



WOMAN TO WOMAN PEER SUPPORT PROGRAM

Since every woman has an individual treatment plan, we carefully match newly diagnosed women with a peer mentor who has gone through a comparable experience. Peer Mentors receive formal training. If you are willing to share aspects of your experience, including information about your treatment decisions, effects of treatment, coping strategies, recovery obstacles, knowledge, support, encouragement, and friendship, then we encourage you to submit an application. *Note: We are committed to your privacy and your information will never be shared with an outside party other than those affiliated with the UAB Woman to Woman Program.*

APPLICANT INFORMATION			
Name:		Date: ___/___/_____	
Date of birth: ___/___/_____	Age:	Cell Phone : (____) _____ Home Phone : (____) _____	
Current address:			
City:	State:	ZIP Code:	
Email address:		Preferred contact method? <input type="radio"/> Cell Phone <input type="radio"/> Home Phone <input type="radio"/> Email For phone, preferred time? _____	
Primary language:	Other language(s):	If your race and/or ethnicity is an element you would like to share, please write that information here:	
Marital status: <input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Divorced <input type="radio"/> Widow <input type="radio"/> Significant Other	Do you have children? <input type="radio"/> YES <input type="radio"/> NO If yes, ages: _____ _____ _____	Did you live alone at time of treatment? <input type="radio"/> YES <input type="radio"/> NO Did you have children living at home while in treatment? <input type="radio"/> YES <input type="radio"/> NO	
Religious Affiliation:		Congregation:	
EMPLOYMENT AND VOLUNTEER INFORMATION			
Current employer:			
Employer address:		How long?	
Phone: (____) _____	E-mail:	Current Status: <input type="radio"/> Full-Time <input type="radio"/> Part-Time <input type="radio"/> Retired	
City:	State:	ZIP Code:	
Position:	Contact Person:	Did you work during treatment? <input type="radio"/> YES <input type="radio"/> NO	
Do you have previous volunteer experience? <input type="radio"/> YES <input type="radio"/> NO		If yes, with which organization?	
Position:	Contact Person:	Date(s) of Service:	
Address:		How long?	
Phone: (____) _____	Email:	Website:	
City:	State:	ZIP Code:	
Please list all prior volunteer experience below:			

YOUR CANCER JOURNEY		
Type of Cancer:	Date Diagnosed (MM/DD/YYYY): ___/___/_____	Are you now cancer free? <input type="radio"/> YES <input type="radio"/> NO
Cancer stage:	Age at diagnosis:	
Did your cancer metastasize? <input type="radio"/> YES <input type="radio"/> NO If yes, location: _____	Did your cancer recur? <input type="radio"/> YES <input type="radio"/> NO	Date of recurrence: ___/___/_____
Hospital/Medical Center where you were treated:	City: _____ State: _____	Treating Doctor: _____ Contact Number: (____) _____
Cancer treatment status (Please choose one): <input type="radio"/> Newly diagnosed <input type="radio"/> Still being treated <input type="radio"/> Recurrence <input type="radio"/> Finished treatment less than 1 year <input type="radio"/> Finished treatment b/w 1 and 5 years ago <input type="radio"/> Finished treatment more than 5 years ago	What treatments were/are you given? (Choose all that apply): <input type="radio"/> Chemotherapy; if yes, what drugs: _____ <input type="radio"/> Radiation <input type="radio"/> Clinical Trial; if yes, which one: _____ <input type="radio"/> Surgery; if yes, what type: _____ <input type="radio"/> Wait and Watch <input type="radio"/> Alternative Treatment; if yes, which one: _____ <input type="radio"/> Other; please explain: _____	
Please let us know of any therapies and practices you used to help manage the physical and emotional symptoms of gynecologic cancer treatment and/or post-treatment (Choose all that apply):	<input type="radio"/> Art Therapy <input type="radio"/> Acupuncture <input type="radio"/> Aromatherapy <input type="radio"/> Chiropractic Therapy <input type="radio"/> Diet and Nutrition <input type="radio"/> Exercise <input type="radio"/> Hypnosis <input type="radio"/> Journaling <input type="radio"/> Massage <input type="radio"/> Meditation	<input type="radio"/> Music Therapy <input type="radio"/> Natural Products <input type="radio"/> Physical Therapy <input type="radio"/> Psychotherapy <input type="radio"/> Reiki <input type="radio"/> Shiatsu <input type="radio"/> Spirituality and Prayer <input type="radio"/> Support Groups <input type="radio"/> Tai Chi <input type="radio"/> Yoga
Additional information you would like to share about your journey (e.g. genetic testing, family dynamics, complications):		
PEER TO PEER COMMUNICATION		
Do you feel comfortable being matching with someone who has a different gynecologic cancer type than yours? <input type="radio"/> YES <input type="radio"/> NO		
Do you feel comfortable being matched with someone who has a different treatment history than yours? <input type="radio"/> YES <input type="radio"/> NO		
How would you prefer to communication with the person you're matched with? (Choose all that apply) <input type="radio"/> Phone <input type="radio"/> Text messaging <input type="radio"/> Video chat <input type="radio"/> Email <input type="radio"/> In Person; if yes, max travel radius in miles: _____	How often do you think you would like to communication with your peer? (Choose all that apply) <input type="radio"/> Daily <input type="radio"/> Weekly <input type="radio"/> Every other week <input type="radio"/> I'm not sure <input type="radio"/> As much as needed	
How many patients are you comfortable mentoring at the same time? <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5	Which of the following would you feel comfortable speaking with your peer match about? (Choose all that apply): Your experience with a particular treatment and/or side effects <input type="radio"/> Parenting and Cancer <input type="radio"/> Fertility/Fertility Preservation/Parenting Options <input type="radio"/> Sex/Dating/Relationships/Intimacy <input type="radio"/> Communicating with family and friends <input type="radio"/> Working during treatment <input type="radio"/> Adjusting to life after cancer <input type="radio"/> Hospice and end of life care	

For questions, please contact Ayushe Sharma, the UAB site's Program Coordinator, at 205-934-5761 or sharma87@uab.edu.

You can return this application to Ayushe Sharma by mail, e-mail, or fax.

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