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PATIENTS REQUESTING SUPPORT FROM THE WOMAN TO WOMAN PROGRAM

Demographic Information:

Name: _____
First Last

Address: _____
Street Apt.

_____
City State Zip

E-Mail Address: _____

Home Phone Number: _____ Work Phone Number: _____

Most Convenient Time for you to be reached:

Days of Week _____ Sun _____ Mon _____ Tues _____ Wed _____ Thurs _____ Fri _____ Sat
Time of Day _____ AM _____ PM
Specific Times: _____

Date of Birth: _____/ _____/_____ Current Age: _____ Your Age(s) at diagnosis: _____

Marital Status: ____ Single ____ Married ____ Divorced ____ Widowed ____ Domestic Partnership

Do you have children? ____ Yes____ No _____If yes, what age(s)

Ethnic Origin: ____ African American ____ Asian American ____ Caucasian ____ Hispanic
____ Native American _____ Other

Primary Language: _____

Language (s) other than English that you speak on a conversational basis: _____

Educational Background: _____

Occupation: _____

Employment status during treatment: _____

Current employment status: _____

Your Information will be kept confidential.

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Special Skills: (i.e., sign language, etc.): _____

Hobbies: _____

More about you:

Please indicate which of the following are currently the most stressful for you:

_____ Career/Job _____ Emotional Distress _____ Fatigue _____ Fear of Death

_____ Fear of Recurrence _____Fertility _____Finances _____Nutritional Concerns

_____ Parenting _____Physical Changes _____ Relationships _____Sexuality

Other: _____

Please indicate which of the emotions you felt after your diagnosis:

_____ Anxiety _____ Depression _____ Fear/Worry _____ Stress_____ Denial _____ Hope _____

Sadness _____ Guilt _____ Loneliness _____ Other, please specify: _____

Please indicate your support system:

_____ Spouse/Significant Other _____ Friends _____ Children _____ Siblings _____ Parents _____ Faith

_____ Other, please specify: _____

Why are you interested in being paired with a mentor?

_____
_____
_____
_____

Is there something that you do (personally, professionally, etc.) or something unique to your cancer journey that you feel might be important when connecting to a mentor?

_____
_____
_____
_____

Your Information will be kept confidential.

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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 gain in my mentorship position to be confidential. I understand that my mentorship position will be terminated in an event of breach of confidentiality.

Print Name: _____

Signature: _____

Date: _____

Please submit your application via email to w2w@nm.org. Once your application is received it will be reviewed by one of our Program Coordinators. You will be contacted to schedule an interview within two weeks to discuss your needs in being matched with a mentor.