

# network of hope

A service of the Northside Hospital Atlanta Auxiliary

## Volunteer Application

Please fill out this application if you are a cancer survivor and would like to help support fellow survivors and their families throughout treatment.

### Contact Information

Applicant's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work/Cell: (\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_

Children: \_\_\_\_\_

If yes, how many?: \_\_\_\_\_ Ages: \_\_\_\_\_

Race:  Asian  African American  White  Hispanic  Other (please specify): \_\_\_\_\_

Do you speak another language?  Yes  No If yes, please specify: \_\_\_\_\_

How did you hear about Network of Hope? \_\_\_\_\_

Please list any volunteer experience from the past 5 years: \_\_\_\_\_

### Cancer Diagnosis Information

Date of Initial Diagnosis: \_\_\_\_\_ Type of Cancer: \_\_\_\_\_ Stage of Cancer: \_\_\_\_\_

Surgeon's Name: \_\_\_\_\_ Oncologist's Name: \_\_\_\_\_

Indicate all treatment you received (please check):

**Radiation** End Date: \_\_\_\_\_ Name of Treatment Facility: \_\_\_\_\_

**Chemotherapy** End Date: \_\_\_\_\_ Name of Treatment Facility: \_\_\_\_\_

**Surgery** Date: \_\_\_\_\_ Type of Surgery: \_\_\_\_\_

Hospital where your surgery occurred: \_\_\_\_\_

Clinical Trial  Oral Medication  Other Specify Type: \_\_\_\_\_

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**Volunteer Information**

Please number your first, second, and third choice of Volunteer Teams.

\_\_\_\_\_ Community Outreach Team \_\_\_\_\_ Special Events Team \_\_\_\_\_ Phone Mentor  
\_\_\_\_\_ Patient Support Team \_\_\_\_\_ Behind The Scenes (BTS) Team

Most convenient day and time for volunteer service:

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

Time of Day:  AM  PM

Are you interested in visiting patients in the hospital?  Yes  No

Are you interested in working/calling from home?  Yes  No

What do you hope to gain from your experience as a Network of Hope volunteer? \_\_\_\_\_

How have you worked through your feelings about cancer? \_\_\_\_\_

What was something you gained from your cancer experience? \_\_\_\_\_

**Emergency Contact Information**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work/Cell: (\_\_\_\_) \_\_\_\_\_

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