

**Catholic Mutual Group**

**PARISH NURSE/HEALTH MINISTRY INFORMATION**

**APPLIES TO ONLY PARISH NURSE:**

Name: \_\_\_\_\_

License number: \_\_\_\_\_  
(Please attach a copy of your current license)

Date of Graduation from Nursing School: \_\_\_\_\_

What Parish Nurse Program did you graduate from?: \_\_\_\_\_

Date of Graduation from Parish Nurse Program: \_\_\_\_\_

Are you a paid Parish Staff Person?    Yes     No

**APPLIES TO BOTH PARISH NURSE AND HEALTH MINISTER VOLUNTEER**

Driver License Number: \_\_\_\_\_

List any training or experiences you have had that would be beneficial to the Parish Health Ministry Program:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

In what Parish do you minister? \_\_\_\_\_

How long? \_\_\_\_\_

Please list two personal references: (please provide names and phone numbers)

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date