

# Network of HOPE

Cancer Support & Mentoring

## Caregiver Volunteer Application

Please fill out this application if you have been affected by cancer and would like to volunteer your time to mentor a caregiver.

### Contact Information

Applicant's Name: \_\_\_\_\_ Age: \_\_\_\_\_ 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: \_\_\_\_\_

### Your Relationship to Cancer

What is your relationship with the person diagnosed with cancer?

Spouse/Significant Other  Parent  Child  Sibling  Other: \_\_\_\_\_

Type of Cancer: \_\_\_\_\_ Stage of Cancer: \_\_\_\_\_

Date of Initial Diagnosis: \_\_\_\_\_ Date of Their Last Treatment: \_\_\_\_\_

Type of Treatment:  Bone Marrow Transplant  Chemotherapy  Clinical Trial  Hormone Therapy  Radiation

Surgery  Wait & Watch

Please indicate which of the following was most stressful for you at the time of the person's cancer diagnosis (check all that apply):

Career/Job  Emotional Distress  Fatigue  Fear of Death  Fear of Recurrence  Fertility

Finances  Nutritional Concerns  Parenting  Physical Changes in Relationships  Sexuality



### Volunteer Information

**Team Preference** (please check):

- Community Outreach  Special Events  Mentor Caregivers (by phone)  
 Behind The Scenes (BTS) Team  Administrative Support

Most convenient day and time for volunteer service:

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

Time of Day:  AM  PM

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

\_\_\_\_\_

How have you and your family dealt with cancer? \_\_\_\_\_

\_\_\_\_\_

What is your best tip for other caregivers? \_\_\_\_\_

\_\_\_\_\_

### Emergency Contact Information

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

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

