to refrain from taking intoxicants or (unprescribed) drugs.

I acknowledge that all the information I have included in this application is true and complete. I agree to uphold the five training precepts as listed above as long as I am a working guest at IMS. I authorize IMS staff to contact any of the individuals named above as references regarding this application. I understand and agree that should this application result in my volunteering for IMS, my volunteer status will not be guaranteed and will be subject to ongoing review.

Applicant Signature _____

Please return your completed form to:

Éowyn Ahlstrom
IMS
1230 Pleasant St
Barre MA 01005

Email: eowyna@dharmia.org

Thank you for applying! Please be sure to complete the following emergency contact information sheet.

Emergency Contact Information

Your Name _____

Persons to Contact in Case of an Emergency

Primary Contact Name _____ Relationship to You _____

Address _____

Phone Numbers: Cell _____ Home _____ Work _____

Secornday Contact Name _____ Relationship to You _____

Address _____

Phone Numbers: Cell _____ Home _____ Work _____

Health Insurance Information

Health Insurance Company _____ Your ID# _____

Your Doctor's Name _____ Doctor's Phone _____