



**SOCIETY OF SAINT VINCENT DE PAUL
National Council**

Date: _____

**TWINNING
ANNUAL REPORT TO REGIONAL COUNCIL
For period of January 1, 20____ to December 31, 20____**

Our Conference Council Our Twin: Conference Council

Name: _____	Name: _____
Address: _____	Address: _____
City/Prov: _____	_____
PC: _____	Country: _____
Contact Person: _____	Contact Person: _____
Phone: _____	Phone: _____
E-mail: _____	E-mail: _____

SPIRITUALITY Please indicate if there were bonds of spirituality shared between the twins:

a) Intentions b) Masses offered c) Joint Rosary: same time via video link

Other forms of shared spirituality: _____

COMMUNICATION Please indicate the forms of communication and frequency shared by the twins:

a) Letters: written Received b) E-mail: c) Telephone: d) Skype (other)

Please explain: _____

FINANCIAL SUPPORT:

Please indicate the support given Twinning Project

Total financial support during this period: \$ _____ No. of contributions: _____

Describe the works your twin uses these funds for: _____

TWINNING Discontinued Suspended Please indicate the reasons:

COMMENTS:

Submitted by (print): _____ Signature: _____ Position: _____

NOTE: Please complete the form by **February 28** and forward to the Regional Twinning Coordinator:

<p>Guido Kelly Society of Saint Vincent de Paul 61 Harbottle Court, Hamilton ON L9C 7N9</p>	<p>Tel (905) 387-4697 gumabradkelly@hotmail.com www.ssvp.ca</p>
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