



Niagara Anglican Cursillo

Niagara Anglican Cursillo Weekend Application Form

Weekend #: _____ Date: _____

The total cost for the weekend is \$250. A deposit of \$75.00 is required with the Application Form, and the remaining \$175 will be covered by Cursillo Niagara.**

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 should be noted: _____

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

If space is unavailable, please place me on the waiting list for the next weekend
(You will be contacted closer to that weekend to confirm your attendance.)

_____ Date: _____

(Applicant's Signature)

The completed and signed Application Form, along with the Health Information Form and deposit of \$75.00 should be sent to the address below. Please make cheques payable to Cursillo Niagara.

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

** Cursillo Niagara has a Sponsorship Fund out of which it pays the cost of the Weekend (minus \$75) as a gift to the participant. Donations towards this Fund are gratefully received and can be sent to the Treasurer: Jan Collinson, 156 Crosthwaite Ave. N., Hamilton, On. L8H 4V5.



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