

Inner Ventures ☯

Kate Robbins, Sue Kochevar, Linda Bronson

Peace through inner wisdom

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Spring 2009 Silence Retreat

Rest Your Mind

May 15, 16, 17

Location: Kairos Retreat Center, 35 minutes north of Spokane, WA. Driving directions are provided upon receipt of registration.

Fee: The sliding scale fee starts at \$150 for 6 vegetarian meals (may include fish) and two nights accommodation; donations for scholarships are welcome. 50% of the fee is due upon registration unless other arrangements are made. The balance is due 5 days before the start of the event unless arrangements are made to pay by credit card (MC and Visa) at the retreat location. Space is limited so early registration is recommended.

Cancellation policy: The deposit/registration fee paid will be refunded until 5 days before the start of the retreat less \$25.

Donations: Donations to assist retreatants who cannot afford to pay for the retreat are gratefully accepted and are used for "scholarships" for other retreats as needed. We do have a 1/2 scholarship available for this retreat.

Please send this form to us along with the second page to register. (Make checks payable to Inner Ventures or call us with your credit card number) Please email or call us if you have any questions or concerns.

Name: _____

Payment included:

Retreat Fee: min. \$150 \$ _____ (1/2 due at time of registration)

Scholarship Donation \$ _____

Total enclosed \$ _____

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Retreat Registration Form

Retreat Title: **2009 Retreat : Rest Your Mind**

Your Name _____

Address _____

City _____ State _____ Zip _____

Phone Number(s) _____

E-mail _____

Please list food allergies (foods you are allergic to: _____

Favorite foods: _____ Foods I do not like: _____

All meals are vegetarian (includes fish), please let us know if you are vegan or have other requirements.

How did you learn about this retreat? _____

Medical, physical or mental health conditions and medications we should be aware of:

Emergency contact numbers *-In the event of an emergency, please contact the following people*

Primary Care Physician or Clinic _____ Phone _____

Medical Insurance Provider: _____

Additional people to contact in case of emergency:

Name _____ Name _____

Phone _____ Phone _____

Relationship _____ Relationship _____

I understand I will be required to sign a release and waiver at the beginning of this retreat.

By signing this Registration Form I agree to abstain from alcohol and illegal drugs and other mood/mind altering substances prior to and during this retreat so I can participate fully in the experience.

Signature _____ Printed Name _____