Rocky Mountain Blood and Marrow Transplant Program

1800 Williams Street, Suite 300
Denver, CO 80218
Phone: 303-285-5082 Fax: 303-267-4472
Attn: Teri Simoneau, Program Psychologist

BMT Volunteer Program
Patient or Caregiver Application

The Rocky Mountain Blood and Marrow Transplant Program has a specialized volunteer program administered by Presbyterian/ St. Luke's Medical Center's Volunteer Program. Following is a list of qualifications for individuals wishing to get involved.

1. You must have had a personal experience with a BMT Transplant either as a patient or a caregiver.
2. You must be at least 1 year out from your transplant.
3. You will need to provide a qualified reference if the transplant was received at a different program.
4. You must be willing to provide a 6-month commitment to the volunteer program.
5. You will require an interview with the BMT Program's Psychologist.
6. You will be required to take a TB test.
7. Background checks are also required of anyone 18 or older to be involved in the volunteer program.

You were a: ❐ Patient ❐ Caregiver

The program where the transplant was conducted:

____

Day 0 of the transplant was ___/___/___.

Exit date of the transplant program was approximately ___/___ (mm/yy).

What type of transplant was conducted? ______________________________

If a caregiver, how were you involved? ______________________________

____

Why do you want to become a BMT Volunteer? __________________________

____

____

____

____

If you have received your transplant from a program other than Rocky Mountain Blood and Marrow Transplant Program you will be required to provide a reference at that program. Preferably the reference will be the program psychologist, if none are available, a social worker, physician or nurse practitioner will suffice.

Name: ______________________ Title: ______________________

Contact Phone: ______________________ Fax: ______________________

In addition you will need to mail the reference check sheet, found on the website, directly to this individual.

BMT Volunteer Program
Patient or Caregiver Application

Your Name: ____
(Last) (First) (Middle) (Nickname)

Mailing Address: ____
(Street) (City) (Zip)

Home Phone (___)____-_____ Work Phone (___)____-_____ E-Mail:___________________________

Work:____
(Company) (Address)

Can we call you at work if necessary?_____

Birth Date: ____/_____/_______ Social Security Number: ______-______-______

Emergency Contact Name: ____

Relationship:____

Contact's Home Phone: (_____)_____-_________ Work Phone: (_____)_____-________

Doctor's Name: ______________________________ Phone: (_____)______-_______

How did you learn about volunteering at P/SLMC?___________________________________

List any restrictions to your volunteer service: ______________________________________

Prior Work and/or Volunteer Experience:____

Education or Specialty Training: ____

Have you ever been convicted of any law violation (except a minor traffic violation)? Yes____ No____

If yes, give details:____

____

(A "yes" answer does not automatically disqualify you from volunteering, since the nature of the offense, date, and the position for which you are applying will also be considered.)

Reference #1 – Name:________________________________ Phone: _________________________

Reference #2 – Name:________________________________ Phone: _________________________

Days and Hours Available:____

I hearby certify that the above information is true and complete to the best of my knowledge. I realize this information is confidential and may be used to determine my eligibility to serve in patient areas. If necessary, I authorize Presbyterian/St. Luke's Medical Center to contact my physician regarding the state of my health. I also authorize those performing health screenings or X-ray films to send results of these examinations to the physician or agent ordering it, and if requested, to my health coverage insurance company.

Signature:_____________________________________ Today's Date:__________________