

# Aahara Spiritual Community of Venus Rising

## Shamanic Healing Initiatory Process

### Family of Origin SHIP

May 15 - 17, 2019

Friday evening through Sunday evening

Mail to: Carley Mattimore / John Malan, 329 S. Douglas, Springfield, IL 62704

Date \_\_\_\_\_

Name \_\_\_\_\_ also called \_\_\_\_\_

Age \_\_\_\_\_ Birth Date \_\_\_\_\_ Birth Time \_\_\_\_\_ Birth Place \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

Phone – Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Fax \_\_\_\_\_ E-mail \_\_\_\_\_

Web site \_\_\_\_\_

Relationship status \_\_\_\_\_ How long? \_\_\_\_\_

Children \_\_\_\_\_ Ages \_\_\_\_\_

Parents living \_\_\_\_\_ Ages \_\_\_\_\_

List significant others, including names, ages, and relationship \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

A brief summary of your birth process, if known \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Place of employment \_\_\_\_\_ How long? \_\_\_\_\_

Please list:

a) Illnesses, injuries or surgeries \_\_\_\_\_  
\_\_\_\_\_

b) Any chronic illness \_\_\_\_\_

c) Level of education \_\_\_\_\_

d) Degrees, Certifications, training (including domestic skill) \_\_\_\_\_  
\_\_\_\_\_

**On a separate sheet of paper, please write a short autobiography emphasizing the important milestones in your life. Include your vision for your healing and training goals, why you are drawn to this workshop and what you hope to gain from this experience.**

**Aahara Spiritual Community, 329 S. Douglas, Springfield, IL 62704**

[www.aaharaspiritualcommunity.org](http://www.aaharaspiritualcommunity.org) [carleymattimore@gmail.com](mailto:carleymattimore@gmail.com), [johnmalan@gmail.com](mailto:johnmalan@gmail.com)

217-494-0587, 217-494-0583

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**DONATION OPTIONS AGREEMENT**

**Donation is \$1875.00 for all 5 sessions, or \$375 per session  
Early Bird: \$325.00 or for all 5 session is \$1625.00**

Your \$1,875.00 program donation includes workshop teachings and materials. You must arrange for a place to stay and meals separately.

This workshop can be attended in any combination of sessions, only one or all. Cost per session is \$375.00 and includes workshop teachings and materials.

A deposit of \$100.00 is due with this application in order to reserve a space in the workshop, with the balance due at the beginning of the workshop.

Payment plans are available. Please contact us to discuss.

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My deposit check or money order is enclosed.

Signature \_\_\_\_\_

Date \_\_\_\_\_

*Aahara Spiritual Community is a 501c3 spiritual organization and is recognized as such by the IRS. Donations for ministerial teachings are tax deductible as a charitable contribution. Please ask us for a receipt for your tax deductible contributions.*

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**[www.aaharaspirtualcommunity.org](http://www.aaharaspirtualcommunity.org) [carleymattimore@gmail.com](mailto:carleymattimore@gmail.com), [johnmalan@gmail.com](mailto:johnmalan@gmail.com)**  
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**EMERGENCY INFORMATION FORM**

**In the event of an emergency of any sort, it is our wish to provide you with support and assistance. We ask that you help us by providing the following information. This information will be kept confidential.**

Date \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Phone numbers: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

**Does your family or significant other(s) know you are attending this workshop? \_\_\_\_\_**  
**In the event of an emergency of any kind, who should we call? Please provide us with the names and telephone numbers, including cell phones, of at least two emergency contacts:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Are you currently under the care of a physician or therapist? \_\_\_\_\_ If yes, please provide names and phone numbers: \_\_\_\_\_**

\_\_\_\_\_

**Recent surgeries or hospitalizations: \_\_\_\_\_**

\_\_\_\_\_

**Chronic illnesses: \_\_\_\_\_**

\_\_\_\_\_

**Known allergies: \_\_\_\_\_**

\_\_\_\_\_

**Please list any history of psychiatric treatment and hospitalizations: \_\_\_\_\_**

\_\_\_\_\_

\_\_\_\_\_

**Prescription medications: \_\_\_\_\_**

\_\_\_\_\_

\_\_\_\_\_