



Niagara Anglican Cursillo

Application Form

The total fee for the weekend of \$50. (incl the \$25. application fee) is due 2 weeks prior to the weekend.

Application to attend: Weekend No. 43 – Nov. 27 – 30, 2008

If space is unavailable, place me on the waiting list for the next weekend

(You will be contacted closer to that weekend to ensure that you are able and willing to attend)

Mr. Mrs. Miss Ms. Rev. Dr. other _____ (circle one)

Name:

_____ (First) (Last) (as you wish it to appear on your name tag)

Address:

_____ (Street)

_____ (City & Province)

_____ (Postal Code)

Home Phone: (____) _____ Business Phone: (____) _____

e-mail: _____

Age: under 25; 26-35; 36-45; 46-55; 56-65; even older and wiser

Parish: _____ City: _____

Please list any allergies (e.g. nuts, gluten or dairy products, perfume), special diets (i.e. food restrictions) or other special requirements (e.g. vegetarian only) that we should be aware of:

Sleeping accommodations are multi-bed (2 or more per room) and there are separate dorms for men and women (spouses do not share a room). Please confirm your willingness to share a room with other participant(s) OR indicate any special room needs due to any physical disability that would require special accommodation e.g. wheelchairs):

Sponsor's name: _____ Has Cursillo been explained to you? yes no

Date: _____

(Applicant's Signature)

The completed and signed Application Form, along with the Health Information Form and application fee of \$25.00 (make cheques payable to Cursillo Niagara), should be sent to:

Blanche Mills
Registrar, Cursillo Niagara
603 - 2435 Second St.
Burlington, ON L7R 1E5



Cursillo Niagara

Health Information

This information will be kept confidential. It will only be used in case of emergency and destroyed after the weekend.

Please complete this form and mail it, along with your application.

Name: _____

Home Address: _____

Home Phone: (____) _____ Business Phone: (____) _____

Date of Birth (dd/mm/yyyy): ____/____/____ OHIP No.: _____

Additional Coverage: yes no

Company: _____ Policy No. _____

Family Physician: _____ Phone No. _____

Address: _____

Emergency Contact: _____ Relationship: _____

Home Phone: (____) _____ Business Phone: (____) _____

Address: _____

Please list any health issues (i.e. dietary restrictions; allergies; any prescription medication that you take) that may impact on emergency treatment:

Thank you for your understanding and assistance in allowing us to be fully prepared for any eventuality.

Date: _____

(Applicant's Signature)

Please check to see that all information is complete