APPLICATION FORM

**SABBATICAL – Invitation to Wisdom-Mission, Conversion & Transformation**

**A Sabbatical for Members of Religious Congregations**

**5 April 2024 – 17 May 2024**

|  |
| --- |
| **Personal Details** |

|  |  |
| --- | --- |
| **Title:** *(please circle)* | Sr Br Fr |

|  |  |
| --- | --- |
| **First Name:** | **Surname**: |

|  |  |  |
| --- | --- | --- |
| **Christian name as you would like it on name tag:** | | |
| **Religious Congregation:** | | |
| **Address:** | | |
| **Suburb/Town:** | | **Postcode:** |
| **Postal Address:** *(if different from above)* | | |
| **Contact No:** | | |
| **Email:** | | |
| **Date of Birth:** | **Citizenship:** | |

|  |
| --- |
| **Emergency Contact Details** |

|  |  |  |
| --- | --- | --- |
| **Name:** | | **Relationship:** |
| **Contact No:** | **Email:** | |

|  |
| --- |
| **Current Health Information** |

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |

As you will be our guest for 4 weeks, we would appreciate a history of any significant health issues of which we need to be aware. This information will ensure your wellbeing during your stay with us.

|  |
| --- |
| How would you describe the general level of your health? |
|  |

|  |
| --- |
| Do you suffer from any chronic conditions which are likely to affect your participation in this program? |
|  |

|  |
| --- |
| Do you have any mobility issues? Please indicate the nature of such. |
|  |

|  |
| --- |
| **Dietary Requirements** |

|  |  |  |
| --- | --- | --- |
| Do you have any dietary requirements? *(Please circle)* | **YES** | **NO** |
| If yes, please specify: |  |  |
|  |  |  |
|  |  |  |

|  |  |
| --- | --- |
| **Support and Endorsement for this application** | |
|  | |
| To process your application, we require the endorsement of Congregational / Provincial/ Regional or Community Leader | |
| **Name:** |  |
| **Signature:** |  |

|  |
| --- |
| **How did you hear about the Program?** |
|  |

**This program will include the options of massage, yoga, and creative arts.** All options are included in the program costs.

|  |  |
| --- | --- |
| **Deposit Details** | |
|  | |
| Deposit of **$880.65** is to be paid on submitting this Application Form. | |
| Please return this Application Form to [bookings@stjosephscentre.org.au](mailto:bookings@stjosephscentre.org.au) | |
| Or post to St Joseph’s Baulkham Hills, PO Box 7386, Baulkham Hills BC NSW 2153 | |
|  | |
| **Methods of Payment** | |
| Direct Transfer | BSB: 012228 | A/C: 8657541  **International Payments** | Swift/BIC code (IBAN) ANZBAU3M |
| Cheque | Payable to **Spirituality Ministry of the Sisters of St Joseph** |
| Credit Card | For Credit Card payments, please contact the Centre during business hours on 02 9634-2317. |

**Please provide the following information of whom the invoice should be addressed and sent to for final payment.**

|  |  |
| --- | --- |
| **Full Name:** |  |
| **Company Name:** *(if applicable)* |  |
| **ABN No:** *(if applicable)* |  |
| **Contact No:** |  |
| **Postal Address:** |  |
| **Email:** |  |

**Thank you for your application. We will be in contact soon.**