

Application Material Required

- ☐ **A. Kenrick-Glennon Application Form**
 - A1.** Personal Data
 - A2.** Family Data (attach photograph of self, approximate size: 2" x 3")
 - A3.** Educational History
 - A4.** Employment/Professional Background Data
 - A5-6.** Ecclesiastical Enrollment Data
 - A7-9.** Health Form (to be completed by the applicant)
 - A10.** Emergency Information
 - A11.** Insurance Information
 - A12.** Confidentiality of Application and Admission Information
 - A13.** Authorization and Release Form
 - A14.** Release Form for Background Investigation
 - A15-16.** Request for Child Abuse or Neglect/Criminal Record Form
 - A17.** Legal Status
 - A18.** Recommendation from the Rector(s) or Religious Superior(s) if applicant has been enrolled in any seminary in the past or has been in formation with a religious community
 - A19.** Canonical Status
 - A20.** Payment Arrangements and Financial Status
- ☐ **B. Autobiographical Essay**
 - B1.** Autobiographical Essay
- ☐ **C. Physical Exam and Immunization History**
 - C1.** Physical Exam (to be completed by health care provider)
 - C2.** HIV Test and Release Information (to be completed by the applicant and given to the examining physician)
 - C3-4.** Immunization History (to be completed by health care provider)
- ☐ **D. Eye Exam**
 - D1-2.** Written report from eye doctor (in addition to Health form)
- ☐ **E. Dental Exam**
 - E1-2.** Written report from dentist (in addition to Health form)
- ☐ **F. Psychological Exam**
 - F1-2.** Psychological Examination and Reports (to be completed by health care provider)
- ☐ **G. Letters of Recommendation:**
(Enclosed you will find a letter which is to be given/sent for these recommendations—Word Document is provided.)
 - G1.** Your Pastor (a letter to request this recommendation is enclosed)
 - G2.** General Letter from: Two other people (friend, employer, non-relative)
- ☐ **H. Baptism Record (dated within the last six months) and Confirmation Record if not noted on the Baptismal Record**

Other Required Application Items for Applicant to include in submitted materials:

- ☐ **I.** Final official transcripts with degree(s) imprinted from all educational institutions attended after high school

An interview with the Admission Committee will be arranged with the applicant at a mutually agreed upon time. All materials are to be submitted to the seminary and the interview is to be completed before July 25th. Please send in the materials as they are completed.

Please Print or Type

Personal Data

1. _____
 Last Name First Name Middle Name

Does the above name agree with the name on your baptismal record? ☐ Yes ☐ No

If no, please explain: _____

2. _____ 3. Citizenship: ☐ U.S. Citizen ☐ Non-U.S. Citizen
 Preferred Name

4. _____ Country of Citizenship Country of Birth
 Date of Birth mm/dd/yy

5. _____ Are you a permanent resident of the U.S.? ☐ Yes ☐ No
 City County State

6. _____ Visa Type Place Issued
 Social Security Number

7. _____ Expiration Date
 Driver License Number State

8. _____
 Permanent Phone Number (including area code)

9. _____ City
 Permanent Street Address

10. _____ 11. _____
 State Zip County

12. _____
 Present Street Address (if different from above) City

13. _____ 14. _____
 State Zip County

15. _____ 16. _____
 Present Phone Number (including area code) Email Address

17. Have you ever served in the Military? ☐ Yes ☐ No Branch Dates of Service from to

18. When do you plan on entering Kenrick Seminary? _____

I am entering as a ☐ Pre-Theology ☐ Theology student.
 (Please check one)

19. Name of the Sponsoring (Arch)Diocese or Religious Community? _____

Please Print or Type

Family Data

1.
Last Name

First Name

Middle Name

2.
Father's First Name

Middle Initial

Last Name

3.
Date of Birth (mm/dd/yy)

Place

4.
Street Address (if different than your permanent address)

5.
City

State

Zip

6.
Work Phone Number (including area code)

7.
Religion

8.
Occupation

9.
Educational Background

10.
Mother's First Name

Middle Initial

Maiden Name

11.
Date of Birth (mm/dd/yy)

Place

12.
Street Address (if different than your permanent address)

13.
City

State

Zip

14.
Work Phone Number (including area code)

15.
Religion

16.
Occupation

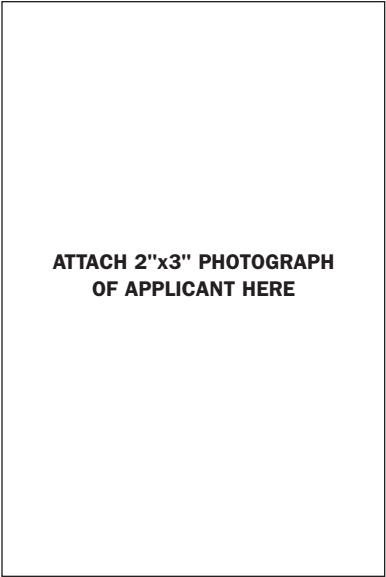
17.
Educational Background

18. Number of Brothers

19. Number of Sisters

22. Your Rank

20. If you are adopted, or if your parents are divorced, separated or remarried, please explain:



Please Print or Type

Educational History

1.

| | | |
|-----------|------------|-------------|
| Last Name | First Name | Middle Name |
|-----------|------------|-------------|

2. Please list the schools you have attended in chronological order. Give the inclusive dates of attendance (month & year).

| Name of School | City, State | From | To |
|----------------|-------------|------|----|
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3. If you have not yet earned a degree, but are working toward one, please give the following information:

| | |
|-----------------------------|-------------------------|
| Type of Degree | Educational Institution |
| Major | Minor (if any) |
| Date Degree to be conferred | |

4. Please list Degrees you have earned:

| Degree | From Educational Institution | Date | Major |
|--------|------------------------------|------|-------|
| | | | |
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NOTE: An official Transcript with your Degree(s) indicated must be sent to the Admissions Office. Please have the Registrar from each Educational Facility (College/Theologate) you have attended, send an official Transcript of your academic record and Degree(s) to the Kenrick-Glennon Admissions Office.



Please Print or Type

Employment/Professional Background Data

1.

| | | |
|-----------|------------|-------------|
| Last Name | First Name | Middle Name |
|-----------|------------|-------------|

2. Please give information concerning previous employment and professional positions held beginning with most recent.
(You may attach an additional sheet if necessary.)

| Place of Employment | Location (city, state) | Dates | Position |
|---------------------|------------------------|-------|----------|
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Please Print or Type

Ecclesiastical Enrollment Data

1.

