☐ **Mens Fall Retreat Date:**
Nov. 13th - Nov. 16th, 2025
Director: Steve Lenox
(318) 286-9076
lenoxsteve@bellsouth.net

☐ **Ladies Fall Retreat Date:**
Nov. 6th - Nov. 9th, 2025
Director: Tabitha Dupont
(318) 426-7680
Tabithadupont147@yahoo.com

ACTS RETREAT REGISTRATION

ACTS is a retreat ministry offering a three-day Catholic retreat for men and women, ages 18 and over, led by a priest and lay members of several local parishes. The goal of the retreat is to help you deepen your relationship with Jesus Christ, receive spiritual renewal, give a new meaning to Sunday liturgy and your prayer life, and build lasting relationships with members of our community.

LOCATION: Round trip transportation from **St. Joseph Catholic Church** to Camp Bethany retreat center is provided for all retreatants. Send-off is in the St Joseph Church Narthex (foyer) on Thursday evening. Plan to be there to check-in at 5:30pm. The retreat ends on Sunday following the 12:30 Mass at St Joseph, followed by a reception in the Family Life Center.

COST: The total cost is **$200.00**. You can now pay by cash, check or ***online**. If for some reason you are not able to attend the retreat you will receive a full refund (by ACTS Core – Financial) immediately after being notified that you are not attending the retreat. Please make your checks payable to **St. Joseph Catholic Church.** There will be a $25 fee for returned checks.
***Online** payments are made through www.stjosephchurch.net • Give Online Now •Sign In• Fund ACTS Retreat • Sub Fund ACTS RETREATANT REGISTRATION• Note **Your Name** • Amount **$200** - you can make 1 payment or multiple payments.

Financial Scholarship-Please do not allow financial difficulties prevent you from attending. If you are unable to pay all or part of the fee financial arrangements can be made by notifying the retreat Director or answering Question 18.

Mailing Address: If mailing please fill out all 3 pages and check if applicable and send to -St Joseph Church, ATTN: ACTS 211 Atlantic Ave, Shreveport, LA 71105. You will be notified when received. Contact the Director if you are not notified within 3 weeks of mailing.

Please Print Clearly

1. Name: _____ (circle one) 2. Male / Female

4. First and last name as you want it to appear on your Name Tag: _____

5. Full Address: _____

6. Cell Phone: _____ 7. Home Phone: _____

8. Email: _____ 9. Date of Birth: _____
(must be 18 years old at the time of the retreat)

10. Three Emergency Contacts:

Name	Relationship	Cell Phone	Email

11. Do you need assistance climbing stairs? Yes / No 12. Do you have trouble walking? Yes / No

13. List special dietary or medical needs, if any: _____

14. What church do you attend? _____
Name City

15. Are you Catholic? Yes / No

16. Do you give permission for your photo and contact information to be added to the retreat directory? Yes / No

17. Do you give permission to receive future ACTS communications via email? Yes / No

18. Check one.

_____I have included my deposit of $75.00(Payable to St Joseph Church)

_____ I have included the entire fee of $200.00

_____I need scholarship help (Someone will contact you)

_____I paid online (St Joseph Church website)

HOLD HARMLESS AGREEMENT

To the fullest extent permitted by law, _____ releases and
(Participant)
agrees to defend, pay on behalf of, indemnify, and hold harmless Bishop Malone, the Diocese of Shreveport and St. Joseph Catholic Church (collectively, the "Sponsor"), its elected and appointed officials, its agents, employees and volunteers and others working on behalf of the Sponsor against any and all claims, demands, suits, or loss, including attorney's fees and all costs connected therewith, and for any damages which may be asserted, claimed or recovered against or from the Sponsor, its elected and appointed officials, its agents, employees, volunteers, or others working on behalf of the Sponsor, by reason of personal injury, including bodily injury or death and/or property damages, including loss of use thereof, suffered by Participant.

Participant Signature: _____

Date: _____

WITNESS 1:

Printed Name: _____

Signature: _____

Date: _____

WITNESS 2:

Printed Name: _____

Signature: _____

Date: _____

ST. JOSEPH CHURCH
EMERGENCY MEDICAL AUTHORIZATION

PURPOSE*: To enable participants to authorize emergency treatment should they become ill or injured while participating in church-sponsored event.*

Name of Participant: _____

Social Security Number: _____ Main Phone Number: _____

Full Address: _____

*** * * PLEASE ANSWER BOTH QUESTIONS * * ***

1. Do you grant consent for treatment in the event of an emergency?

❑ YES, I GRANT CONSENT TO TREAT

In the event of an emergency, contact will be made in the following order:

A. A reasonable attempt will first be made to contact the following designated individuals:

Emergency Contact 1: _____ Relation: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

Emergency Contact 2: _____ Relation: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

B. If unsuccessful in contacting the above persons, I hereby give my consent for administration of any treatment deemed necessary by:

Preferred Physician: _____ Office Phone: _____

Physician #2: _____ Office Phone: _____

C. In the event the designated preferred practitioner is not available, I give consent to be treated by another licensed physician or dentist; and/or to be transferred to either ❑ **Nearest Hospital reasonably accessible** or ❑ **Preferred Hospital** _____.

- This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring the necessity for such surgery, are obtained before surgery is performed.
- I, the undersigned, understand that participation in activities inherently involve risk, including injury. As such, I hereby release, waive, discharge, and covenant not to sue from any loss, damage, or injury, including death, that may be sustained by myself, whether caused by negligence while participating in such activity where the activity is being conducted.
- Facts concerning my medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted are listed below in Question 2.

Signature: _____ ***Date***: _____

❑ NO, I REFUSE CONSENT TO TREAT

I do not give my consent for emergency treatment of myself. In the event of illness or injury requiring emergency treatment, I wish the church authorities to take no action or to: _____
_____

Signature: _____ ***Date***: _____

2. Do you have medical conditions or take medications? ❑ Yes ❑ No

Medical conditions (i.e. diabetes, bee sting allergy): _____
_____
_____

Medications: _____
_____
_____

Drug allergies: _____
_____