



WAYNE MEMORIAL HOSPITAL

An Affiliate of Wayne Memorial Health Systems, Inc.

Grief Support Registration

I am interested in participating in the next sessions of Wayne Memorial's Grief Support Group.

Name _____
Address _____
City/State/Zip: _____
Phone: Home: _____ Work _____
Cell: _____ Email: _____

Please provide the following information about the person who died:

Name _____ Relationship _____
Birth Date _____ Date of Death _____

Which best describes your personal support system:

Excellent Good Fair Poor

How did you hear about this group ? (check all that apply)

mailing I called for information newspaper
 friend relative clergy other: _____

What do you hope to learn/obtain from attending this grief support?

Emergency Contact

Name _____ Relationship _____
Emergency Contact Phone Number _____

I give the consent for the support group facilitator(s) to contact the above listed emergency contact in the event of an emergency.

Signature: _____ Date: _____

PLEASE RETURN FORM TO:
by **May 15, 2019**

ANNA WALSH
c/o WAYNE MEMORIAL HOSPITAL
601 PARK ST., HONESDALE, PA 18431

for more information: edwardkerb@aol.com or 570-241-2685