Become a Mentor

Demographic Information:

Name: _____
First Last

Address:_____
Street Apt.

_____
City State Zip

E-Mail Address:_____

Home Phone Number:_____ Work Phone Number: _____

Date of Birth: _____/ _____/_____ Age:_____

Marital Status: ___ Single ___Married ___Divorced _____ Widowed

Number of Children: Girls_____ Age(s) at time of diagnosis_____
Boys_____ Age(s) at time of diagnosis_____

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

Educational Background:_____

Occupation: _____

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

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

Hobbies:_____

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: _____

WISCONSIN OVARIAN CANCER ALLIANCE

woman to woman
A program of OVARIAN CANCER RESEARCH FUND ALLIANCE

Diagnosis Information

Date of Diagnosis: _____/ _____/_____ **Stage of Cancer:** _____

Type and Sub type of Gynecologic Cancer: _____
(Type Examples: Ovarian, Uterine, Endometrial, and Vaginal)
(Sub Type Examples: Clear Cell, Germ Cell, Serous Carcinoma, ETC.)

Date of Last Treatment: _____/ _____/_____
Treatment: (please check all that apply)

_____ Surgery

Please Elaborate:_____

_____ Chemotherapy How Many Treatments?_____

_____ Radiation How Many Treatments?_____

_____ Clinical Trail

Please Elaborate:_____

Are you currently undergoing treatment? _____

Please Specify: _____

_____

_____

Where were you treated? (Hospital / Cancer Center) _____

Treatment Notes:_____

_____

_____

Surgeon's Name: _____
First Last
Location: _____

Oncologist's Name: _____
First Last
Location: _____

Please indicate which of the following were the most stressful for you at the time of diagnosis:

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

_____ Fear of Recurrence _____Fertility _____Finances _____Nutritional Concerns

_____ Parenting _____Physical Changes _____ Relationships _____Sexuality

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

_____ Anxiety/Stress _____ Depression _____Fear/Worry _____ Gratitude

_____ Denial _____Hope _____Sadness/Depression _____Guilt _____Loneliness

Please indicate if any of these issues are still a concern to you:

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

_____ Fear of Recurrence _____Fertility _____Finances _____Nutritional Concerns

_____ Parenting _____Physical Changes _____ Relationships _____Sexuality

Employment Status During Treatment: _____

Current Employment Status: _____

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 newly diagnosed patient who is seeking a mentor?

_____

_____

_____

_____

Why are you interested in becoming a mentor?

_____

_____

_____

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: _____

If you are unable to submit your application via email to ashley.wagner@wisconsinovariancancer.org, please mail your application and photo to:

WOCA – 13825 W. National Ave. Suite 103 – New Berlin – WI – 53151

ATTN: Ashley Wagner