Last Name

First Name

Middle Name

2. To be completed by (Arch)Diocesan candidate:

Diocese

Home Parish

Pastor

Parish Street Address

City

State

Zip

Phone Number (including area code)

Director of Vocations

Phone Number of Director of Vocations

If you were not born in the above diocese, please give the name of the diocese in which you were born: _____

Have you ever been affiliated with a religious community? ☐ Yes ☐ No

Community

Dates:

Did you profess vows? ☐ Yes ☐ No

Date professed:

Date of dispensation from vows

Explain:

3. To be completed by a member of a Religious Community/Order/Institute:

Name of Community/Order/Institute

Initials

Immediate Supervisor

Phone Number (including area code)

Street Address

City

State

Zip

Name of Major Superior

Street Address

City

State

Zip

What is your status in the Community/Order/Institute? _____

Please Print or Type

To be completed by all applicants:

4. Have you ever been refused admission or asked to leave a seminary or religious community?
- ☐
- Yes
- ☐
- No

If yes, explain:

Name of Seminary/Community/Order/Institute

Street Address

City

State

Zip

5. Are you at the present time attending a seminary?
- ☐
- Yes
- ☐
- No

Seminary

Entrance Date

Street Address

City

State

Zip

6. Have you ever lived in another (Arch)Diocese for a period of six (6) months continuously, after your fourteenth (14) year by reason of attendance at a college or seminary, or as a member of the military, an extended vacation, or employment for any reason?
- ☐
- Yes
- ☐
- No

Name of (Arch)Diocese

Name of Parish(es)

Dates of Residence

7. Have you ever received Ecclesiastical Tonsure, Minor Orders, or Candidacy?
- ☐
- Yes
- ☐
- No

Order/Ministry

Place

Name of Diocese/Community

Date Received

8. Have you ever completed any Field Education Program at the Theologate level?
- ☐
- Yes
- ☐
- No

Supervisor

Type of Ministry/Service

Place Performed

Dates

Please Print or Type

Health Form

1. _____
 Last Name First Name Middle Name

Applicants for admission to Kenrick School of Theology must have this report completed and returned as noted below. No registration is complete until this requirement is met. The pages in Section C are to be completed by your physician. Page C2 should be signed by you in the physician's office. Page C4 is an explanation of immunization requirements.

2. _____
 Last Name First Name Middle Name

3. _____
 Social Security Number

4. Family Physician _____
 First Name Last Name

5. _____
 Street Address City State Zip

6. _____
 Phone Number (including area code)

7. Local Hospital Preference _____
 Street Address City Phone Number (including area code)

Family History

If any immediate family members are in poor health, please comment. If any immediate family members are deceased, please indicate the age of the family member at death in the space provided.

8. Father _____
 First Name Last Name Age

Is your father in good health? ☐ Yes ☐ No If no, please comment: _____

8. Mother _____
 First Name Last Name Age

Is your mother in good health? ☐ Yes ☐ No If no, please comment: _____

9. Siblings (You may attach a separate sheet if necessary):

A. _____
 Name Relationship Age

In good health? ☐ Yes ☐ No If no, please comment: _____

B. _____
 Name Relationship Age

In good health? ☐ Yes ☐ No If no, please comment: _____

C. _____
 Name Relationship Age

In good health? ☐ Yes ☐ No If no, please comment: _____

D. _____
 Name Relationship Age

In good health? ☐ Yes ☐ No If no, please comment: _____

Please Print or Type

Health Form

1. _____
 Last Name First Name Middle Name

2. Please indicate which of the following have occurred in members of your family and list the relationship to you:

| | | | |
|-------------------------|------------------------------|-----------------------------|---------------------|
| A. Allergies | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Relationship: _____ |
| B. Asthma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Relationship: _____ |
| C. Cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Relationship: _____ |
| D. Heart Trouble | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Relationship: _____ |
| E. High Blood Pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Relationship: _____ |
| F. Psychiatric Disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Relationship: _____ |
| G. Seizure Disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Relationship: _____ |
| H. Tuberculosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Relationship: _____ |

3. Have you been under the care of a physician in the past five (5) years? ☐ Yes ☐ No

If yes, please explain: _____

4. Have you ever experimented with drug usage or used drugs without the advice of a physician? ☐ Yes ☐ No

If yes, please explain: _____

5. Have you been closely associated with a person known to have tuberculosis? ☐ Yes ☐ No

6. Have you ever been hospitalized? ☐ Yes ☐ No

If yes, please explain, giving approximate date (month/year) of hospitalization: _____

7. Have you ever had an operation? ☐ Yes ☐ No

If yes, please explain, giving approximate date (month/year) of operation: _____

8. Do you have any dietary restrictions for medical reasons? ☐ Yes ☐ No

If yes, please explain: _____

9. Please list any medications you take on a regular or frequent basis: _____

10. Do you smoke? ☐ Yes ☐ No

11. Are you allergic to any medications? ☐ Yes ☐ No If yes, please specify: _____

Please Print or Type

Health Form—Personal History

1. _____
 Last Name First Name Middle Name

2. Please indicate whether or not you have had or now have any of the conditions listed below. If there are any conditions to which a positive answer is given, please explain when the condition occurred and if and how it was corrected.

| | | | |
|--------------------------------|--|------------------------------------|--|
| Alcohol Abuse | <input type="checkbox"/> Yes <input type="checkbox"/> No | Chronic Cough | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Allergies | <input type="checkbox"/> Yes <input type="checkbox"/> No | Dentures or Partial Plates | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Depression | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Back Trouble, Worn Brace | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diphtheria | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding Disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No | Discharging from Ears | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood in Urine | <input type="checkbox"/> Yes <input type="checkbox"/> No | Dizziness or Fainting Spells | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood in Stools | <input type="checkbox"/> Yes <input type="checkbox"/> No | Eye Trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bone, Joint or Other Deformity | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fractures | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Burning in Urination | <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequency of Urination | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent Wheezing | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chicken Pox | <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent Chest Pains | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| German Measles | <input type="checkbox"/> Yes <input type="checkbox"/> No | Repeated Severe Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hearing Trouble/Loss | <input type="checkbox"/> Yes <input type="checkbox"/> No | Repeated Tonsillitis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No | Repeated Abdominal Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hepatitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Seizure Disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hypoglycemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Severe Sprains | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Irregular Heart Beat | <input type="checkbox"/> Yes <input type="checkbox"/> No | Severe Diarrhea | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Jaundice | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sexually Transmitted Disease (STD) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Measles | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shortness of Breath | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Mumps | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sleep Disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Nervous Stomach | <input type="checkbox"/> Yes <input type="checkbox"/> No | Substance Abuse | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Nose Bleeds | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sugar in Urine | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Palpitations | <input type="checkbox"/> Yes <input type="checkbox"/> No | Trick Knee or Shoulder | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Pleurisy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Pneumonia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Whooping Cough | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Psychiatric Disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

Comments:

Please Print or Type

Emergency Information

| | | | | | |
|----|---------------------------|------------|-------------|------------------------|------------|
| 1. | Last Name | First Name | Middle Name | Social Security Number | |
| 2. | Home Street Address | City | State | Zip | |
| 3. | Date of Birth (mm/dd//yy) | 4. | Age | 5. | Blood Type |

8. In case you are involved in a serious accident or experience a serious medical problem, please list the names of two people who should be contacted by seminary officials:

| | | | | | |
|----|----------------|------------|------------------------------------|-----|--------------|
| 7. | Last Name | First Name | Phone Number (including area code) | | |
| | Street Address | City | State | Zip | Relationship |
| 8. | Last Name | First Name | Phone Number (including area code) | | |
| | Street Address | City | State | Zip | Relationship |

9. If you are on any regular medication, please list the name of medication, the dosage, how often you take it, and where it is kept: (You may attach an additional sheet if necessary)

| | | | |
|------------|--------|---------------|---------------|
| Medication | Dosage | Times Per Day | Location Kept |
| | | | |
| | | | |
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10. Please list all allergies:

| |
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11. Physician

| | | |
|-----------|------------|------------------------------------|
| Last Name | First Name | Phone Number (including area code) |
|-----------|------------|------------------------------------|

12. Please list any other necessary medical information that emergency personnel should know about you:

| |
|--|
| |
| |
| |

Please Print or Type

Insurance Information

1. Last Name First Name Middle Name

Medical Insurance

2. Name of Insurance Company 3. Expiration Date of Policy

4. Street Address City 5. Name of Policy Holder if not Self State Zip

6. Policy Number

7. Telephone Number of Company (including area code)

8. Hospital of preference in St. Louis in the event of an emergency

In case of an emergency, I hereby give permission to the person in charge at Kenrick School of Theology to secure proper medical attention for me and to notify the contact persons I have indicated on the "Emergency Information Sheet".

