National Share Chapter Application

Chapter Application *to be completed by applying Share Chapter representative*

Date of Application ________________________________**Anticipated Chapter Start Date**_____________

Name of Proposed Chapter ____

**Please note: the official Chapter name must include "Share."*

Your Name____

Phone___________________________Email____

Address____

Are you affiliated with any local hospital or facility? ___Yes ___No

If yes, please provide the following information:

Hospital/Facility Name & Address____

Your role within hospital/facility____

Supervisor name and contact information____

Please read the following membership options and select your desired level of membership:

- ☐ **Independent Chapter** ($350 joining fee, $100 annual dues)
  - Chapter will be self-staffed, operating independently without local hospital/facility sponsorship
- ☐ **Hospital/Facility-Based Chapter** ($350 joining fee, $300 annual dues)
  - Chapter will be staff-supported, operating within this facility to enhance patient/client perinatal bereavement care
- ☐ **Uncertain**
  - My Chapter membership level is yet to be determined

Are you the primary contact for this Chapter? ____Yes ____ No

Additional Chapter Contact ____

Additional Contact information ____

Email address *Phone*

How did you learn about Share? ____

____

I understand that the requirements of forming a Share Chapter are (1) completion of this application; (2) completion of Share Chapter Agreement; (3) payment of Share Chapter start-up fees; (4) agreement of Share Chapter Leader to complete the online *Sharing and Caring* training seminar within 60 days of application.

Signature of Applying Chapter Representative: ____

Chapter Leader Application *to be completed by the intended Share Chapter Leader*

Name__________________________________ Phone ______________________________________

Email________________________________ Alternate Email _________________________________

Address____

Have you previously attended a *Sharing and Caring* Perinatal Bereavement Training? If yes, please list date and location:

____

**Please be aware that this training is required of the Share Chapter Leader and must be attended within 6 months of this application. Sharing and Caring and is offered by the National Office in the Spring and Fall of each year.*

Are you a bereaved parent? ____ Yes ____ No

If yes, please indicate what type or types of losses you have experienced **with the date(s) written next to each:**

- ☐ Early Pregnancy Loss _____________
- ☐ Stillbirth _____________
- ☐ Neonatal Loss _____________
- ☐ Pregnancy interruption _____________
- ☐ Other:____

**Please be aware that we respectfully request that applicants wait at least 18 months after their first experience of loss before applying to be a Share Chapter Leader. Thank you.*

Chapter Leader Experience (if applicable)

Occupation:____

Supervisor: ____

Relevant Experience: ____

Completed Levels of Education: ____

Degrees/Certifications:____

Please attach your answers to the following questions to your completed application:

1.) If you are a bereaved parent, what sources of support did you receive, and which did you find the *most* helpful? Why? What source of support did you find the *least* helpful and why?
2.) If you are a care provider, what types of support are currently offered in your facility? What would you like to see improve through your Share program?
3.) Given your personal and/or professional experience, what do you feel you can offer bereaved parents?
4.) What do you anticipate being your first goal as a Share Chapter? For example, starting a support group, improving care received in facility, enhancing materials offered to bereaved parents, creating memorial events, educating care providers, etc.
5.) What do you anticipate as your biggest challenge to starting or maintaining a Share Chapter?
6.) Please feel free to share any additional information you would like The National Share Office to know about your vision for your Chapter, your sense of mission to serve bereaved parents, your desires for your program, and any specific needs you feel you may require of our staff.

Chapter Leader References

Please list the contact information of two people to whom you are not related:

Reference Name: ____ Phone: ____________________

Occupation/Title:____

Address:____ City, State, Zip _______________________

Email:____ Years known:________________________

Reference Name: ____ Phone: ____________________

Occupation/Title:____

Address:____ City, State, Zip _______________________

Email:____ Years known:________________________

Thank you for applying to the Share Chapter network,
and for your willingness to bring compassionate support to bereaved families in your community.
We are looking forward to our partnership with you!

For Office Use Only

- ☐ References Checked and Approved
  Approval Date: ______________________________
- ☐ Acceptance into Share Network
  Acceptance Date: ____________________________
- ☐ Share Chapter Agreement Received
  Received Date: ______________________________
  Approval Date: ______________________________

Current Chapter Status: Approved

Signed: ___________________________________ Date: ____________________
Share Chapter Coordinator

Signed: _________________________________ Date: ____________________
Executive Director Signature