



Point of Hope  
Grief Counseling  
Center

**Capital Hospice  
Grief Support Group Application**

In order to attend a support group, each person must commit to attending a minimum of six of the eight sessions. Each attendee must be pre-registered, and registrations are made on a first-come, first-serve basis. A maximum of twelve persons will be allowed per group.

**IMPORTANT:** Please do not assume you are registered until you have received confirmation. Capital Hospice reserves the right to cancel any group due to insufficient number of registrants. In this event, notifications will be made by phone.

Please select one group from the enclosed schedule: Group Name: \_\_\_\_\_

Date/Time: \_\_\_\_\_ Location: \_\_\_\_\_

**Please provide the following information about yourself:**

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

Telephone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Are you currently receiving any medical care? Circle one: Yes No

If yes, please explain: \_\_\_\_\_

Are you currently receiving any counseling or psychiatric care? Circle one: Yes No

If yes, what is your counselor/therapist's name? \_\_\_\_\_

*(We would not contact this person without your permission.)*

**Please provide the following information about the person who died:**

Was your loved one a Hospice patient? Circle one: Yes No

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

Date of Death: \_\_\_\_\_ Age at Death: \_\_\_\_\_ Cause of Death: \_\_\_\_\_

Please list any other significant losses in your life: \_\_\_\_\_

Do you have any friends, family or other loved ones that are supportive? Circle one: Yes No

How did you hear about our Grief Support Groups? \_\_\_\_\_

Please send completed form to:

Capital Hospice  
2900 Telestar Court  
Falls Church, VA 22042  
703.538.2044 (voice) – 703.531.2390 (fax)