



# INSTITUTE *of* PASTORAL STUDIES

## SEMESTER CONFORMATION OF SPIRITUAL DIRECTION

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Name: \_\_\_\_\_

Date: \_\_\_\_\_

Email address: \_\_\_\_\_

Semester: \_\_\_\_\_

We the undersigned agree to meet a minimum of 6 times during the semester, fulfilling the Spiritual Direction requirement for students in the:

Check one:

M.A. Christian Spirituality: Spiritual Direction Concentration

Graduate Certificate: Spiritual Direction

Name of Spiritual Director: \_\_\_\_\_

\_\_\_\_\_  
Signature of Student

\_\_\_\_\_  
Signature of Spiritual Director

Please return this form to Roberta McLaurin(e-mail [rmclaur@luc.edu](mailto:rmclaur@luc.edu)), fax: 312-915- 7410, mail: c/o IPS, LT 630, 820 N. Michigan Ave., Chicago, IL 60611, or hand deliver to the IPS Office) at the beginning of each semester. The form will be kept into your confidential student file.