

Participant Information Form

Welcome to LivingWell Cancer Resource Center. Please take a moment to complete this confidential participant form.
Your personal information will not be shared with anyone outside of LivingWell Cancer Resource Center.

Primary

Name: _____ Home Phone: _____ ☐

Address: _____ Work Phone: _____ ☐

City: _____ State: _____ Zip: _____ Cell Phone: _____ ☐

Email: _____ ☐ Male ☐ Female D.O.B. ____/____/____

Name of Person with Cancer: ☐ SELF or Name: _____ Relationship: _____

Primary Cancer Type: _____ Cancer Stage: 1 2 3 4 Other: _____

Date of Diagnosis: ____/____/____ Date of Recurrence (If applicable): ____/____/____

☐ Metastatic ☐ Active ☐ Remission

Primary Oncologist/Cancer Specialist: _____ Hospital: _____

Treatment Status: ☐ Pre-treatment ☐ Active Treatment ☐ Completed treatment during past 18 months

☐ Treatment completed more than 18 months ago ☐ Other _____

Other Family Members In Household Participating In Programs : (If more than two, please record on back of paper.)

Name: _____ Gender: M/F Phone: _____ Birthdate: ____/____/____

Name: _____ Gender: M/F Phone: _____ Birthdate: ____/____/____

Release and Waiver:

I, the undersigned, acknowledge that I have voluntarily chosen to participate in the classes/programs/services offered by LivingWell Cancer Resource Center. I am aware that participation in some of these classes/programs/services may require physical exertion and a minimum level of physical fitness. I am voluntarily participating in the classes/programs/services and I assume all responsibility and liability for any and all injuries I may sustain due to my participation in these activities. In consideration for participation in the classes/programs/services I waive any claims or liability against LivingWell Cancer Resource Center and/or the LivingWell Cancer Resource Center staff/instructors/other participants for injury or damages that I may sustain as a result of my participation. I have read the above release and waiver of liability and fully understand its contents. I voluntarily agree to the terms and conditions stated above.

Participant Name: (Please Print) _____

Participant Signature: _____ **Date:** ____/____/____

***OR If Participant Is Under Eighteen Years Old:**

Parent/Guardian Signature _____ **Date:** ____/____/____

Over, please ►

How did you hear about LivingWell? (Please select one)

- ☐ LivingWell Printed Program Guide through the mail
- ☐ LivingWell Program Guide in cancer centers or hospitals
- ☐ E-mail
- ☐ Facebook (facebook.com/livingwellcrc)
- ☐ LivingWell website (livingwellcrc.org)
- ☐ Fliers at cancer centers or hospitals
- ☐ My physician
- ☐ Social worker
- ☐ Friend or family member
- ☐ Other _____