

**Clinical Pastoral Education – Request for Financial Assistance**

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| --- | --- |
| Name: | Date:  |
| Email Address: | Phone Ext: |
| Home Address: |  |
| Social Security #: | Requested Amount: $ |

Please attach a one-page letter describing the need for financial assistance and the amount requested.

□ Approved $ \_\_\_\_\_\_ □ Denied

This section indicates that the application has been seen and read by:

□ ACPE Certified Educator / Trinity Health of New England Regional Director of Spiritual Care \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ ACPE Certified Educator / St. Francis Hospital Director of Spiritual Care

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_