9. Printed Name of Applicant Signature of Applicant

Auto Insurance

10. Type of Automobile Make Model Year Color

11. License Plate Number 12. State

13. Name of Insurance Company

14. Street Address of Company City State Zip

15. Policy Number 16. Starting Date of Policy

17. Telephone Number of Company (including area code)

18. Printed Name of Applicant Signature of Applicant

Confidentiality of Application and Admission Information

Confidentiality of records is very important to the individual and to the Kenrick School of Theology. In order to insure this confidentiality with respect to information related to the admissions process, each applicant must sign a release form which clearly defines who will have access to which records.

The President-Rector and the Admissions Committee will have access to the complete file prior to admission. After admission, the following will have access to those records listed below provided that there is a signed release:

After admission, the Faculty will have access to the Academic File (application form pages A1-A6, as well as transcripts and grades from academic institutions attended prior to admission).

After admission, the results of the psychological tests performed as a part of the admissions process will be accessible to the President-Rector, Vice Rector for Formation, Dean of Seminarians, the Director of Psychological and Counseling Services, and the Assistant to the President-Rector.

Release Form

I, _____, give my permission for the following people to have access to specific personal files:

Faculty may have access to my Academic File (application form pages A1-A6, as well as transcripts and grades from academic institutions attended prior to admission).

The President-Rector, Vice Rector for Formation, Dean of Seminarians, the Director of Psychological and Counseling Services, and the Assistant to the President-Rector may, during my stay at Kenrick School of Theology, may have access to the results of my psychological testing performed as a part of the admissions process.

The President-Rector and the Admission Committee may have access to all of the above plus my letters of recommendation, health records, and other pertinent documents prior to my admission.

Statement of Consent to Release

I hereby authorize the persons holding the above named offices to read the specific designated files during the time periods listed above. Access to my files by anyone not named above will require a signed release by me.

Student Signature _____

Witness _____

Date _____

At the termination of a student's attendance at Kenrick School of Theology or upon Ordination to the Priesthood, it is the policy of Kenrick School of Theology to destroy results of psychological testing performed as part of the admission process.

Revised 6/17/2015

Please Print or Type

Authorization and Release Form

1.

Last Name

First Name

Middle Name

2. You must sign this application:

I grant permission to Kenrick School of Theology and its agents (collectively "the seminary") to investigate my complete personal, educational and work histories and to verify all information that may be given in connection with my seeking admission as a seminarian. In addition, I release the seminary, as well as any individual or organization and all of its agents who supply written or oral information regarding myself to the office of the seminary, from any and all liabilities resulting from such investigation or verification. I understand and agree that I may be denied admission or, if I am already admitted, that my admission may be terminated based on information obtained during that investigation or verification. Upon the termination of my admission, regardless of when, how or why my admission is terminated, and whether such termination is effected by me or by the seminary, I authorize the release of reference information on all aspects of my personal history with any agency of the seminary and release the seminary and all its agents from any and all liability resulting from disclosure or information on my personal history.

Finally, I certify that I have given true and accurate information, and that I have read and agreed to the conditions of admission stated in this application and authorize the release as set forth above. If any information contained in this application is found to be false in the opinion of Kenrick School of Theology in any respect, my application for admission may be rejected. Similarly, if I am already admitted, I will be subject to discharge without notice at any time.

Name (Type or Print)

Official Signature

Date

Please Print or Type

Release Form for Background Investigation

(return this completed form with your application)

I, the undersigned, understand that investigative background inquiries are to be made on myself including consumer, criminal, driving and other reports. These reports will include information as to my character, work habits, performance and experience along with reason for termination from past employment from previous employers. Further, I understand that you will be requesting information from various Federal, State and other agencies relating to my driving, credit, criminal, civil and other experiences as well as claims involving me in the files of insurance companies.

I hereby authorize all individuals and organizations named or referred to in my application and any law enforcement organization named or referred to in my application or any law enforcement organization to give me all information relative to such verification and hereby release the Archdiocese of St. Louis, its authorized agents and all person and organizations providing information from all claims and liabilities of any nature in connection with this investigation. I hereby further authorize that a photocopy of this authorization may be considered as valid as the original.

I understand that I have specific rights as a consumer under the federal Fair Credit Reporting Act ("FCRA"), and may have additional rights under relevant state law.

Signature of Applicant _____ Date _____

Please Print Clearly on All Information Below

Print Full Name (Last) _____ (First) _____ (Middle) _____

Social Security Number _____ Date of Birth (DD/MM/Year) _____

Driver's License Number _____ State of Issue and Year of Issue _____

Current Address _____ City/State/Zip Code _____

Please list all addresses you lived at for the past ten (10) years. Include the year you moved to the address and the year you moved out.

Address Including City, State and Zip Code _____ Year moved in and out _____

Address Including City, State and Zip Code _____ Year moved in and out _____

Address Including City, State and Zip Code _____ Year moved in and out _____

Address Including City, State and Zip Code _____ Year moved in and out _____

Please use a separate sheet of paper if you have more addresses to report.

Please attach a copy of your driver's license and social security card as well as a copy of your passport if you lived out of the United States.

If you lived outside the United States for any period of time, please complete the following:

Countries previously lived in _____

Mother's Maiden Name _____

Please provide the address(es) of where you lived in these countries, providing exact mailing addresses below. Include the year you moved in and out of the address.

Please use a separate sheet of paper if you have more addresses to report.

