# ZEN CENTER SAN DIEGO MEMBERSHIP APPLICATION

Name: _____Gender: _____ Birthdate: _____

Address: _____
*street* *city* *state* *zip+4*

Home phone: _____ Work/mobile phone (optional): _____

Emergency Contact: _____ Phone: _____

Address: _____

Married? _____ (Y/N) E-Mail Address: _____

Field of Study/Occupation: _____

Other experiences, interests: _____

Previous meditation experience (type, teachers, length of time): _____

_____ _____

_____ _____

_____ _____

Length of time coming to ZCSD: _____ Phone student (Y/N): _____

How often do you come to ZCSD: _____

Have you ever been hospitalized or medicated for psychological or emotional reasons? (yes/no): _____
Have you ever attempted suicide? (yes/no): _____
Have you been in therapy/counseling during the past two years? (yes/no): _____

*If the answer to any of the above questions is "yes," please give details on the back of this page or on a separate confidential paper (give to teacher).*

Type of membership for which you are applying:

| | | |
|---|---|---|
| _____ | FOUNDING | $45/month |
| _____ | PRACTICING | $30/month |
| _____ | FAMILY PRACTICING | $45/month |
| _____ | STUDENT/SENIOR | $20/month |
| _____ | AFFILIATE *(live at a distance)* | $20/month |
| _____ | FAMILY AFFILIATE | $25/month |

Names of other family members included in family membership: _____

_____ _____

Please enclose the first two months' dues with this application. If paying by check, make your check payable to Zen Center San Diego. If for any reason the Practice Leaders decide that membership would not be beneficial for you at this time, we will let you know and your payment will be refunded in full.

I hereby state that the information above is correct, and that I have not withheld any pertinent information. I understand that Zen practice is for persons who take full responsibility for their physical, mental, and emotional health. I understand that it is my responsibility to seek appropriate treatment elsewhere for any medical condition (physical, mental, or emotional) that I may have.

_____ _____
*Legible signature* *Printed name* *Date*