APPLICATION FORM

Ministry Formation Program

Name _____ Age _____

Street address _____

City/State/Zip _____

Phone: Home ( )_____ Work ( )_____

V.P. ( ) _____ Cell ( )_____

E-mail: _____

Place of Employment _____

Present Job Title _____

STATUS: Married Single Widowed Divorced Religious Clergy

Spouse's Name: _____

Children(Names/Ages _____

_____

Parish _____ Pastor _____

Arch/Diocese _____

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Tell us about yourself:

1) Have you gone to any workshop, conference, or training related to Catholic Deaf Ministry? If yes, please explain your answer.

_____

_____

2) What do you do for your church and/or in Catholic Deaf Ministry?

_____

_____

3) Why do you want to join the Ministry Formation Program?

4) When you complete four years in the MFP, what would you like to do as an active lay minister?

5) How did you find out about the MFP?

6) Do you have present health problems that would need our attention or concern during the MFP sessions? If yes, please explain.

7) Are you on medication at present and/or permanently? If yes, please give name of medicine and why you are taking this medicine.

8) Please answer "yes" or "no" and sign your name on the blank lines below.

If something happens during the weekend that might require us to call emergency, would you allow us to do it?

_____ _____
(Your answer) (Your signature and today's date)

Give <u>TWO</u> names/phone numbers of contact persons for emergency purposes:

_____ _____ _(_____)_____
Name Relationship Phone number

_____ _____ _(_____)_____
Name Relationship Phone number