



REQUEST FOR FACULTIES
IN THE DIOCESE OF LAS CRUCES

For official use of the Chancery
Date: _____
 Process
 Approved
 Not approved
Initials: _____

Date Request Submitted: _____

Extern Diocesan Priest Religious Priest Deacon

Name of Priest/Deacon: _____

Address: _____

Phone: _____ Email: _____

First Time Request for Faculties Renewal of Faculties

Diocese of Incardination/Religious Congregation: _____

Bishop/Superior's name: _____

Address: _____

Telephone: _____ Cell: _____ Fax: _____

E-mail: _____

PROPOSED MINISTRY IN THE DIOCESE OF LAS CRUCES:

Date(s): From _____ To _____

Place: (Parish, Mission, Apostolate, etc.): _____

Event Name: _____

Parish Retreat /Mission Workshop/ Conference Other: _____

Name of Pastor/Director requesting permission: _____

Address: _____

Email: _____ Phone: _____

Pastor's/Director's Signature: _____