Health Care Apostolate

Bereavement Education Program Registration & Interview Form
Bereavement Class # ___ Date: _____

Name _____

Phone: Home_____ Phone:
Work_____

Address_____Postal Code: _____

E-mail:_____ Parish/Facility: _____

If retired, state occupation prior to retirement: _____

Are you presently in (a) Pastoral (b) Palliative (c) Bereavement ministry/work? Yes___ No ___

Indicate which ministry and where? _____

Date of Birth: Day ___ Month ___ Age Group: 18-29 ___ 30-39 ___ 40-49 ___ 50-59 ___ 60-69 ___ 70+ ___
Previous Training
Pastoral Care training program _____ where and date_____
Palliative Care education program ____ where and date_____
Bereavement Program ____ where and date_____

What languages do you speak, read or write other than English?

_____

Would you be willing to translate? Yes ___ No ___

Why are you taking this program? _____
_____

Other related Volunteer work or Family Experience? _____
_____

Have you had significance losses? Please comment_____
_____
_____

What sources of support do you turn to?
_____
_____

Do you give us your permission to contact you via the information you have provided above?
Yes ___ No ___

In case of emergency notify:

Name: _____ Phone: Home _____

Work: _____ Relationship: _____

Signature_____Date_____

Please return this application by Mail, Fax or E-mail:
H. White, Health Care, 120 - 17th Avenue SW, Calgary, AB T2S 2T2
For more information: **Phone:** 403-218-5501 or 403-218-5508 or Fax: 403-264-0526
E-mail: healthcareprograms@calgarydiocese.ca