Farmacy Volunteer/ Treatment Space Form

Name ____________________

Address ____________________

Phone ____________________ E-mail ____________________

Healing Modality ____________________

Years Practicing ____________________ Private Practice? Yes ___ No ___

Does your practice require state licensing and insurance? Yes ___ No ___

# of Monthly Volunteer Shifts Available
(depending on modality, shifts range from 2-5 hours) ____________________

Most Convenient Days ____________________

Most Convenient Hours ____________________

Do you have space available for treatments?

If so, what type of treatments could be held in it? ____________________

____

What hours/ days would the space be available?

____

Have you worked with cancer patients in the past?? Yes ___ No ___
If so, please describe. (Use back of page if needed)

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We are currently organizing our calendar in 6 month increments.

Can you commit to volunteering or the use of your treatment space 1-2 times a month for 6 months starting in May 2008? Yes ___ No ___

We also need volunteers for these services. (Please check if interested in any of these)

___ Interpreters ___ Drivers

___ Support Staff (event coordinators, outreach, fundraising, mailings, office work)