



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

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

Internal:  OR External:

**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:

Bernie McCracken  
Society of Saint Vincent de Paul  
29 Greenview Cres., St. Albert AB T8N 0S9

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