Please Print or Type

Request for Child Abuse or Neglect/Criminal Record Form

The following form is necessary for admission. Please complete and return to Kenrick-Glennon.

| | | | | | | | | | | | | | |
|---|--|------|--|--------------------------|--|---|---|-----|-------|-------------|-----------|---------|-----------------------|
| TYPE OF SERVICE (Check only one) See reverse side for further instructions. <input type="checkbox"/> (1) Name Search - \$5.00 (Criminal record, offender registry, and child abuse search) <input type="checkbox"/> (2) Fingerprint Search - \$14.00 (Criminal record, offender registry, and child abuse search) <input type="checkbox"/> (3) DFS Central Registry Child Abuse Search Only - No Charge | | | | | TYPE OF DAYCARE PROVIDER <input type="checkbox"/> (1) License <input type="checkbox"/> (2) License Exempt <input type="checkbox"/> (3) Registered | | | | | | | | |
| IDENTIFYING DATA (Please type or print information legibly in ink.) The subject of the request must complete the next section and sign. | | | | | | | | | | | | | |
| APPLICANT S NAME (Last, First, MI, Jr., Sr., III) | | | | | | | | | | | | | |
| MAIDEN NAME | | | | DATE OF BIRTH (MM/DD/YY) | | STATE OF BIRTH | | SEX | RACE | | | | |
| ALIAS NAME(S) | | | | SOCIAL SECURITY NUMBER | | | DRIVER S LICENSE NUMBER / STATE / | | | | | | |
| ADDRESSES FOR PAST 5 YEARS | | | | | | | | | | | | | |
| STREET | | CITY | | STATE | STREET | | CITY | | STATE | | | | |
| | | | | | | | | | | | | | |
| | | | | | | | | | | | | | |
| Have you ever been found guilty to or been convicted of any criminal act in this state or any state? | | | | | | | | | | | | | |
| <input type="checkbox"/> YES (Complete section below) <input type="checkbox"/> NO, I have not been found guilty to or been convicted of any criminal offense in this state or any state. | | | | | | | | | | | | | |
| DATE | | CITY | | STATE | COUNTY | | CIRCUMSTANCES (Identify charges, attach separate page, if necessary.) | | | | | | |
| | | | | | | | | | | | | | |
| | | | | | | | | | | | | | |
| Have you ever been substantiated as a perpetrator in any child abuse or neglect report made to the Division of Family Services in this state or any state? | | | | | | | | | | | | | |
| <input type="checkbox"/> YES (Complete section below) <input type="checkbox"/> NO, I have not been substantiated as a perpetrator in any child abuse or neglect report. | | | | | | | | | | | | | |
| DATE | | CITY | | STATE | COUNTY | | CIRCUMSTANCES (Attach separate page, if necessary.) | | | | | | |
| | | | | | | | | | | | | | |
| | | | | | | | | | | | | | |
| The information provided is complete and accurate to the best of my knowledge. I understand it is unlawful to withhold or falsify information required on this form. I grant permission to the Department of Social Services to obtain any and all information needed to process my request and to use the information as permitted by law. | | | | | | | | | | | | | |
| SIGNATURE OF APPLICANT (REQUIRED IN INK) | | | | | | DATE | | | | | | | |
| SIGNATURE OF REQUESTOR (Required in ink) | | | | | | DATE | | | | | | | |
| TITLE OF CHILD CARE PROVIDER | | | | | | TELEPHONE | | | | | | | |
| STATE AGENCY | | | | | | STATE VENDOR OR CONTACT NO. (If applicable) | | | | | | | |
| CHECK APPROPRIATE BOX | | | | | | | | | | | | | |
| <input type="checkbox"/> CHILD CARE RELATED EMPLOYMENT | | | <input type="checkbox"/> DOH / CCB CHILD CARE BUREAU | | | <input type="checkbox"/> SCHOOLS / PUBLIC AND PRIVATE | | | | | | | |
| <input type="checkbox"/> CHILD CARE RELATED VOLUNTEER | | | <input type="checkbox"/> DMH / DMH VENDOR | | | <input type="checkbox"/> DFS CONTRACT PROVIDER | | | | | | | |
| <input type="checkbox"/> DFS LICENSURE | | | <input type="checkbox"/> HEALTH CARE | | | <input type="checkbox"/> OTHER _____ | | | | | | | |
| RETURN ADDRESS (REQUIRED ON EACH APPLICATION) Complete your mailing label below Confidential Mail | | | | | | | | | | | | | |
| <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="padding: 5px;">AGENCY NAME</td> </tr> <tr> <td style="padding: 5px;">ATTENTION</td> </tr> <tr> <td style="padding: 5px;">ADDRESS</td> </tr> <tr> <td style="padding: 5px;">CITY, STATE, ZIP CODE</td> </tr> </table> | | | | | | | | | | AGENCY NAME | ATTENTION | ADDRESS | CITY, STATE, ZIP CODE |
| AGENCY NAME | | | | | | | | | | | | | |
| ATTENTION | | | | | | | | | | | | | |
| ADDRESS | | | | | | | | | | | | | |
| CITY, STATE, ZIP CODE | | | | | | | | | | | | | |

Last Name

First Name

Middle Name

Please Print or Type

The purpose of this form is to provide information available to child care agencies including volunteer agencies. The records you receive will be based on the search options you select. The Missouri State Highway Patrol will respond when you choose option 1 or 2. The Missouri Division of Family Services will respond when you choose option 1, 2, or 3. Direct questions regarding criminal records to the Missouri State Highway Patrol (573-526-6153); direct questions regarding child abuse or neglect to the Division of Family Services (573-526-1438, TT: 1-800-735-2466).

The information on this form, and responses generated as a result of this form, are confidential. Any person disclosing the information in violation of 43.540, 589.400, RSMo. and /or 210.150 RSMo. is guilty of a class A misdemeanor.

For information on how to participate in the Child Abuse/Neglect Central Registry examination program, submit a written request from the CEO, owner, director, etc. of your child care related group or organization to: **Director, Division of Family Services, P.O. Box 88, Jefferson City, MO 65103.**

PROCESSING FEE SCHEDULE INFORMATION (43.527 AND 43.530 RSMo.)

By checking boxes 1 thru 3 on the front page of this form, the following applies:

1. Name Search - \$5.00 Provides open records obtained from the Missouri Criminal Record Repository and information from Missouri Division of Family Services Central Registry.
 - a) Complete the request form.
 - b) Make a check or money order for \$5.00 payable to "State of Missouri Criminal Records System."
 - c) Mail completed form and check or money order to: **Missouri State Highway Patrol, Criminal Records and Identification Division, P.O. Box 9500, Jefferson City, MO 65102.**
2. Fingerprint Search - \$14.00 Provides open and closed records with positive identification obtained from the Missouri Criminal Records Repository and information from Missouri Division of Family Services Central Registry.
 - a) Complete the request form.
 - b) Obtain fingerprints on: Applicant card FD-258 or Patrol card SHP-152. Official taking fingerprints must verify identity of person fingerprinted with an official id such as a drivers license and sign the card as the person taking the fingerprints. Complete the rest of the card as applicable.
 - c) Make a check or money order for \$14.00 payable to "State of Missouri Criminal Records System."
 - d) Mail completed forms and check or money order to: **Missouri State Highway Patrol, Criminal Records and Identification Division, P.O. Box 9500, Jefferson City, MO 65102.**
3. DFS Central Registry Child Abuse Search Only - No Charge Provides information obtained from the Division of Family Services Central Registry only. The Division of Family Services (DFS) Central Registry screening will reflect information contained in the DFS database. Any questions about the accuracy of that information should be directed to the DFS office in the residential county of the applicant or the county of employment if the applicant is not a Missouri resident.
 - a) Complete the request form.
 - b) Mail completed form to: **Missouri Division of Family Services, Background Screening / Investigations Unit, P.O. Box 88, Jefferson City, MO 65103.**

OPEN RECORDS - convictions, charges pending, arrests less than thirty days old, and suspended imposition of sentence during probation.

