

Volunteer	Mentor	Program
-----------	--------	---------

Mentor Application Form

Demographic Information

Name:					
First	Last				
Address:					
Street/Apt.					
City	Ctata	7in			
City	State	Zip			
E-Mail Address:					
Home Phone Number:	Work Phone Number:				
Cell Phone Number:					
Date of Birth://	Age:				
Marital Status: Single	Married Divorced	Widowed			
Number of Children: Girls Ag	ge(s) at time of diagnosis				
Boys Age	e(s) at time of diagnosis				
Ethnic Origin: African American	Asian American	Caucasian Hispanic			
•	Other	·			
Educational Background:					
Occupation:					
Language(s) other than English that y	ou speak on a conversational	basis:			
Special Skills: (i.e., sign language, et	c.):				
Hobbies:					
Previous Volunteer Experience:					
Most Convenient Time for Volunteer S Days of Week Sun Mon _ Time of Day AM PM Specific Times:		Γhurs Fri Sat			

Referral Information

Surgeon's Name:				
Fi Surgeon's Address:	rst		Last	
Oncologist's Name:	First		Last	
Oncologist's Address:				
Primary Care Physicia				
Primary Care Physicia	First n's Address:		Last	
Diagnosis:				
Date of Diagnosis:				
Type of Surgery:				
Surgery Date:				_
Treatment (For matc Radiation		•	s much information as :	•
Chemotherapy				
Hormonal	Date/	/Details:		
Other	Date/	/Details:		
	at you do (profes cancer or other	sionally, recreati wise) that you fe	No ionally, etc.) or someth el might help you to co	nnect with a
Signature:		return your applic		
	Attn: Volunteer Me	entor Coordinator, I	PO Box 2010, East Syracus	e, New York 13057
For Office Use Application Received Physician Letter Sen Physician Letter Rec Training Schedule Se Training Scheduled Training Attended	d/ _ t/ _ evived/ _ ent/ _ / _	/ / / /		