



**CULTIVATING PRESENCE
SIX DAY TRAINING IN COMPASSIONATE END-OF-LIFE CARE**

APPLICATION

Application submission date: _____

How did you learn about the program? Metta Flyer Metta Website Email Workshop
 Metta Graduate Advertisement (*where*): _____ Other (*describe*): _____

Personal Contact Information

Full Name _____ Home Phone _____

Mobile Phone _____ Email _____

Home Street Address _____

City _____ State _____ Zip _____ Gender _____ Age _____

Emergency Contact _____ Phone Number _____

Affiliated Organization Information (*if applicable*)

Affiliated Occupation Work Phone _____

Organization Street Address _____

City _____ State _____ Zip _____

Organization Website _____

End-of-Life Care/Counseling Experience

In what capacity do you currently serve the dying? As a: Professional Volunteer Family Caregiver

How Long? _____ Setting: Hospice Hospital Home Care Other _____

Describe (*frequency, place, role*) _____

Current work or study: _____

Current professional title: _____ Years in professional practice: _____

Please list type and dates of any training you have received in end-of-life care, psychotherapy, coaching, spiritual direction, communications training, or other counseling modalities?

Spiritual Tradition/Inner Work

Do you currently have what you would describe as a “spiritual path”? Yes No

How would you name it? _____ Years of practice in this tradition? _____

Do you have a contemplative or meditation practice? Yes No

Please name your specific spiritual practice(s) and frequency (*i.e. church one a week, daily chanting, one hour daily meditation*) _____

Health Concerns (*If you prefer to discuss this by phone, please let us know.*)

Do you have any significant physical health concerns or medical conditions that could impact your participation? Yes No

If yes, please describe: _____

Do you have, or do have you ever had, any mental health concerns such as depression, anxiety, addictions, or other psychiatric conditions? Yes No

If yes, please describe: _____

How Do You Plan To Apply Your Training?

Briefly describe how you will utilize the training:

In Your Professional/Volunteer Work? (*i.e. private practice, healthcare setting, educational institution, community organization*) _____

In Your Personal Life (*i.e. family caregiver, spiritual development, educational training*) _____

Retreat Experience (*check all that apply*)

This will be my first Meditation Retreat I've completed a 2-3 day Meditation Retreat

I've completed a 7 day or longer Meditation Retreat

Logistics

Preferred Occupancy (*check only one that applies*)

Commuter (*commuters will only be accepted after all residential places have been filled*)

Single Occupancy (*when available, there is an additional \$150 cost*)

Double Occupancy (*name of requested roommate*) _____

Do you have medical needs or mobility limitations? Please provide information that will assist the Retreat Manager in making room assignments _____

Dietary Restrictions (*check all that apply*) Vegetarian No Dairy No Wheat Other: _____

I Can Attend the Entire Retreat (Friday, August 6, 2010 at 5:00 pm – Wednesday, August 11, 2010 at 12:00 pm)

I have enclosed my deposit of \$200