



INSTITUTE *of* PASTORAL STUDIES

SEMESTER CONFIRMATION OF

SPIRITUAL DIRECTION

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), 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.

Last Updated:
11/07/2018