

# BCRC Volunteer Data Form

The Breast Cancer Resource Center (BCRC) is a non-profit organization dedicated to increasing breast cancer awareness in the community, and providing information and support to women and men affected by breast cancer. In order to carry out its many programs and services, BCRC relies a great deal on the many volunteers who give so generously of their time, experience and expertise.

There are many ways you can help, whether you have been affected by breast cancer or not, whether you can spare one hour a week or one hour every 6 months, whether you are a professional, a stay-at-home mom, or a student! Read the volunteer position descriptions below and decide how you would like to get involved. All information provided on this form will be treated confidentially.

<b>BCRC Volunteer Positions (tick ✓ all the positions you are interested in)</b>	
<b>Education &amp; Community Outreach</b>	
<input type="checkbox"/> <b>Peer Educator – Breast Cancer Awareness Talks &amp; Community/Health Fairs</b> <i>Increase breast cancer awareness in the community by sharing your breast cancer experience, distributing educational materials, answering questions, teaching breast self-examination etc..</i>	
<input type="checkbox"/> <b>Community Liaison</b> <i>Distribute information about BCRC's programs and services to your organization/community/group</i>	
<b>Information &amp; Support</b>	
<input type="checkbox"/> <b>Peer Supporter – Woman to Woman Network</b> <i>Provide emotional support, via telephone, to women coping with breast cancer.</i>	
<input type="checkbox"/> <b>Peer Supporter – Breast Buddies Hospital Program</b> <i>Provide emotional support, through hospital visits, to women coping with breast cancer.</i>	
<input type="checkbox"/> <b>Comfort Crew Volunteer</b> <i>Make someone's treatment for breast cancer a bit more comfortable by making hats, scarves, pillows, quilts etc.</i>	
<b>Events</b>	
<input type="checkbox"/> <b>Breast Cancer Awareness Month</b> <i>Help coordinate the Pink Ribbon Campaign, the In the Pink Fashion Show &amp; Silent Auction or the Surviving &amp; Thriving Breast Cancer Seminar (registration, soliciting donations, decorating, etc..)</i>	
<b>Administration</b>	
<input type="checkbox"/> <b>Administration &amp; Ad Hoc Projects Volunteer</b> <i>Ensure that day-to-day BCRC operations run smoothly and ad hoc projects are accomplished in a timely manner.</i>	
<b>Professional Services</b>	
<input type="checkbox"/> Support Group Facilitator	<input type="checkbox"/> Guest Speaker
<input type="checkbox"/> Volunteer Trainer (public speaking, counselling skills)	<input type="checkbox"/> Graphic Design
<input type="checkbox"/> Wellness Program Instructor (yoga, Pilates, tai chi, water aerobics, dance, meditation, art therapy, visualization)	<input type="checkbox"/> Marketing
	<input type="checkbox"/> Other _____
If none of the volunteer positions listed above interest you, please explain how you would like to help BCRC.	
Why are you interested in being a BCRC Volunteer?	
Have you volunteered for BCRC before? <input type="checkbox"/> Yes _____ <input type="checkbox"/> No	
What days/hours are you available to volunteer with BCRC?	

**PERSONAL INFORMATION (tick ✓, fill in, or circle as appropriate)**

Are you a:  breast cancer patient/survivor  
 spouse/partner of a breast cancer patient/survivor  
 family member/friend of a breast cancer patient/survivor  
 healthcare professional  
 Other \_\_\_\_\_

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Tel (home): \_\_\_\_\_ Tel (work): \_\_\_\_\_ Cell: \_\_\_\_\_ Fax: \_\_\_\_\_

Email address: \_\_\_\_\_

Ethnicity:

Caucasian  Hispanic/Latino  Native American  
 African American  Asian  Other \_\_\_\_\_

Languages spoken:

English  Spanish  French  German  
 Mandarin  Cantonese  Japanese  Korean  
 Hindi  Tamil  Other \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed  Domestic Partner

Spouse/partner's name: \_\_\_\_\_ Age: \_\_\_\_\_

Spouse/partner's occupation: \_\_\_\_\_

Did you have children after treatment?  Yes  No

Children:	Male / Female	Age:	Male / Female	Age:
	Male / Female	Age:	Male / Female	Age:

**MEDICAL INFORMATION (tick ✓, fill in, or circle as appropriate)**

\*\*for breast cancer patients/survivors only

Date of diagnosis: \_\_\_\_\_ Age at diagnosis: \_\_\_\_\_

Site of Diagnosis:  Left  Right  Bilateral (both breasts)

Method of Detection  Breast Self-Examination  Clinical Breast Exam  
(how was your breast  Mammogram  Ultrasound  
cancer first found):  Other \_\_\_\_\_