CLOSED RECORDS - charges not filed, not prosecuted, dismissed, or subject found not guilty or suspended imposition of sentence after probation.

SPACE RESERVED FOR SHP/DFS RESPONSE STAMP

DFS USE ONLY

☐ FG ☐ FH ☐ RH ☐ AD (IF RH OR AD, MUST PROVIDE RELATIONSHIP) _____

SIGNATURE OF DFS CSW

SIGNATURE OF COUNTY DIRECTOR

TELEPHONE

REQUESTING COUNTY

Please Print or Type

Legal Status

1. _____
 Last Name First Name Middle Name

2. Are you prevented from lawfully becoming employed in this country because of your visa or immigration status?
☐ Yes ☐ No (Check one)

3. Have you at any time been accused of child abuse?
 (You are required to answer this inquiry whether or not a criminal conviction arose out of the allegation.)
☐ Yes ☐ No (Check one)

If yes, please provide in detail the date, the place, and an account of the circumstances surrounding each allegation of child abuse and respond to questions 4 and 5 below.

4. Did any judicial proceeding arise out of the allegations of child abuse? ☐ Yes ☐ No (Check one)

If yes, please identify the court in which the proceeding was brought and its location, the parties to that proceeding, the docket number of the proceeding, and any judgment or resolution that was entered or reached.

5. Are you under the supervision of any federal, state or local corrections agency as a result of any allegations of child abuse?
☐ Yes ☐ No (Check one)

6. Have you ever been convicted of or pleaded guilty to a misdemeanor or felony (other than a parking violation)?
☐ Yes ☐ No (Check one)

If yes, please state the nature of the offense for which you were convicted or pleaded guilty, the date of the conviction or the entering of the plea, the judgment imposed, the court imposing the judgment and its location, and the docket number of the proceeding.

7. Has any surety company ever refused to issue or continue any bond on your behalf? ☐ Yes ☐ No (Check one)

If yes, please provide in detail the date, the reasons for and the circumstances surrounding the surety company's refusal.

A "yes" response to either of the two preceding questions will not disqualify you from consideration for admission to Kenrick School of Theology. A record of a conviction, or a refusal by a surety company to issue or continue a bond on your behalf, does not mean that you cannot be admitted. The nature and circumstances of any conviction or bond refusal, how long ago either occurred, and other factors, including the relationship of the conviction or bond refusal to the position for which you are applying, are all important in the admission consideration. Thus, please provide a complete response to these questions so that an appropriate decision may be made.

Letter of Recommendation—Former Rector/Religious Superior

If you have been previously enrolled in a seminary or if you have been associated with a religious community, we must have the information requested in the following letter. Please type a letter in the following format to the former seminary or community superior for each prior seminary or religious community. A copy of each recommendation request sent to a former seminary or religious community must be included with your application to Kenrick School of Theology. Your admission to Kenrick-Glennon will not be complete and an interview may not be scheduled until we have this information.

To the President-Rector (or Religious Superior):

I am currently applying for admission to Kenrick School of Theology in St. Louis, Missouri, to pursue formation for the Roman Catholic priesthood. I request that you write a letter to the rector of Kenrick School of Theology describing my time at _____ Seminary (or “with the community”) and review the circumstances of my departure.

I also authorize you to release to Kenrick School of Theology a copy of my most recent evaluation as well as all information you deem relevant from my time at _____ Seminary (or “with the community”). Please send all information to:

President-Rector
Kenrick School of Theology
5200 Glennon Drive
St. Louis, MO 63119

I understand that no person has a right to be accepted into a program for priestly formation but I intend to apply to Kenrick School of Theology in the hope of discerning my vocation. I ask for your prayers as I continue in this endeavor.

Sincerely yours,

(Name)
(Address)

Please Print or Type

Canonical Status

1. _____
 Last Name First Name Middle Name

The following pertain to your canonical status according to the Roman Catholic Church and require dispensation before ordination can occur.

2. Insanity: have you ever committed yourself to or been committed to a psychiatric facility? ☐ Yes ☐ No
- 2a. Have you ever been treated for any reason by a mental health care professional? ☐ Yes ☐ No
- 2b. Have you ever been prescribed medication for a mental or emotional condition? ☐ Yes ☐ No
- 2c. Have you ever been diagnosed or treated for alcoholism? ☐ Yes ☐ No
- 2d. Do you possess an allergic condition to gluten (wheat)? ☐ Yes ☐ No
3. Apostasy, heresy, or schism:
- 3a. Have you ever abandoned the Christian religion? ☐ Yes ☐ No
- 3b. Have you ever denied or held an opinion contrary to the teachings of the Church with regard to faith or morals? ☐ Yes ☐ No
- 3c. Have you ever abandoned the Catholic Church and joined a religious denomination by a formal act? ☐ Yes ☐ No
4. Have you ever entered into marriage either civilly or in a religious ceremony? ☐ Yes ☐ No
- 4a. If Yes, has a civil decree of divorce obtained for this union? ☐ Yes ☐ No
- 4b. If Yes, has a decree of nullity been granted by an ecclesiastical tribunal or a dissolution of the bond been granted by a competent ecclesiastical authority? ☐ Yes ☐ No
- 4c. If Yes, were any children produced from this union? ☐ Yes ☐ No
- 4d. If Yes, and the children have not yet reached majority has provision been made for their spiritual and material needs? ☐ Yes ☐ No
- 4e. Do you have responsibility for a former spouse or children rising from natural obligations? ☐ Yes ☐ No
- 4f. If Yes, are you fulfilling these obligations? ☐ Yes ☐ No
5. Have you ever taken vows in a religious institute? ☐ Yes ☐ No
6. Voluntary homicide or abortion:
- 6a. Have you ever been involved in taking another human life? ☐ Yes ☐ No
- 6a. Have you ever assisted another to procure an abortion, to perform an abortion, or to cooperate in obtaining an abortion for another person? ☐ Yes ☐ No
7. Have you ever attempted suicide, self-mutilation, or the mutilation of another? ☐ Yes ☐ No
8. Have you ever impersonated a deacon, priest or bishop in a religious ceremony? ☐ Yes ☐ No
9. Have you ever incurred an ecclesiastical penalty (excommunication, interdiction)? ☐ Yes ☐ No

Signature _____ Date _____

Please Print or Type

Financial Status

1.

Last Name

First Name

Middle Name

2. Please list any outstanding debts you are currently responsible for:

☐ Student Loan(s) Approximate \$ _____

☐ Credit Cards(s) Approximate \$ _____

☐ Other—i.e.,

Car Loan Approximate \$ _____

Medical Approximate \$ _____

Misc. Approximate \$ _____

Payment Arrangements

3. For tuition, board and fees, send bills to:

Name of person(s) to be billed (Pastor, Parents(s), self...) _____

(Rev., Mr., Mrs.)

First Name

Last Name

Street Address

City

State

Zip

(Rev., Mr., Mrs.)

First Name

Last Name

Street Address

City

State

Zip

(Rev., Mr., Mrs.)

