WAYNE MEMORIAL HOSPITAL

An Affiliate of Wayne Memorial Health Systems, Inc.

Grief Workshop Registration

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

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 work shop?

Emergency Contact:

Name _____________________________ Relationship_________________________

Emergency Contact Phone Number ______________________

I give 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:

Anna Walsh
c/o Wayne Memorial Hospital
601 Park Street, Honesdale, PA 18431

For more information email edwardkerb@aol.com or 570-241-2685