CANCER CONNECTS

Patient Buddy 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 _____

Referral Source: ☐ Self-referral ☐ Healthcare Provider ☐ Relative / Friend ☐ Mentor Volunteer

☐ Community Organization or Agency ☐ Other (please specify) _____

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 Convenient Time for Mentoring:

Days of Week: ☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐Fri ☐ Sat

Time of Day: ☐ AM ☐ PM **Specific Times:** _____

Primary Care Physician and/or Oncologist Name: _____

_____

Physician's Address: _____

Diagnosis: _____ **Date of Diagnosis:** _____

Treatment (if applicable)

Are you currently undergoing treatment? ☐ Yes ☐ No

_____ Chemotherapy Date ___/___/___ Type: _____

_____ Radiation Date ___/___/___ Type: _____

_____ Hormonal Date ___/___/___ Type: _____

_____ Other Date ___/___/___ Type: _____

_____ Surgery Date ___/___/___ Type: _____

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 newly diagnosed patient 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:

_____ Application Received: ___/___/___
_____ Physician Letter Sent: ___/___/___
_____ Physician Letter Received: ___/___/___
_____ Interview: ___/___/___
_____ Training Scheduled: ___/___/___
_____ Training Attended: ___/___/____

Additional Comments: _____

_____

_____