APPLICATION FOR HOLY ORDERS: DEACON
FORM 2: WAIVER OF CONFIDENTIALITY AND PERMISSION TO SHARE INFORMATION

DIRECTIONS: You may print this form and complete it manually **OR** you may type your responses on this form then print it for further processing.

I, the undersigned, an applicant for Holy Orders in the Episcopal Church, give my permission to the Bishop of the Episcopal Diocese of Rhode Island (the "Diocese") to share my applications for Nomination, Postulancy, and Candidacy, to be ordained a Deacon and all supporting material supplied by me or my congregation with the Commission on Ministry of the Diocese and the Standing Committee of the Diocese.

I further give permission to the Bishop of Rhode Island to share reports of my physical examination, my psychological examination, my psychological evaluation with appropriate health care professionals with whom he may take counsel as he deems necessary. I also give permission to the psychological examiners, psychological evaluators and medical examiners to exchange information about me with each other for the purposes of a full and comprehensive assessment of me for Holy Orders.

I understand that the results and reports of the psychological examinations, the psychological evaluations and the medical examinations are the property of The Diocese of Rhode Island, subject to the rules of the Diocese and The Episcopal Church for management of personal information, and may be utilized pursuant to agreements between me and the Diocese. I further agree that the Diocese's psychiatric or psychological evaluator will be held harmless in any action associated with the management of information gathered in the evaluation process.

I understand and agree that written reports of my medical examination, psychological or psychiatric examination and psychological evaluation will be sent directly to the Bishop of the Diocese or his other designees and these reports will remain a part of my permanent record with the Diocese.

Aspirant's signature:		
PRINT full name:		
Date (m/d/y) of birth:	SSN:	Date:

NOTE: Please complete this form, keep one copy for yourself, one copy for your medical doctor, and one copy for the psychiatrist/psychologist, and then mail this original form to:

Bishop's Office, Episcopal Diocese of Rhode Island, 275 North Main Street, Providence, Rhode Island 02903-1298