Caregiving Mentor Program

Volunteer Application Form

☐ Auxiliary Mentoring ☐ Traditional Mentoring

Auxiliary Mentoring: Occasional check-ins and messages of encouragement

Traditional Mentoring: More consistent check-ins and on-going communication

Participant's Name: _____
First Last

Address: _____
Street/Apt.

_____
City State Zip

E-Mail Address: _____

Home Phone Number: _____ **Cell Phone Number:** _____

Preferred Contact: ☐ Email ☐ Home Phone ☐ Cell Phone

Date of Birth: _____/ _____/_____ **Age:** _____ **Sex:** ☐ Female ☐ Male

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Number of Children: Girls _____ Age(s) at time of diagnosis _____
Boys _____ Age(s) at time of diagnosis _____

Ethnic Origin: ☐ African American ☐ Asian American ☐ Caucasian ☐ Hispanic/Latino
☐ Native American ☐ Other _____

Educational Background: _____

Occupation: _____

Language(s) other than English that you speak on a conversational basis: _____
_____

Special Skills (i.e. sign language, etc.): _____
_____

Hobbies: _____
Previous Volunteer Experience: _____
_____

Most Convient Time for Mentoring:
Days of Week: ☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐Fri ☐ Sat
Time of Day: ☐ AM ☐ PM **Specific Times:** _____

Please tell us about your experience as a caregiver: _____
_____
_____

Relationship to the Patient: _____

Patient's Diagnosis: _____ **Date of Diagnosis:** _____

Patient's Treatment (if applicable)

____ Chemotherapy Type: _____

____ Radiation Type: _____

____ Surgery Type: _____

Patient's Prognosis: _____

How long were you a caregiver? _____ **Are you currently caregiving?** _____

What challenges did you face as a caregiver? _____
_____
_____

Is there something that you do (professionally, recreationally, etc.) or something unique to your experience (with cancer or otherwise) that you feel might help you connect with a caregiver who is seeking a mentor? _____
_____
_____

Volunteer's Signature: _____ **Date:** _____

Please return your application to:

CancerConnects, Inc.
Attn: Administrative Specialist
PO Box 2010
East Syracuse, NY 13057

or by email to:
officecancerconnects@gmail.com

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FOR OFFICE USE:

Date Application Received: _____
Training Schedule: _____
Training Attended: _____