APPLICATION FOR HEALING LOSS WORKSHOP

3-DAY

☐ **April 4th-6th, 2018** ☐ **October 17th -19th, 2018**

The Healing Loss workshop is a three-day, residential workshop for Montefiore associates, held at a nearby retreat center.

All personal information entered on this application form will be kept confidential, and will only be reviewed by the staff and facilitators of the Healing Loss workshop. This information is important to ensure safety and to help us be aware of any issues that might be important for you as a workshop participant. This information will not be available to anyone else within or outside of Montefiore Medical Center and will be destroyed at the end of the workshop. Please feel free to contact Terysia Browne at (718) 920-6778 or tbrowne@montefiore.org with any questions or concerns. Thank you very much!

NAME: _____ DATE OF BIRTH: _____ AGE: _____

HOME ADDRESS: _____

CELL#: _____ WORK#: _____ EMAIL: _____

OCCUPATION: _____ WORK DEPARTMENT & CAMPUS: _____

YEARS OF PRACTICE IN YOUR FIELD: _____ # OF YEARS WORKING AT MMC: _____

Reasons for attending: Please describe why you would like to attend this workshop

_____

_____

_____

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_____

Please describe anything else you hope to gain by attending this workshop _____

_____

_____

_____

Please describe your personal experiences with grief and loss *(you may continue on back or another page)*: _____

_____

_____

_____

_____

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_____

Do you have any special dietary requests? _____

Do you have any special physical needs/requests? _____

Are you currently in therapy, under medical care and/or on medication of any kind? If so, please list medications, and describe any chronic or past conditions *(including any hospitalizations or surgeries you have had in the last 5 years)*:

_____

_____

_____

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_____

Have you ever been hospitalized for psychiatric treatment? Yes No

If yes, please explain: _____

_____

_____

Do you have a therapist? Yes No

If yes, is he/she supportive of your attending? Yes No

If you are in recovery from drug or alcohol use, how long have you been in recovery? *(We suggest at least one year of recovery before attending this workshop)* _____

_____

Is there anything else you would like us to know about you before this workshop?

(You may continue on back or on another page)

_____

_____

_____

_____

_____

Do you need transportation to and from the retreat center site? No_____ Yes _____

(We are able to provide car service to and from the Moses Division and the retreat center location for those that are not able to drive.)

In case of emergency, please notify:

Name: _____

Phone: _____

Relationship: _____

How did you learn about this workshop? _____

Do you want continuing education credits CEUs)? ❑ Yes ❑ No

If yes, what is your profession? ❑ MFT/LCSW ❑ RN ❑ Other _____

After your application has been received, Dr. Selwyn, one of the workshop leaders will contact you via phone to discuss your application in confidence. He will provide you with some more information about the workshop process and content, and address any questions or concerns that you may have. We do this with all applicants, to make sure that people have a good understanding of what to expect and confirm that the timing and the type of experience are right for them to participate. Please indicate the days of the week and time windows when you are in general most likely to be available. (Check all that apply):

	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
8am-9am							
9am-12pm							
12pm-1pm							
1pm-5pm							
5pm-8pm							

DEPOSIT

Since we can only accept a limited number of participants for each workshop, we want to make sure that everyone who wants to attend can have a place. **The workshop is offered free of charge. However, to hold your place, application for this workshop includes *a refundable $50.00 deposit.*** Please submit a check for this amount made out to ***Montefiore Medical Center*** with this application form.

We will return your check in the full amount, uncashed, upon completion of the workshop. If you are accepted into the workshop and become unable to attend, you must inform us of this cancellation two weeks prior to the workshop start date to be refunded. If we receive the cancellation after Tuesday, October 10, 2017, the deposit is nonrefundable.

SUBMITTING THIS APPLICATION

Please complete this form and return it together with your deposit check of $50.00 via interoffice or regular mail to:

Terysia Browne
Montefiore Medical Center
Department of Family and Social Medicine
3544 Jerome Avenue
Bronx, NY 10467

If you would prefer to fax the form, and send the check to the above address, please fax to our secure fax line, at: (718) 881-1458.

Likewise, if you would prefer to scan and email the form, and send the check to the above address, please email the scanned form to our confidential email address: healingarts@montefiore.org

For any questions related to this form or the workshop please contact Terysia Browne at (718) 920-6778 or tbrowne@montefiore.org.

Please see next page for release form.

RELEASE

Please read carefully and sign below

I understand that my participation in the Healing Loss workshop is voluntary. It may evoke my emotions in a manner that could cause me emotional distress. I agree to accept such risks and assume the responsibility for any effects that may arise from my own interpretation of the process. I understand that this workshop is not intended as psychotherapy or a substitute for psychotherapy. Further, I release Montefiore Medical Center and its affiliates, employees, agents and contractors from all claims made by me or on behalf of me (or my estate) by reason of any illness, claims or damages arising from participation in this workshop.

Signature: _____ Date: _____