<b>Biopsy Type:</b>	<input type="checkbox"/> Fine Needle Aspiration	<input type="checkbox"/> Vacuum Assisted Biopsy (Mammotome)			
	<input type="checkbox"/> Core Needle Biopsy	<input type="checkbox"/> Large Core Biopsy			
	<input type="checkbox"/> Open Excisional Biopsy	<input type="checkbox"/> Other _____			
<b>Stage:</b>	<input type="checkbox"/> 0 (DCIS)	<input type="checkbox"/> 1	<input type="checkbox"/> 2A	<input type="checkbox"/> 2B	<input type="checkbox"/> 2C
	<input type="checkbox"/> 3A	<input type="checkbox"/> 3B	<input type="checkbox"/> 3C	<input type="checkbox"/> 4	
<b>Hormone Receptor Status:</b>	<input type="checkbox"/> ER Positive	<input type="checkbox"/> ER Negative			
	<input type="checkbox"/> PR Positive	<input type="checkbox"/> PR Negative			
<b>HER2 Status:</b>	<input type="checkbox"/> HER2 Positive	<input type="checkbox"/> HER2 Negative			
<b>Lymph Node Biopsy:</b>	<input type="checkbox"/> Sentinel Node	<input type="checkbox"/> Auxiliary Dissection			
<b>Lymph Node Status:</b>	# nodes removed _____	# nodes positive _____			

<b>Surgery Type:</b>	<input type="checkbox"/> Lumpectomy (Breast conservation)	<input type="checkbox"/> Bilateral Mastectomy
	<input type="checkbox"/> Mastectomy	<input type="checkbox"/> Other _____
<b>Surgery date:</b>	<b>Surgeon's name:</b>	
<b>Hospital:</b>		

<b>Reconstruction Type:</b>	<input type="checkbox"/> Immediate	<input type="checkbox"/> Delayed ( _____ yrs after initial surgery)
	<input type="checkbox"/> Saline Implant	<input type="checkbox"/> Silicone Implant
	<input type="checkbox"/> Latissimus Dorsi Flap	<input type="checkbox"/> TRAM Flap
	<input type="checkbox"/> Nipple Tattoo	<input type="checkbox"/> Other _____
<b>Reconstructive Surgeon's name:</b>		
<b>Hospital:</b>		

<b>Adjuvant Therapy Type:</b>			
<input type="checkbox"/> Chemotherapy <input type="checkbox"/> Radiation Therapy <input type="checkbox"/> Hormonal Therapy			
<b>Chemotherapy:</b>	Drug _____	# of cycles _____	Every _____ weeks
	Drug _____	# of cycles _____	Every _____ weeks
	Date started:	Date completed:	
Did you have chemotherapy before surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>Radiotherapy:</b>	Date started:	Date completed:	
<b>Hormonal Therapy:</b>	Drug _____		

	Date started:	Date completed:
	Drug _____	
	Date started:	Date completed:
Medical Oncologist's name:		Hospital:
Radiation Oncologist's name:		Hospital:
Did you experience any extreme treatment side effects (ie. nausea, neuropathy, lymphedema)? If so, please explain:		

Have you had a recurrence? <input type="checkbox"/> Yes <input type="checkbox"/> No
Where did the cancer recur (i.e. breast, lungs, bones, etc)?
What treatment(s) have you had?

Do you have a family history of breast cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Mother                      Age at Diagnosis _____
<input type="checkbox"/> Sister                         Age at Diagnosis _____
<input type="checkbox"/> Other _____              Age at Diagnosis _____
<input type="checkbox"/> Other _____              Age at Diagnosis _____
Have you had genetic testing? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have the BRCA1 or BRCA2 gene mutation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Prefer not to say

<b>REMARKS (additional personal, medical or volunteer related information)</b>

<b>BCRC VOLUNTEER PROGRAM PARTICIPANT WAIVER</b>
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<p>I certify that all details furnished above are true.</p> <p>I am an adult over 18 years of age and wish to participate in YWCA activities. I understand that even when every reasonable precaution is taken, accidents can sometimes still happen. Therefore, in exchange for the YWCA allowing me to participate in YWCA activities, I understand and expressly acknowledge that I release the YWCA and its staff members from all liability for any injury, loss or damage connected in any way whatsoever to my participation in YWCA activities, whether on or off the YWCA premises. I understand that this release includes any claims based on negligence, action or inaction of the part of the YWCA, its staff, directors, members and guests. I have read and am voluntarily signing this release</p> <p>Signature of volunteer: _____ Date: _____</p>
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<b>Please mail form to: BCRC, YWCA Princeton, 59 Paul Robeson Place, Princeton NJ 08540 or fax to: 609-497-1211</b>
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