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:

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

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