APPLICATION TO BECOME A MENTOR

PART 1: DEMOGRAPHIC INFORMATION

TODAY'S DATE: _____ **DATE OF BIRTH:** _____ / _____ / _____ **AGE:** _____

NAME: _____
FIRST LAST

MAILING ADDRESS: _____
STREET CITY STATE ZIP

E-MAIL ADDRESS: _____

HOME PHONE NUMBER: _____ **CELL PHONE NUMBER:** _____

RELATIONSHIP STATUS: ☐ SINGLE, NEVER MARRIED ☐ MARRIED ☐ DIVORCED/SEPARATED
☐ WIDOWED ☐ DOMESTIC PARTNERSHIP
NAME OF SPOUSE/PARTNER: _____

CHILDREN: SONS _____ AGE(S) AT TIME OF DIAGNOSIS: _____
DAUGHTERS_____ AGE(S) AT TIME OF DIAGNOSIS: _____

RACE: ☐ AFRICAN AMERICAN ☐ ASIAN ☐ CAUCASIAN ☐ HISPANIC ☐ NATIVE AMERICAN
☐ OTHER (PLEASE SPECIFY) _____

EDUCATION: ☐ GED ☐ HIGH SCHOOL ☐ COLLEGE ☐ GRADUATE SCHOOL

OCCUPATION: _____

LANGUAGE(S) YOU CONVERSATIONALLY SPEAK OTHER THAN ENGLISH: _____

HOBBIES: _____

MOST CONVENIENT TIMES FOR YOU TO BE REACHED:

DAYS OF WEEK: ☐ SUN ☐ MON ☐ TUES ☐ WED ☐ THURS ☐ FRI ☐ SAT

TIME OF DAY: ☐ MORNING ☐ AFTERNOON ☐ EVENING

PREFERRED METHOD OF CONTACT: ☐ CELL PHONE ☐ HOME PHONE ☐ TEXT ☐ EMAIL ☐ ANY

NAME: _____

PART 2: DIAGNOSIS AND TREATMENT INFORMATION

DATE OF DIAGNOSIS: _____ / _____ / _____ **STAGE OF CANCER:** _____

TYPE OF OVARIAN CANCER: _____
(EXAMPLE: CLEAR CELL, GERM CELL, SEROUS CARCINOMA, ETC.)

DATE OF RECURRENCES (IF ANY): _____/ _____/_____ _____/ _____/_____ _____/ _____/_____

DATE OF LAST TREATMENT: _____/ _____/_____ *

* TO BE ELIGIBLE, YOUR LAST TREATMENT MUST HAVE BEEN MORE THAN ONE YEAR AGO

TYPE OF TREATMENT: (PLEASE CHECK ALL THAT APPLY)

☐ SURGERY IF YES, DATE: _____/ _____/_____ TYPE: _____

☐ CHEMOTHERAPY IF YES. TYPE: ☐ INFUSION ☐ INTRAPERITONEAL ☐ ORAL

☐ RADIATION NUMBER OF TREATMENTS: _____

☐ CLINICAL TRIAL TYPE: _____

WHERE WERE YOU TREATED: _____
(CANCER CENTER, HOSPITAL, PRIVATE DOCTOR)

TREATMENT DETAILS: (PLEASE SHARE ANY SPECIFIC EXPERIENCES OR REACTIONS)

_____

_____

_____

_____

SURGEON'S NAME: _____
FIRST LAST

LOCATION: _____

ONCOLOGIST'S NAME: _____
FIRST LAST

LOCATION: _____

NAME: _____

PART 3: MORE ABOUT YOU

PLEASE INDICATE WHICH OF THE FOLLOWING WERE THE <u>MOST</u> STRESSFUL FOR YOU DURING DIAGNOSIS AND TREATMENT:

_____ CAREER/JOB _____ EMOTIONAL DISTRESS _____ FATIGUE _____ FEAR OF DEATH

_____ FEAR OF RECURRENCE _____ FERTILITY _____ FINANCES _____ NUTRITIONAL CONCERNS

_____ PARENTING _____ PHYSICAL CHANGES _____ RELATIONSHIPS _____ SEXUALITY _____ PET CARE

PLEASE INDICATE WHICH OF THE EMOTIONS YOU FELT AFTER YOUR DIAGNOSIS: (CHECK ALL THAT APPLY)

_____ ANXIETY/STRESS _____ DEPRESSION _____ FEAR/WORRY _____ GRATITUDE

_____ DENIAL _____ HOPE _____ SADNESS _____ GUILT _____ LONELINESS _____ ANGER

PLEASE INDICATE WHICH OF THESE STILL CONCERN YOU:

_____ CAREER/JOB _____ EMOTIONAL DISTRESS _____ FATIGUE _____ FEAR OF DEATH

_____ FEAR OF RECURRENCE _____ FERTILITY _____ FINANCES _____ NUTRITIONAL CONCERNS

_____ PARENTING _____ PHYSICAL CHANGES _____ RELATIONSHIPS _____ SEXUALITY _____ PETS

EMPLOYMENT STATUS DURING TREATMENT: _____

DO YOU SMOKE CIGARETTES: _____ DAILY _____ OCCASIONALLY _____ NOT AT ALL

WHY ARE YOU INTERESTED IN BECOMING A MENTOR?

_____

_____

_____

IS THERE SOMETHING THAT YOU DO (PERSONALLY, PROFESSIONALLY, ETC.) OR OTHER INFORMATION THAT YOU FEEL MAY BE IMPORTANT WHEN CONNECTING TO A MENTEE?

_____

_____

_____

I HEREBY CONFIRM THAT THE INFORMATION PROVIDED IN THE ABOVE APPLICATION FORM IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT PROVIDING FALSE INFORMATION MAY DISQUALIFY ME FROM CONSIDERATION AS A MENTOR. I WILL CONSIDER ALL INFORMATION THAT I GIVE AND GAIN IN MY MENTORSHIP POSITION TO BE CONFIDENTIAL. I ALSO UNDERSTAND THAT MY MENTORSHIP POSITION MAY BE TERMINATED IF A BREACH OF CONFIDENTIALITY OCCURS.

PRINT NAME: _____

SIGNATURE: _____ **DATE:** _____

NAME OF EMERGENCY CONTACT: _____ **PHONE NUMBER:** _____

PLEASE SUBMIT YOUR APPLICAITION VIA EMAIL TO: KKURTZ@OVARIANCANCERPROJECT.ORG
OR YOU CAN MAIL YOUR APPLICATION TO:
OVARIAN CANCER PROJECT, P.O. BOX 1002, WILLIAMSVILLE, NY 14231 ATTN: KATHY KURTZ