

Volunteer Experience (1) _____
Organization Name and Address

Dates Volunteered

Duties

(2) _____
Organization Name and Address

Dates Volunteered

Duties

Personal References
(List names of 2 people we may contact who know you but are not related to you)

Name Relationship

Address Phone Number

Name Relationship

Address Phone Number

In the space below, please tell us about your interest in volunteering for Hope Cancer Resources:

Thank you for your interest in volunteer opportunities with Hope Cancer Resources. After receipt of your application, a representative from Hope Cancer Resources will contact you to set up an appointment for an interview. Please remember, a volunteer position with Hope Cancer Resources is contingent upon compatibility between our mission and potential volunteers; position availability when you are available to work and satisfactory background check.

If you are a **survivor** and you are applying to become a *clinic volunteer* or "*Been There*" volunteer, please complete the attached questionnaire.

Cancer Survivors Supplemental Information

Survivors are a very special part of the volunteer program at Hope Cancer Resources. "Been There" volunteers are all cancer survivors who wish to provide support to a patient who is currently battling cancer. To best match our "Been There" volunteers with current patients, the Hope Cancer Resources staff needs the following information about your cancer and treatment. For survivors wishing to have a role in the clinic or with patients, it is helpful for us to know a little bit about your personal cancer experience. This information will remain confidential between the Hope Cancer Resources staff and you. Thank you for providing this information and for your willingness to share your experience.

What type of cancer were you diagnosed with? _____

What was your date of diagnosis? _____

What was your age at that time? _____

Did you have surgery for your cancer? Yes No Date: _____

Did you have radiation for your cancer? Yes No
Dates: _____ # of treatments? _____

Did you have chemotherapy for your cancer? Yes No
Dates: _____ # of treatments? _____

Did you have other treatments? Yes No If yes, what? _____
Dates: _____ # of treatments? _____

Have you had any recurrence? Yes No Date: _____

Have you had any metastases? Yes No Date: _____
Where? _____

Date of last treatment: _____

Describe any significant problems or problems you experienced while having cancer and how you dealt with them. _____

What was the most difficult aspect of having cancer?

What did you learn while having cancer?

When facing cancer, what do you think is the most important kind of help or support?

In what areas would you have liked more support?

Related to cancer, what support services did you use?

Hope Cancer Resources (formally HOPE, Inc.) Other social service agencies

Support Groups Counseling Spiritual Support Non-traditional therapies

other _____

Below, please provide any other information that we might need and have forgotten to ask. We appreciate your willingness to share yourself with cancer patients.