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Please mail, FAX or email completed application form to:

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BMT Volunteer Program Volunteer Application

The Colorado Blood Cancer Institute at Presbyterian/St. Luke's Medical Center has a specialized volunteer program administered by PSL's Volunteer Office. Volunteers provide a valuable service to BMT patients and their family members. The following is a list of qualifications for individuals wishing to volunteer:

1. You must have personal experience with a stem cell transplant either as a patient or a caregiver.
2. If you received a transplant, you must be at least 1 year out from transplant.
3. You must provide a reference from a psychosocial or medical provider (e.g., social worker, psychologist, BMT doctor, advance practice nurse, etc.) from the program where you had your transplant or where your loved one had their transplant.
4. You must be willing to provide a 6-month commitment to the volunteer program.
5. You must interview with a coordinator of the BMT Volunteer Program.
6. You must take a TB test (unless your physician states that you are not to receive a TB test for medical reasons).
7. You must have a background check

Name: _____
(First) (Last) (Nickname)

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

Home Phone (____) ____-____ Work Phone (____) ____-____

E-Mail: _____

Work: _____
(Company) (Address)

Can we call you at work if necessary? YES NO

Birth Date: ____ / ____ / ____ Social Security Number: ____-____-____

Emergency Contact: _____ Relationship: _____

Contact's Home Phone: (____) ____-____ Work Phone: (____) ____-____

Doctor's Name: _____ Phone: (____) ____-____

You were a BMT: Patient Caregiver

BMT Doctor's Name: _____ Phone: (____) ____ - _____

The program where the transplant was conducted: _____

Type of transplant: Autologous Allogeneic

Transplant Day 0: ____/____/_____

If a caregiver, how were you involved? _____

Why do you want to become a BMT Volunteer? _____

Days and hours available as a volunteer: _____

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

If yes, please provide details: _____

Reference #1 - Name: _____ Phone: _____

Reference #2 - Name: _____ Phone: _____

I hereby 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: _____

Please mail, email or FAX this form to the address listed at the top of the application.