GRIEFSHARE®

REGISTRATION FORM

Name _____ Date _____

Street address _____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____

Please print email address _____

Date of birth (month/day) _____/ _____

Emergency contact (name and phone number) _____

How did you hear about GriefShare? _____

_____

_____

_____

Please share a little information about the person you lost and when the loss occurred. _____

_____

_____

_____

_____

Registration fee: $**10.00** (includes workbook and other expenses during the 13 week of sessions)

_____ Fee already paid

_____ I'll bring in the payment to a COR GriefShare Rep

_____ I'll mail this form along with a check or money order to:

Mt. Rose Church (and payable to)
Attn: COR GriefShare
PO Box 3155
Crosby, TX 77532

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