LivingWell CANCER RESOURCE CENTER
part of Northwestern Medicine

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.

Name: _____ Home Phone: _____

Address: _____ Work Phone: _____

City: _____State: _____Zip:_____ Cell Phone: _____

Email Address: _____ Gender: ☐Male ☐Female Date of Birth___/____/____

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: _____

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

☐LivingWell Welcome Guide - in cancer centers or hospital ☐E-mail ☐ Flyers

☐Facebook (facebook.com/livingwellcrc) ☐ LivingWell website (www.livingwellcrc.org)

☐ My Physician ☐ Social Worker ☐Friend or family member ☐ other _____

Other Family Members in Household Participating in Programs:

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

Emergency Contact: _____ Phone Number: _____

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/ser-

vices 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/ instructions/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 content. 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: ____/____/____

Return your completed form to:

Email: info@livingwellcrc.org
Fax: 630.262.1110
or
Mail:
LivingWell Cancer Resource Center
442 Williamsburg Avenue
Geneva, IL 60134