

**FirstHealth of the Carolinas  
Moore Regional Hospital**

**Department of  
Pastoral Care**

***Application  
Chaplain  
Associate  
Clinical Pastoral  
Education  
Program***

Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Present Mailing Address \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Telephone: Home ( ) \_\_\_\_\_ Office ( ) \_\_\_\_\_ Other ( ) \_\_\_\_\_

Email address: \_\_\_\_\_  
 Denominational Affiliation \_\_\_\_\_

Association, Conference, Diocese, Presbytery, Synod \_\_\_\_\_  
 Present Position \_\_\_\_\_

Ordained Commissioned Recorded? \_\_\_\_\_ Date \_\_\_\_\_

Education \_\_\_\_\_ Degree \_\_\_\_\_ Date \_\_\_\_\_

College		
Seminary		
Other		

Dates	Previous Clinical Pastoral Education Units Center	Supervisor
_____	_____	_____
_____	_____	_____
_____	_____	_____

References: Name, Address, and Phone

Denominational \_\_\_\_\_

Academic \_\_\_\_\_

Other \_\_\_\_\_

**Attach to Application:**

1. A reasonably full account of your life including important events and relationships with persons who have been significant to you, and the impact of these on your development. Describe your immediate family, your health, and your education experience. (3-5 pages)
2. A discussion of the development of your religious life, religious organizations you have affiliated with, your participation in the life and ministry of the church, your decision to enter ministry, and other significant religious experiences. (1-2 pages)
3. A description of an incident in which you were called on to help someone, the nature of the request, your understanding of the request and how you attempted to help.
4. Your impression of the clinical pastoral education program and your expectation of the program.
5. If you have had previous clinical pastoral education, please include your evaluations and those written by your supervisors.
6. A description of any special needs you will have during the Clinical Pastoral Education Unit (e.g. financial aid, transportation, disability considerations, and schedule).

**APPLICATION FOR:**

\_\_\_\_\_ Winter/Spring      \_\_\_\_\_ Summer      \_\_\_\_\_ Fall

**SIGNATURE OF APPLICANT** \_\_\_\_\_

**SOCIAL SECURITY NUMBER** \_\_\_\_\_

**DATE** \_\_\_\_\_

**RETURN FORM/APPLICATION TO:**

**Dr. Beverly C. Jessup, FAPC  
FirstHealth of the Carolinas/ Moore Regional  
PO Box 3000  
Pinehurst, NC. 28374  
910-215-1955 /1092**