



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 **September 15, 2019**

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

for more information: [edwardkerb@aol.com](mailto:edwardkerb@aol.com) or 570-241-2685 or [walsha@wmh.org](mailto:walsha@wmh.org)