

Name: _____

Address: _____

Phone: (h) _____ (w) _____
(cell) _____

Email: _____

When is the best time of day/week to contact you?

May we leave a voice mail containing confidential information on your answering machine? ___ Yes ___ No



Please complete the information below in detail. This information will be used to match you with a Volunteer Buddy who is best equipped to meet your needs.

Date of Birth: _____ Gender: _____

Primary Language: _____

Occupation/Employment Status: _____

Do you have children under age 18?: _____

Diagnosis: _____ Type/Stage: _____

Date(s) of diagnosis/es: _____

Are you currently receiving treatment for melanoma? Yes No

If so, what type?: _____ *Surgery*
_____ *Interferon*
_____ *Radiation*
_____ *Chemotherapy*
_____ *Clinical Trial/Other*

The Billy's Buddies program will match you with a Volunteer who can provide assistance and support to help meet some of your needs. In what ways would you like your Buddy to help support you? (Please check all that apply):

- Patient Support:** Provide active listening and support through telephone contact.
- Transportation Assistance:** Provide transportation to and from medical appointments.

Is it important to you to be matched with a Volunteer who has had melanoma, or who has a family member who's had melanoma? Yes No

Please use the space below to list any preferences you may have regarding the age, gender, health status, religious preference, etc. of the volunteer who you are matched with.

Please review the Billy's Buddies Confidentiality Policy below, then sign the application at the bottom of the page.

CONFIDENTIALITY

As a Billy's Buddies participant, it is important to know that the Melanoma Foundation of New England works very hard to protect the privacy of both the volunteers and patients. Because the relationship between the Volunteer Buddy and the patient is an important one and can best be developed when trust is established, both parties must agree to maintain confidentiality. It is critically important that both parties agree not to share with others the information that is exchanged in conversations and correspondences. This information should not be shared with family, friends, co-workers or others or discussed in public settings or places where information could be easily overheard. Written correspondence, contact logs and written patient information must be kept confidential and disposed of in a manner that would maintain confidentiality (torn, shredded).

Because the safety and well-being of both parties are of the utmost importance to the Melanoma Foundation of New England, the Foundation will provide support to the members of the Billy's Buddies program. Supervision and peer support are an important part of being a volunteer. Volunteer Buddies need to be able to count on the support of professionals and Foundation staff. Patients need to understand that while privacy will be respected, information may be shared within these boundaries. Both parties understand that, in the context of supervision or support, or if either party is concerned about the safety or well-being of the other, or about the relationship, content of conversations/correspondences will be shared. Under these conditions, information may be shared, with as much respect to privacy as possible (i.e. exclusion of last names), with a Foundation staff member involved in the Billy's Buddies program, a medical team member or an emergency professional.

I hereby attest that the above information is true to the best of my knowledge, and that I have read and agree to adhere to the Billy's Buddies Confidentiality Policy.

Signature: _____

Date: _____