

# THE NATIONAL ASSOCIATION OF CATHOLIC CHAPLAINS

OFFICE USE ONLY

Membership Number: \_\_\_\_\_

Month/Year Joined: \_\_\_\_\_

Please clearly print or type:

**1. MEMBERSHIP:**

I am applying for membership as a:  
(Please check one)

- Member (\$265.00 annual)  
 Board Certified Chaplain (\$265.00 annual)  
 Certified CPE Supervisory Candidate (\$265.00 annual)

Note that a subscription to NACC's publications, *Vision* and *NACC Now* (email newsletter), are included in all of the above membership levels.

**2. TITLE:**  Rev.  Sister  Brother  Deacon  Mr.  Mrs.  Miss  Ms.  Dr.  Other \_\_\_\_\_  
(Please check one)

**3. NAME:** \_\_\_\_\_  
(Last Name) (First Name) (MI)

**4. RELIGIOUS ORDER:** \_\_\_\_\_ **RELIGIOUS INITIALS:** \_\_\_\_\_  
(If applicable) (If applicable)

**5. GENDER:**  Male  Female

**6. RESIDENCE ADDRESS:** \_\_\_\_\_  
 \_\_\_\_\_  
 (City) (State) (Zip)  
 \_\_\_\_\_  
 (County) (Diocese)

**7. HOME TELEPHONE NUMBER:** (\_\_\_\_) \_\_\_\_\_ **MOBILE TELEPHONE NUMBER:** (\_\_\_\_) \_\_\_\_\_

**8. EMPLOYMENT:**

WORKPLACE: \_\_\_\_\_

YOUR TITLE: \_\_\_\_\_

DEPARTMENT: \_\_\_\_\_

**9. WORKPLACE ADDRESS:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 (City) (State) (Zip)

**10. WORKPLACE TELEPHONE NUMBER:** (\_\_\_\_) \_\_\_\_\_ **EXT:** \_\_\_\_\_ **PAGER:** \_\_\_\_\_

**11. I would like my mail to be directed to my:**  Residence  Workplace

**12. E-MAIL ADDRESS:** \_\_\_\_\_ **SECOND EMAIL ADDRESS:** \_\_\_\_\_

**13. FAX NUMBER:** (\_\_\_\_) \_\_\_\_\_

**14. DATE OF BIRTH:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(Month) (Day) (Year)

**15. RELIGIOUS AFFILIATION:**  Roman Catholic  Other \_\_\_\_\_

**16. DATE OF ORDINATION/PROFESSION:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(If applicable) (Month) (Day) (Year)

**17. PLACE OF ORDINATION/PROFESSION:** \_\_\_\_\_  
(If applicable)

**18. MEMBERSHIP/CERTIFICATION:**

18a. Have you ever been a member of the NACC?:  Yes (go to 18b.)  No (skip to 18d.)

18b. Have you ever been certified by the NACC?:  Yes (go to 18c.)  No (skip to 18d.)

18c. What is the date of your original certification?: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(Month) (Day) (Year)

(Please include a copy of your certification certificate or letter of recognition of your certification, for documentation purposes.)

18d. If you are a Catholic joining as a member (\$265.00), would you like to receive a certification application?  
 Yes  No (Student and Associate members are **not** eligible to receive a certification application)

19. List any other pastoral care associations that have certified you: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**20. CLINICAL PASTORAL EDUCATION:**

If you are currently enrolled in a Clinical Pastoral Education (CPE) Program, please provide:

LOCATION: \_\_\_\_\_  
(Center) (City) (State)

SUPERVISOR: \_\_\_\_\_

21. NUMBER OF CPE UNITS COMPLETED TO DATE:  CPE \_\_\_\_\_  Supervisory CPE \_\_\_\_\_

**22. EDUCATIONAL BACKGROUND:**

COLLEGE / GRADUATE SCHOOL / SEMINARY: \_\_\_\_\_

DEGREE(S): \_\_\_\_\_

FIELD: \_\_\_\_\_

YEAR DEGREE EARNED: \_\_\_\_\_

COLLEGE / GRADUATE SCHOOL / SEMINARY: \_\_\_\_\_

DEGREE(S): \_\_\_\_\_

FIELD: \_\_\_\_\_

YEAR DEGREE EARNED: \_\_\_\_\_

**23. PASTORAL MINISTRY EMPLOYMENT BACKGROUND:**

EMPLOYER: \_\_\_\_\_  
(Name) (City) (State)

DATES: \_\_\_\_\_ to \_\_\_\_\_  Full-time  Part-time

EMPLOYER: \_\_\_\_\_  
(Name) (City) (State)

DATES: \_\_\_\_\_ to \_\_\_\_\_  Full-time  Part-time

**24. TYPE OF WORKPLACE / INSTITUTION: (Please check one)**

- Academic  Prison/Corrections  Hospital/Medical Center  Hospice  Mental Health
- Nursing/Retirement Home  Parish  Rehabilitation  Diocese  Religious Community
- Funeral Home/Mortuary  Other \_\_\_\_\_

**25. SPONSORSHIP OR WORKPLACE / INSTITUTION:** *(Please check one)*

- Catholic       Jewish       Protestant       Federal       State     Local     Other \_\_\_\_\_

**26. YOUR PRIMARY RESPONSIBILITY:** *(Please check one)*

- Administration     Chaplain       Director       Educator       Parish Ministry     Nurse     Student
- Other \_\_\_\_\_

**27. VOLUNTEERING:**

- I would like to share my gifts by volunteering with the NACC:
- National Conference Task Force
  - Other event committees
  - Certification interview team (certified chaplains and CPE supervisors only).
  - Speaker (please list topic): \_\_\_\_\_

**28. OPTIONAL FOR USCCB/CCA STATISTICAL PURPOSES**

**ETHNICITY** *(Please check all that apply):*

- White
- Black or African American
- American Indian and Alaska Native
- Asian
- African
- Native Hawaiian and other Pacific Islander
- Hispanic or Latino
- Multiracial
- Other \_\_\_\_\_

**29. National Association of Catholic Chaplains Member Ethics Statement**

Membership in the National Association of Catholic Chaplains (NACC) means that you will abide by the NACC Code of Ethics and are qualified for the membership category selected. By becoming an NACC member, you are agreeing to be subject to the rules, regulations, and enforcement of the terms of the NACC Code of Ethics (available to you at <http://www.nacc.org/certification/standards-and-procedures.asp>).

Your signature below attests that all information provided on this application is true and accurate, you have reviewed the NACC Code of Ethics and pledge to uphold it, and you acknowledge that you can be held accountable under the NACC Standards and Procedures for any violation of the Code.

\_\_\_\_\_  
*(Signature)*

\_\_\_\_\_  
*(Date)*

**PLEASE NOTE:**

- Please enclose the appropriate dues in U.S. funds with this application. Make your check payable to: NACC.
- Mail completed application and fee to:

National Association of Catholic Chaplains  
5007 S. Howell Avenue, Suite 120  
Milwaukee, WI 53207-6159

\_\_\_\_\_  
*(Date)*

\_\_\_\_\_  
*(Applicant Signature Required)*