

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

FOR OFFICE USE:

____ Application Received: __/__/__

____ Training Scheduled: __/__/__

____ Interview: __/__/__

____ Training Attended: __/__/__

Additional Comments: _____
