

VOLUNTEER APPLICATION

The information which is requested on this form will be used for the sole purpose of matching a renal patient with a Renal Resource Peer (RRP) or Transplants Assisting Transplants (TAT) volunteer from the Kidney Foundation of Northwest Ohio. The information supplied on this form will be kept confidential and will be used only by KF staff.

**ATTENTION SOCIAL WORKER OR HEALTH PROFESSIONAL:
UPON COMPLETION OF THIS FORM PLEASE CONTACT THE KIDNEY FOUNDATION BY PHONE AT
419-329-2784 OR FAX THIS FORM IN FULL AT 419-531-6080. THANK YOU**

PLEASE PRINT ALL INFORMATION:

NAME: _____

ADDRESS: _____

(CITY) (STATE) (ZIP)

PHONE: _() - _____

BIRTHDATE: ____/____/_____
(MM) (DD) (YYYY)

SEX: _____

WOULD YOU FEEL MOST COMFORTABLE WITH PEERS WHO ARE:

____ WITHIN 5 YEARS OF YOUR OWN AGE

____ ANY AGE

____ OTHER _____

ARE YOU: _____ CURRENTLY ON DIALYSIS

IF YES, _____ HEMODIALYSIS

(Please Circle) MWF TRS

____ CAPD

____ CCPD

APPROXIMATE DATE THIS BEGAN: _____

____ A TRANSPLANT RECIPIENT

DATE OF TRANSPLANT: _____

____ FAMILY MEMBER OF RENAL PATIENT

PLEASE INDICATE RELATIONSHIP AND TYPE OF
TREATMENT PATIENT RECEIVES _____

INTERESTS: (Hobbies, Activities, Social Groups, Etc.) _____

DO YOU HAVE ACCESS TO TRANSPORTATION? _____

DO YOU HAVE ANY PHYSICAL LIMITATIONS? _____

WOULD YOU PREFER SESSIONS TO BE: _____ FACE-TO-FACE
**PREFERENCE:
_____ YOUR HOME
_____ PUBLIC PLACE
PLEASE LIST _____

_____ TELEPHONE
**MAY WE GIVE YOUR
NUMBER TO PATIENT?
YES NO

**ARE YOU WILLING TO
PLACE A LONG DISTANCE
CALL TO PATIENT?
YES NO

PLEASE INDICATE THE DAY(S) AND TIME(S) AT WHICH YOU WOULD BE AVAILABLE TO SPEAK WITH A PATIENT.

	Sun.	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.
Morning							
Afternoon							
Evening							

ANY ADDITIONAL REQUESTS AND/OR COMMENTS? _____

Referring Social Worker or Health Professional
(MUST HAVE SIGNATURE): _____
Facility: _____
Phone Number: _____

FOR OFFICE USE ONLY

Date received: _____

Date referral made: _____