First Name

Last Name

Street Address

City

State

Zip

4. How do you plan to finance your education?

5. Have you applied for Grants and Financial Aid?

Signature

Date

Please Print or Type

Autobiographical Essay

1. _____
Last Name First Name Middle Name

2. Please write an essay reflecting on your life. Please type the autobiography.

SUGGESTED OUTLINE:

1. Name
2. Birth, Parents, Siblings
3. Describe your home life
4. Friends, relationships, hobbies
5. Schools attended and memorable teachers
6. Describe yourself as a student
7. Activities in which you were involved
8. Memorable events in your life:
 - Jobs
 - Peak experiences
 - Special persons
9. Faith background and experiences
10. Faith practices
11. Present situation:
 - Have you dated?
 - With whom do you associate?
12. What draws you to the priesthood?
13. What have you done to benefit others?
14. What are your strongest/weakest qualities or characteristics?

We are looking for a comprehensive history of your life so we may better know your background and what has brought you to this point in your life.

Please conclude your essay with what you hope to bring to the life of the seminary and what you hope to gain from your seminary experience.

Please Print or Type

Physical Examination

(to be completed by examining physician)

| | | |
|-----------------|---------------|-------------------------|
| Last Name | First Name | Middle Name |
| Height | Weight | Blood Pressure |
| Pulse | Vision: Right | Corrected Vision: Right |
| Color Blindness | Left | Left |

For the following, please check if normal or comment upon any abnormal conditions.

| | | |
|---------------------------|-------------|-------|
| Musculature | Comments: | |
| Nutrition | Comments: | |
| Skin | Comments: | |
| Eyes | Comments: | |
| Ears | Comments: | |
| Nose | Comments: | |
| Teeth | Comments: | |
| Tongue | Comments: | |
| Tonsils | Comments: | |
| Throat/Pharynx | Comments: | |
| Neck/Nodes | Comments: | |
| Thyroid | Comments: | |
| Chest/Lungs | Comments: | |
| Heart | Comments: | |
| Abdominal/Palpable Masses | Comments: | |
| Hernia | Comments: | |
| Rectal | Comments: | |
| Genitalia | Comments: | |
| Extremities | Comments: | |
| Reflexes | Comments: | |
| Urine: VDRL or Equivalent | Microscopic | Sugar |
| ALB | | |

Recommendations (Please comment on the health or fitness of the applicant, including your perception of mental health as well as physical health):

| | | | |
|---------------------------|------------------------------------|-------|-----|
| Printed Name of Physician | Date | | |
| Signature of Physician | Phone Number (including area code) | | |
| Street Address | City | State | Zip |

Please Print or Type

HIV Test and Release of Information

I hereby give permission to _____ to take a sample of my blood and test for the presence of the antibody to the Human Immunodeficiency Virus (HIV).

This virus may well be the cause of the Acquired Immune Deficiency Syndrome (AIDS) and is associated with that disease. I understand this test in itself is not diagnostic for AIDS, and the meaning of a positive test is still under investigation.

AIDS is a disease which reduces the body's ability to fight infection. The HIV is thought to cause AIDS. The test for the HIV antibody has a high probability of detecting previous exposure to this virus. However, it is possible to have HIV antibodies without any other evidence of the disease and to remain symptom free, possibly indefinitely. I understand it is possible to have some signs of the disease which may appear after a period of time.

I understand the HIV blood test can, in some cases, indicate that a person has antibodies to the virus when the person is not infected with the HIV virus (false positive) or the test may fail to detect that a person is infected with the virus (false negative). I understand that if my initial test is positive, other tests may be performed to attempt to confirm these results, and in order to perform such additional tests, an additional blood sample may be necessary and I give my consent for taking such a sample. I understand if the test is positive, in combination with other data, a diagnosis of AIDS by my physician is possible. If my physician determines my test for HIV is positive, the law requires that my case be reported to the St. Louis Department of Health, and will be investigated by them. The physician will report the results in your physical examination report for your application.

By my signature below, I acknowledge that I have been given all of the information I desire concerning the blood test and release of results, and have had all my questions answered by my physician or his or her authorized representative. Furthermore, I acknowledge that I have been given consent for the performance of a blood test to detect antibodies to the HIV and understand the conditions for the release of these test results.

This consent has been fully explained to me, and I have read it or had it read to me and fully understand and accept its terms and conditions.

| | | |
|----------------------|-------------------|------|
| Patient Name (print) | Time | Date |
| Signature | Witness Signature | |

Refusal to consent to HIV Test

An HIV antibody test has been recommended for me. I have been counseled about the reasons for the test, the nature of the test, and the nature of the HIV Virus and the disease it causes. I do not want to be tested and refuse to consent to the test. If a health care provider has a significant exposure to the blood or bodily fluid from me or equipment used on me, and I or my next of kin or legal guardian refuses to grant consent to HIV antibody testing and a sample of blood is available, the sample shall be tested for the presence of infectious disease.

| | |
|-------------------|------|
| Signature | Date |
| Witness Signature | Date |

Please Print or Type

Immunization History

(to be completed by examining physician)

1. Last Name First Name Middle Name

| 2. Vaccine or Test | Vaccine Type | Date(s) | Doctor/Clinic |
|---------------------|----------------|---------|---------------|
| Polio (PPV or eIPV) | Primary Series | | |
| | Booster | | |

Polio Vaccine is not routinely given to adults, and therefore students are not required to receive booster or a primary series if they were previously immunized. Student s should, however, document their childhood polio vaccine immunization.

| | | | |
|---|----------------|--|--|
| Diphtheria, Pertussis, Tetanus (DPT, DT, or Td) | Primary Series | | |
| | Booster | | |

Documentation of primary series of diphtheria and tetanus toxoid, and a booster within the past 10 years.

| | | | |
|-----------------|-------------|--|--|
| Combination MMR | First Dose | | |
| | Second Dose | | |
| Measles | First Dose | | |
| | Second Dose | | |

Documentation of two doses of live measles (or MMR combined) vaccine on or after the first birthday or, documentation of physician-diagnosed disease or laboratory evidence of immunity.

| | | | |
|-------|--|--|--|
| Mumps | | | |
|-------|--|--|--|

Documentation of one dose of live mumps (or MMR combined) vaccine on or after the first birthday or, documentation of physician-diagnosed mumps or laboratory evidence of immunity.

| | | | |
|---------|--|--|--|
| Rubella | | | |
|---------|--|--|--|

Documentation of one dose of rubella (or MMR combined) vaccine on or after the first birthday or, documentation of laboratory evidence of immunity.

| | | | |
|-----------------|--|--|--|
| Other Vaccines | | | |
| | | | |
| | | | |
| Tuberculin Test | | | |

Result

N.B.: Positive skin test requires a separate physician statement documenting absence of active/infectious tuberculosis.

