

BURN FOUNDATION

Application for Services



APPLICANT INFORMATION

Last Name	First	M.I.	Date		
Street Address		Apartment/Unit #	Date of Birth		
City	State	ZIP			
Phone	E-mail Address	DOB			
Dates/Times Available					
Please Contact me at:					
I am a . . .	Male <input type="checkbox"/>	Female <input type="checkbox"/>	I am a . . .	Burn Survivor <input type="checkbox"/>	Family Member/Caretaker <input type="checkbox"/>
Are you able to travel?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Are you able to drive?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Would you prefer to work with a certain type of Peer?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	If yes, explain		

BACKGROUND

Who Was Injured?	Self <input type="checkbox"/>	Family Member <input type="checkbox"/>	Name of Burn Injured Person:	Age
Date of Injury:	Injury Type:			
Please describe how the injury occurred (continue on back):				
Please describe the extent of injury and treatment received. Please include where and when. you were treated.				

FAMILY

Please list other members of your family

Full Name, Age	Relationship	Do they live with the injured person? Y N
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How Are they Coping?

Full Name, Age	Relationship	Do they live with the injured person? Y N
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How are they Coping?

Full Name, Age	Relationship	Do they live with the injured person? Y N
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How are they Coping?

HOW CAN WE HELP?

I am looking for:

- Individual Peer Support Family Peer Support A Support Group To Interact with Other Burn Survivors Professional Counseling
 Other: _____

Please describe the things you would like help with?

Have you ever tried to harm yourself or another person? YES NO

If Yes, when?

Please Describe:

Who referred you to the Burn Foundation?

Relationship to you?

Contact Information (Address/Phone/Email):

May we contact this person? YES NO

Are you currently in counseling? YES NO

May we contact this person? YES NO

Please sign a release of information form to the Burn Foundation with your provider.

Please describe:

Are you currently being treated for a medical condition? YES NO

Contact Information (Address/Phone/Email):

May we contact your health care provider? YES NO

IN CASE OF EMERGENCY

Emergency Contact Name

Relationship

Address

Phone

ADDITIONAL INFORMATION

Is there anything else that you would like to share with us that might be important to matching you with an appropriate Burn Foundation volunteer?

DISCLAIMER AND SIGNATURE

I certify that my answers are true and complete to the best of my knowledge. I give permission to the burn foundation to use this information on my behalf and release the Burn Foundation from any liability or harm that may occur from involvement with the Foundation.

Signature

Date

Witness

Date

BURN FOUNDATION MENTORSHIP PROGRAM
PARTICIPANT CONSENT AND ACKNOWLEDGEMENT FORM

I, _____ (Participant), by signing this Consent and Acknowledgement Form, hereby represent that I fully understand that the Burn Foundation Mentorship Program (the “Program”) is a voluntary program that provides support in a group or individual setting and that the mentors of the program are themselves burn victims, or have family members who are burn victims, but they are not licensed medical professionals. The Program is not intended to be a substitute for professional medical advice, diagnosis, or treatment. Always seek the advice of your physician or other qualified health provider with any questions you may have regarding any medical condition. Never disregard professional medical advice or delay in seeking it because of something you have heard while participating in the Program.

If you think you may have a medical emergency, call your doctor or 911 immediately. The Burn Foundation does not recommend or endorse any specific tests, physicians, products, procedures, opinions, or other information that may be mentioned in the Program. Reliance on any information gathered during participation in the Program is solely at your own risk.

PARTICIPANT

_____ (Date) _____

Print Name: _____

WITNESS

_____ (Date) _____

Print Name: _____