BABY DEDICATION/BLESSING REQUEST

[PLEASE PRINT CLEARLY AND LEGIBLY]

Baby's Full Name: _____

Baby's Date of Birth: _____ Gender: ◯ M ◯ F

Hospital of Birth: _____

City: _____ State: _____

** AT LEAST ONE PARENT OF BABY MUST BE A MEMBER OF TRINITY FOR DEDICATION

Mother's Full Name: _____

****Member of Trinity** ◯ Yes (*If yes, envelope number:* _____) ◯ No

Mother's Address: _____

City: _____ State: _____ Zip code: _____

Home Phone: _____ Mobile Phone: _____

E-mail Address: _____

Father's Full Name: _____

****Member of Trinity** ◯ Yes (*If yes, envelope number:* _____) ◯ No

Father's Address (if different) ☐ ***Address, same as above***

Father's Address: _____

City: _____ State: _____ Zip code: _____

Home Phone: _____ Mobile Phone: _____

E-mail Address: _____

Godparents' Names:

_____ _____

_____ _____

Desired date of dedication/blessing: _____ **Confirmed date:_____**

Call church at (718) 231-3639 x0 for appointment and date confirmation

***BABY DEDICATIONS/BLESSINGS ARE HELD AT 2:00PM ON THE FIRST SUNDAY OF EACH MONTH (October – June) AND 9:30AM (July – September)**