Documentation of a negative tuberculin skin test within the past 12 months

Please respond to the following, which summarize the immunization requirements for Kenrick School of Theology:

3. The student has completed a primary series of diphtheria and tetanus immunization: ☐ Yes ☐ No
4. The student has had a tetanus booster within the past ten years: ☐ Yes ☐ No
5. The student has received at least one dose of rubella and mumps vaccines: ☐ Yes ☐ No
If no, is there documentation of physician-diagnosed illness of mumps, or laboratory evidence of immunity of rubella or mumps? Please attach documentation/evidence.
6. The student has received two doses of measles vaccine (alone or in combination) on or after the first birthday.
☐ Yes ☐ No If no, is there documentation of physician-diagnosed illness or laboratory evidence of immunity?
Please attach documentation/evidence.
7. The student has had a negative tuberculin test within the last 12 months. ☐ Yes ☐ No

Physician/Clinic Name

Street Address

City

State

Zip

Signature of Physician

Date

Exemption: Students claiming exemption from immunizations of medical contraindications must submit a written statement signed and dated by a physician.

Immunization History—Student Requirements

Last Name

First Name

Middle Name

1. Diphtheria and Tetanus

Documentation of a primary series of diphtheria and tetanus toxoid, and a booster within the past ten years.

2. Measles

Documentation of two doses of live measles (or MMR combined) vaccine separated by at least one month on or after the first birthday, or documentation of physician-diagnosed disease or laboratory evidence of immunity.

3. Mumps

Documentation of one dose of live mumps (or MMR combined) vaccine on or after the first birthday, or documentation of laboratory evidence of immunity.

4. Rubella

Documentation of one dose of rubella (or MMR combined) vaccine on or after the first birthday, or documentation of laboratory evidence of immunity.

5. Tuberculin Test

Documentation of a negative tuberculin skin test within the past twelve (12) months. Positive skin tests require a separate physician statement documenting absence of active/infectious tuberculosis.

6. Polio

Polio vaccine is not routinely given to adults, and therefore students are not required to receive a booster or a primary series if they were not previously immunized. Students should, however, document their childhood polio vaccine immunization. In the unlikely event of epidemic disease, special requirements may be instituted.

7. Hepatitis

Immunization against Hepatitis B is strongly recommended for all students.

Please Print or Type

Eye Examination

Applicant Name

Please return completed form to:

Director of Admissions
Kenrick School of Theology
Kenrick-Glennon Seminary
Archdiocese of Saint Louis
5200 Glennon Drive
St. Louis, MO 63119

Notice to examining physician

The above-named individual is applying for admission to a program of priestly formation in the Roman Catholic Church. Part of the application process includes a thorough dental examination. Church law requires that applicants must have good health which will enable them to undergo the rigors of the seminary as well as the life-long obligations of the priesthood. We rely on your professional expertise to assist us in determining that this applicant is in good health. Thank you.

NOTE: This information is strictly for use by the Director of Admissions of Kenrick-Glennon School of Theology and will not be released to anyone else without the knowledge or consent of the applicant.

Please Print or Type

Eye Examination

(to be completed by examining physician)

Patient Name

Examination Date

Significant Complaint/History:

| Visual Acuity | At Distance | | At Near | |
|-----------------------------|-------------|------|---------|------|
| [] Without correction | R20/ | L20/ | R20/ | L20/ |
| [] With present correction | R20/ | L20/ | R20/ | L20/ |
| [] With new correction | R20/ | L20/ | R20/ | L20/ |

Intraocular Pressure: R

Method:

L

Special Test Procedures:

Diagnosis:

Treatment/Recommendations:

Recommend next examination:

Months

Examining Physician Name

Examining Physician Signature

Address

Phone Number (including area code)

Please Print or Type

Dental Examination

Applicant Name

This section should be completed by patient prior to dental examination.

| Questions | Yes | No | Comments |
|--|-----|----|----------|
| Do you have any current dental complaints? | | | |
| Do you get regular dental care? | | | |
| Were you ever treated for a mouth infection? | | | |
| Have you ever had Trench Mouth? | | | |
| Have you ever been treated for periodontal disease? | | | |
| Have you ever had pain in your jaws or near your ears? | | | |
| Do you grind your teeth in your sleep? | | | |
| Do hot or cold liquids cause pain to your teeth? | | | |
| Do you brush your teeth regularly? How often? | | | |
| Do your gums bleed when you brush your teeth? | | | |
| Have you ever had a gum abscess or mouth sores? | | | |

Signature of Applicant

Date

Please return completed form to:

Director of Admissions
 Kenrick School of Theology
 Kenrick-Glennon Seminary
 Archdiocese of Saint Louis
 5200 Glennon Drive
 St. Louis, MO 63119

Notice to examining dentist

The above-named individual is applying for admission to a program of priestly formation in the Roman Catholic Church. Part of the application process includes a thorough dental examination. Church law requires that applicants must have good health which will enable them to undergo the rigors of the seminary as well as the life-long obligations of the priesthood. We rely on your professional expertise to assist us in determining that this applicant is in good health. Thank you.

NOTE: This information is strictly for use by the Director of Admissions of Kenrick-Glennon School of Theology and will not be released to anyone else without the knowledge or consent of the applicant.

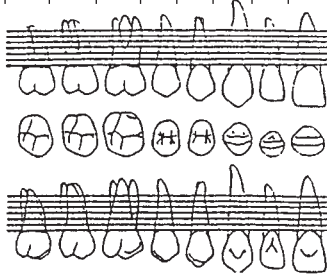
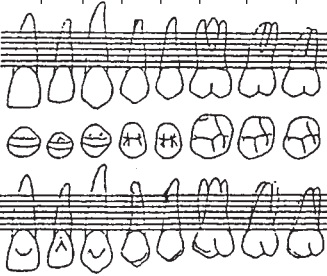
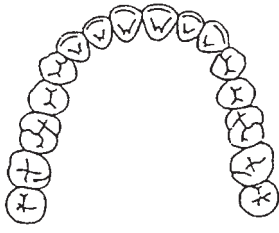
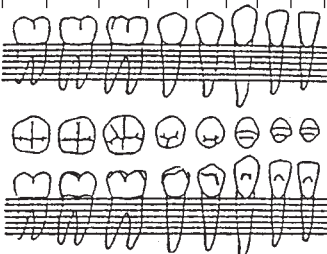
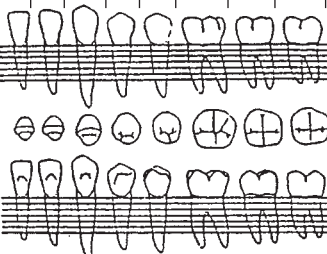
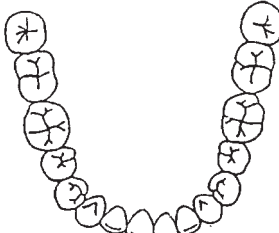
(to be completed by dentist)

Dental Examination

SECTION

E

E2

| | | |
|---|---|---|
|  |  |  |
|  |  |  |

Special Restoration:

Summary of Treatment:

Tongue Thrusting

Mouth Breathing

Pain Opening or Closing Mouth

Clench or Grind Teeth

Sore Areas in Mouth or Gums

Food Impaction

Sensitive Teeth

Complications Following Extraction

Gum Infections

Frequency

Previous Gum Treatments

Bleeding Gums

Frequency

Tooth Brushing

Remarks

Dentist Name

Address

City

State

Zip

Phone Number (including area code)

Signature

| Tooth | | | Treatment Needed |
|-------|---|---|------------------|
| L | R | # | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Occlusions

Prematurities

Right Lateral

Left Lateral

Orthodontics

Please Print or Type

Psychological Examination and Reports

Because psychological evaluation can provide important insights for the process of seminary formation, formatted reports will enhance application to student growth plans. Psychological evaluations serve the dual purpose of clearly identifying student strengths and weaknesses in addition to ruling out psychiatric disease.

