



REGISTRATION FORM 2018

**Incomplete applications will not be accepted.
Pastor's endorsement and fees must accompany this form.**

Check one: ___ \$200 Church Nurse Education Program (RN's only) – Fridays and Saturdays 8am – 5p February 23, 24 and March 9, 10, 23 & 24
___ \$50 Congregational Health Promoter Program – Tuesdays & Wednesdays 6pm to 9pm February 20, 21 and March 6, 7, 20, 21

Name _____ DOB _____

Address _____

City, State, Zip _____

Home Ph _____ Work Ph _____ Cell Ph _____

E-mail _____

Ministry or community volunteer experience _____

Current occupation and area of specialty _____

Retired Yes ___ No ___ Former occupation _____

Schools attended _____

GED ___ HS ___ AD ___ BA ___ BS ___ MA ___ Doctorate ___ Other _____

Current licenses (TYPE) _____ RN License # _____

List any special needs (physical, dietary, etc.) _____

Pastor/ Clergy/ Church Leader _____

Church _____ Denomination _____

Website _____ # of Adult Members _____

Wellness Ministry Leader Acknowledgement (if your church has an established ministry with a leader)

Name _____ Signature _____

Referred by alumni (Name) _____

By signing below, I agree to attend orientation on February 15th, 6pm – 8pm, 6 class dates and graduation on April 9, 2018, 7pm – 8pm.

Signature of Applicant _____ **Date** _____

For additional information call: Nurse Manager 504-593-2339 or Lay Health Coordinator 504-593-2330

**Make checks payable to: Baptist Community Ministries (BCM)
Mail to: CW Registrar, 2222 Lakeshore Drive, New Orleans, LA 70122**



PASTOR'S ENDORSEMENT

Dear Pastor:

Please complete and sign the memorandum below to signify that you support the enrollment of volunteers from your church in the BCM Congregational Wellness' (check one)

Church Nurse Program _____ **Congregational Health Promoter Program** _____

Your endorsement also represents your church's commitment to strongly consider the establishment of a wholistic wellness ministry at your church (if none exists) once the volunteer has completed training.

As pastor of the church listed below I fully support the enrollment of the following person(s) in the Baptist Community Ministries-Congregational Wellness Training Program:

Names of volunteer(s)

Once volunteers complete the training program, I commit to working with them to establish or further wholistic wellness at our church. I will fully explore implementing the STAR (Strategies To Trim and Reduce) weight loss and blood pressure control program as part of our ministry.

(Signature of Pastor) _____ (Date)

CONTACT INFORMATION

(Please print)

PASTOR'S NAME: _____

CHURCH: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

PHONES:

Church: _____ Fax: _____ Home: _____ Cell: _____

Email: _____

Are you a full time pastor? _____ If no, do you have other employment? _____

If yes, list your employer? _____

EMPLOYER ADDRESS: _____

CITY, STATE, ZIP: _____

WORK PHONE: _____ BIRTHDAY _____