



**JACKSON MEMORIAL HOSPITAL  
APPLICATION FOR CLINICAL PASTORAL EDUCATION**

**APPLICATION FOR:** \_\_\_\_\_ **Extended Unit (Spring Unit – February to June)**  
\_\_\_\_\_ **Summer Unit (June to August -Full Time, 11 to 12 Weeks)**  
\_\_\_\_\_ **Extended Unit (Fall Unit - August to February)**  
\_\_\_\_\_ **Residency Program (August to August)**

**CURRENT CPE STANDING:** \_\_\_\_\_ **Units of CPE Completed**  
\_\_\_\_\_ **Prospective CPE Student**  
\_\_\_\_\_ **Supervisor in Training**  
\_\_\_\_\_ **Supervisor Candidate**

**Name** \_\_\_\_\_

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

\_\_\_\_\_ **Zip Code** \_\_\_\_\_ **Telephone ( )** \_\_\_\_\_

**Permanent Mailing Address** \_\_\_\_\_

\_\_\_\_\_ **Zip Code** \_\_\_\_\_ **Telephone ( )** \_\_\_\_\_

**Denomination/Faith Group Affiliation** \_\_\_\_\_

**Association, Conference, Diocese, Presbytery, Synod** \_\_\_\_\_

**Present Position** \_\_\_\_\_ **Ordained** \_\_\_\_\_ **Date** \_\_\_\_\_

**EMAIL** \_\_\_\_\_

**EDUCATION**

**DEGREE**

**College** \_\_\_\_\_

**Seminary** \_\_\_\_\_

**Graduate** \_\_\_\_\_

**PREVIOUS CLINICAL PASTORAL EDUCATION:**

**Dates** \_\_\_\_\_ **Center** \_\_\_\_\_ **Supervisor** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

ATTACH TO APPLICATION

- A reasonably full account of your life, including important events, relationships with people who have been significant to you, and the impact these events and relationships have had on your development. Describe your family or origin, your current family relationships and your educational growth dynamics. (Minimum 3 pages, single-spaced)
- A description of the development of your religious and spiritual life, including events and relationships that affected your faith and currently inform your belief and your theology. (Minimum 3 pages, single-spaced)
- A description of the development of your work (vocation) history, including a chronological list of positions and dates.
- An account of an incident in which you were called to help someone, including the nature of the request, your assessment of the "problem," what you did, and a summary evaluation.
- Your impression of Clinical Pastoral Education and your educational goals, including how this training will be used to meet your goals for doing ministry.
- A nonrefundable application fee of \$25.00 payable to Jackson Health System.

**THOSE WITH PREVIOUS CPE SHOULD COMPLETE THE FOLLOWING:**

- Copies of previous supervisor's CPE evaluations and your self-evaluations.
- What are some of the most significant learning experiences in your previous CPE?
- What are your professional goals and how do you plan to achieve them?

Applicant

Signature \_\_\_\_\_

Date \_\_\_\_\_

Social Security # \_\_\_\_\_

Send application directly to:

**The Rev. Dr. Jacqueline D. Kelley**  
**Jackson Health System**  
**Spiritual Care Services**  
**1611 NW 12<sup>th</sup> Avenue**  
**PPW – L301-D**  
**Miami, FL 33136**

Jackson Health System offers three CPE units per year:

1. **Spring unit:** 1<sup>st</sup> Monday in February until 1<sup>st</sup> Monday in June (Monday's only 8:00 AM to 4:30PM). Application deadline for this unit is the last week of September.
2. **Summer unit:** 1<sup>st</sup> Monday in June to the *end of first week* in August (Monday thru Friday 8:00 AM to 4:30PM). Application deadline for this unit is the last week of January.
3. **Fall unit:** 3<sup>rd</sup> Monday in August until 1<sup>st</sup> Monday in February (Monday's only 8:00 AM to 4:30PM). Application deadline for this unit is the last week of May.

Although these are our deadlines, please call the office and inquire of possible openings.

**Telephone (305) 585-2529 – Fax (305) 585-5033**

Please make three copies of this reference form and have the three reference persons to mail or fax the form to Rev. Dr. Jacqueline Kelley

**JACKSON HEALTH SYSTEM**  
*Reference Form for Clinical Pastoral Education*

*Applicant's Name:* \_\_\_\_\_

*Will the applicant make good use of the CPE program and be able to participate at a profound and professional level?*

*What do you think are some of the applicant's strengths?*

*What are some areas of needed growth for the applicant?*

*Additional Comments:*

*Name* \_\_\_\_\_ *Signature* \_\_\_\_\_  
(Print)

*Phone:* \_\_\_\_\_ *May we contact you if necessary?* \_\_\_\_ *yes* \_\_\_\_ *no*

*Please return form by email to [Jacqueline.kelley@jhsmiami.org](mailto:Jacqueline.kelley@jhsmiami.org)*

*Or Mail to: Rev. Dr. Jacqueline D. Kelley*

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- **Jackson Health System**
- **1611 NW 12<sup>th</sup> Avenue**
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