Evaluation Guidelines

1. The process of the evaluation should include both interview and testing, emphasizing character description, abilities, strengths, weaknesses, motivations and psycho-social and psycho-sexual development.
2. The administration of the following tests or similar testing instruments meets the minimum standards for Seminary admission. Additional testing may be included at the discretion of the examiner.
 - Edwards Personal Preference Schedule
 - Minnesota Multiphasic Personality Inventory (MMPI-2)
 - California Personality Inventory (CPI)
 - Rorschach Test

If adult learning disabilities are suspected, tests such as the following are to be included:

- Wechsler Adult Intelligence Scale - Revised
- Wechsler Memory Scale - Revised

Raw test data may be included at the discretion of examiners; however, if not accompanied by a narrative summary, it will not be admissible.

3. Psychological reports should be prepared in a narrative style.

In addition to findings regarding psychopathology, the report should include a summary of candidate's social history, sexual history, emotional and relational history, strengths, weaknesses, aversions, motivations and other aspects of a character profile.

4. The preparation of the candidate's psycho-sexual history should include (but not be limited to) the following information:
 - Candidate's first information about sex
 - First sexual experience (sex play, masturbation, abuse)
 - Family attitudes about sex
 - History of sexual abuse (perpetrator and/or victim)
 - Mutual genital experiences
 - Sexual orientation and security in that orientation
 - Aspects of the candidate's sexuality which cause concern (cause the candidate discomfort, shame, or to engage in secrecy)
 - Sexual attractions, attractiveness
 - History of dating relationships, intimate relationships, friendships
 - Management of sexuality, impulse control

5. The preparation of the candidate's social history should include (but not be limited to) the following information/questions:

- Family structure/history/interactions
- Information about self originating in family
- Career work history
- Significant events in life
- Beliefs/values
- Support systems
- Goals, aspirations
- Medical history, health (any addictions)
- Use of recreational time/hobbies
- When desire for priesthood originated/why

6. Diagnosis (if applicable)

Cooperation with this format will facilitate admission decisions, formational growth and accurate information for candidates. This information is only shared with the Admissions Committee during the application process. Following acceptance into the program this report is placed in a secured file with strictly limited access. This report is destroyed if the student is not accepted into the program or at the completion of the program.

7. Formational Goals

The following qualities are essential to a positive recommendation for Holy Orders. This information is provided to psychological examiners for informational purposes and the psychologist need not refer to each of these characteristics in the report. However, if there are any obstacles that would prevent the development of these characteristics or if there are particular areas of concern related to these goals, these obstacles and areas of concern should be noted.

- The human qualities of truthfulness, respect for others, justice integrity, affability, generosity, kindness, courtesy and prudence
- The capacity to relate to others in a positive manner and the ability to get along with others and work with them in the community
- Good self-knowledge, self-discipline, and self-mastery, including emotional self-control
- Good physical and mental health
- A balanced lifestyle and balance in making judgments
- Affective maturity and healthy psychosexual development; clarity of masculine identity; an ability to establish and maintain wholesome friendships; the capacity to maintain appropriate boundaries in relationships
- Skills for leadership and collaboration with women and men
- Capacity to receive and integrate constructive criticism
- Simplicity of life and stewardship of resources
- Mature respect for and cooperation with Church authority
- Engagement in the community life of the seminary

Letter of Recommendation—Pastor

Dear Father Pastor:

The applicant listed below, from your parish, is beginning the application process to enter Kenrick School of Theology as a candidate for the priesthood in the Roman Catholic Church. The pastor's recommendation is required. Please address the following issues, in letter form, as accurately and thoroughly as possible. Your information will be held confidential.

How long have you known the applicant and how well do you know him?

Why does he want to be a priest? How does he view the priesthood?

What do you believe to be his motivation in studying for the priesthood?

Do you foresee any unusual problems/difficulties if this applicant were to be accepted as a seminarian (e.g., academic, emotional, celibacy, etc.)?

Describe the relationship he has with his parents and other members of his family?

How do they feel about his desire to study for the priesthood?

Please comment on your observations about the applicant's spiritual life.

Please describe his personal lifestyle.

To your knowledge, has the applicant ever been in the religious life or in a seminary?

If so, why did he leave?

Has the applicant ever married, taken vows or been ordained? Has he ever left the Catholic Church?

In comparison with other men his age and experience, how would you rate this applicant as a candidate for the priesthood?

How do you feel we can best help this applicant to form him into the best priest possible?

Please offer any other comments which you believe may be helpful in evaluating the applicant.

Thank you for your cooperation in this matter. Please send your letter to:

Director of Admissions
Kenrick School of Theology
5200 Glennon Dr.
St. Louis, MO 63119.

Applicant's Name: _____

Letter of Recommendation—General Request

Regarding recommendation for Kenrick School of Theology:

The applicant listed below is beginning the application process to enter Kenrick School of Theology as a candidate for the priesthood in the Roman Catholic Church. Please address the following issues, in letter form, as accurately and thoroughly as possible. Your information will be held confidential.

How long have you known the applicant and how well do you know him?

Why does he want to be a priest? How does he view the priesthood?

What do you believe to be his motivation in studying for the priesthood?

Do you foresee any unusual problems/difficulties if this applicant were to be accepted as a seminarian (e.g., academic, emotional, celibacy, etc.)?

Describe the relationship he has with his parents and other members of his family?

How do they feel about his desire to study for the priesthood?

Please comment on your observations about the applicant's spiritual life.

Please describe his personal lifestyle.

To your knowledge, has the applicant ever been in the religious life or in a seminary?

If so, why did he leave?

Has the applicant ever married, taken vows or been ordained? Has he ever left the Catholic Church?

In comparison with other men his age and experience, how would you rate this applicant as a candidate for the priesthood?

How do you feel we can best help this applicant to form him into the best priest possible?

Please offer any other comments which you believe may be helpful in evaluating the applicant.

Thank you for your cooperation in this matter. Please send your letter to:

Director of Admissions
Kenrick School of Theology
5200 Glennon Dr.
St. Louis, MO 63119.

Applicant's Name: _____

Please Print or Type

Proof of Baptism and Confirmation

Applicant Instructions: Please fill out the information below and take it or send it to the parish where you were baptized and/or confirmed.

Dear Father,

I have decided to apply for admission to Kenrick School of Theology to begin formal education and formation toward the Roman Catholic Priesthood. As part of the application process, each candidate is required to provide proof of Baptism and Confirmation. Please send copies of the certificates of Baptism and/or Confirmation or other documented proof thereof, dated within the last six months for:

Applicant's Full Name (including Baptismal name)

Date of Birth

Father's Name

Mother's Name

Godfather's Name

Godmother's Name

Please send the requested documents to:

Director of Admissions
Kenrick-Glennon School of Theology
Kenrick-Glennon Seminary
5200 Glennon Drive
St. Louis, MO 63119

Thank you for your cooperation.

Applicant's Signature

Date