



THE VISITORS PROGRAM
VOLUNTEER APPLICATION

Name: _____ Phone: _____

Address: _____ City & Zip: _____

Birthdate: _____ Current Marital Status: M ___ D ___ S ___ W ___ No. of Children: _____

Business Phone: _____ Okay to call at Business: Y ___ N ___

Most convenient time for volunteer service: Days: _____ Times: _____

Available for: ___ Home visits ___ Hospital visits ___ Telephone calls only

Special interests, hobbies, skills : _____

Please list any foreign languages you speak: _____

Medical Information:

Diagnosis (stage/grade): _____ Mo./Yr. of Diagnosis: _____

Types of treatment received:

___ Surgery (type/date): _____

___ Chemotherapy (type/date): _____

___ Radiation Therapy: ___ External Beam ___ Other _____

___ Ostomy (type/date): _____

___ Other (please list): _____

Did you have reconstructive surgery? Y ___ N ___ Type: _____

Do you wear a prosthesis? Y ___ N ___ What Type: _____

Please list any long term side effects you have experienced: _____

Comments: _____

I hereby agree to maintain patient confidentiality and abide by the responsibilities set forth for the Visitors Program.

Date _____ Signature: _____

Name of referring person: _____ Date: _____