MENTOR APPLICATION

Since every woman has an individual treatment plan, we carefully match newly diagnosed women with a peer mentor who has gone through a comparable experience. Peer Mentors receive formal training. If you are willing to share aspects of your experience, including information about your treatment decisions, effects of treatment, coping strategies, recovery obstacles, knowledge, support, encouragement, and friendship, then we encourage you to submit an application. *Note: We are committed to your privacy and your information will never be shared with an outside party other than those affiliated with the LCBF Woman to Woman Program.*

APPLICANT INFORMATION			
Name:			Date: ___/____/_____
Date of birth: ___/____/_____	Age:		Cell Phone: : (____)_____ Home Phone: : (____)_____
Current address:			
City:	State:	ZIP Code:	
Email address:		Preferred contact method? ◯Cell Phone ◯ Home Phone ◯ Email For phone, preferred time? _____	
Primary language:	Other language(s):	If your race and/or ethnicity is an element you would like to share, please write that information here:	
Marital status: ◯ Single ◯ Married ◯ Divorced ◯ Widow ◯ Significant Other	Do you have children? ◯ YES ◯ NO If yes, ages: _____ _____ _____	Did you live alone at time of treatment? ◯ YES ◯ NO Did you have children living at home while in treatment? ◯ YES ◯ NO	
Religious Affiliation:		Congregation:	

EMPLOYMENT AND VOLUNTEER INFORMATION		
Current employer:		
Employer address:		How long?
Phone: (____)_____	E-mail:	Current Status: ◯Full-Time ◯Part-Time ◯ Retired
City:	State:	ZIP Code:
Position:	Contact Person:	Did you work during treatment? ◯ YES ◯ NO
Do you have previous volunteer experience? ◯ YES ◯ NO		If yes, with which organization?
Position:	Contact Person:	Date(s) of Service:
Address:		How long?
Phone: (____)_____	Email:	Website:
City:	State:	ZIP Code:
Please list all prior volunteer experience below:		

YOUR CANCER JOURNEY		
Type of Cancer:	Date Diagnosed (MM/DD/YYYY): ___/____/_____	Are you now cancer free? ◯ YES ◯ NO
Cancer stage:		Age at diagnosis:
Did your cancer metastasize? ◯ YES ◯ NO If yes, location:_____	Did your cancer recur? ◯ YES ◯ NO	Date of recurrence: ___/____/_____
Hospital/Medical Center where you were treated:	City: _____ State:_____	Treating Doctor: _____ Contact Number: (____)_____
Cancer treatment status (Please choose one): ◯ Newly diagnosed ◯ Still being treated ◯ Recurrence ◯ Finished treatment less than 1 year ◯ Finished treatment b/w 1 and 5 years ago ◯ Finished treatment more than 5 years ago	What treatments were/are you given? (Choose all that apply): ◯ Chemotherapy; if yes, what drugs: _____ ◯ Radiation ◯ Clinical Trial; if yes, which one: _____ ◯ Surgery; if yes, what type:_____ ◯ Wait and Watch ◯ Alternative Treatment; if yes, which one: _____ ◯ Other; please explain: _____	
Please let us know of any therapies and practices you used to help manage the physical and emotional symptoms of gynecologic cancer treatment and/or post-treatment (Choose all that apply):	◯ Art Therapy ◯ Acupuncture ◯ Aromatherapy ◯ Chiropractic Therapy ◯ Diet and Nutrition ◯ Exercise ◯ Hypnosis ◯ Journaling ◯ Massage ◯ Meditation	◯ Music Therapy ◯ Natural Products ◯ Physical Therapy ◯ Psychotherapy ◯ Reiki ◯ Shiatsu ◯ Spirituality and Prayer ◯ Support Groups ◯ Tai Chi ◯ Yoga
Additional information you would like to share about your journey (e.g. genetic testing, family dynamics, complications):		

PEER TO PEER COMMUNICATION		
Do you feel comfortable being matched with someone who has a different gynecologic cancer type than yours?	◯ YES	◯ NO
Do you feel comfortable being matched with someone who has a different treatment history than yours?	◯ YES	◯ NO

How would you prefer to communicate with the person you are matched with? (Choose all that apply) ◯ Phone ◯ Text messaging ◯ Video chat ◯ Email ◯ In Person; if yes, max travel radius in miles: _____	How often do you think you would like to communicate with your peer? (Choose all that apply) ◯ Daily ◯ Weekly ◯ Every other week ◯ I'm not sure ◯ As much as needed
How many patients are you comfortable mentoring at the same time? ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5	Which of the following would you feel comfortable speaking with your peer match about? (Choose all that apply): ◯ Your experience with a particular treatment and/or side effects ◯ Parenting and Cancer ◯ Fertility/Fertility Preservation/Parenting Options ◯ Sex/Dating/Relationships/Intimacy ◯ Communicating with family and friends ◯ Working during treatment ◯ Adjusting to life after cancer ◯ Hospice and end of life care

With questions, please contact Ayushe Sharma, Interim Program Coordinator, at 205-783-1285 or A.Sharma@ThinkofLaura.org.

You can return this application to Ayushe Sharma by mail, e-mail, or fax.

Ayushe Sharma
Laura Crandall Brown Foundation
P.O. Box 26791
Birmingham, AL 35260

E-mail: A.Sharma@ThinkofLaura.org **Fax:** 205-278-5311