

PEER MENTOR APPLICATION

Thank you for completing the Facial Pain Association Peer Mentor application. If you need additional space to answer any of the questions, feel free to add to the end of the application.

Please review the Peer Mentor Program Guidelines. Submit your completed application to Regina Gore, Volunteer Coordinator at rgore@tnasupport.org.

You may scan, and email or simply email with your electronic signature.

Your completed application will be reviewed, and if appropriate, you will be contacted to schedule a short phone screen interview.

CONTACT INFORMATION

Name _____

Address _____

City, State, Zip _____

Phone _____

Email _____

If different from above

Preferred Peer Mentor Phone _____

Preferred Peer Mentor Email _____

PERSONAL INFORMATION

Relationship to facial pain

Patient___ Caregiver___ Spouse___ Family Member___ Health Professional___

Other (specify)

Language(s) spoken

Volunteer activities and experiences, current or past

TREATMENT INFORMATION

Please provide the following information for yourself, if you are the patient. Or, keep in mind the person in your life affected by facial pain.

Diagnosis

Diagnosis Date

Age at diagnosis

Treatment(s) and date(s)

Symptoms you can discuss

Facial pain related topics you can discuss

Is there anything else you would like to share about yourself?

QUESTIONNAIRE

Why do you want to be an FPA Peer Mentor?

Can you communicate effectively about current treatment options for facial pain? If no, do you need additional information?

Do you consider treatment outcome(s) generally positive?

Do you enjoy speaking with people? Why?

Do you consider yourself a good listener? Why?

Do you attend an FPA support group or other support group?

Are you available to respond to emails and telephone inquiries in a timely manner?

Do you read the FPA quarterly newsletter?

Do you read the FPA email Bulletin?

Do you regularly visit the FPA website?

Do you follow or participate in any FPA or other facial pain-related Facebook Groups? If so, which ones?

Are you willing to distribute FPA information to relevant healthcare providers in your area?

Are you willing to serve a two year term if your application is approved?

ACKNOWLEDGEMENT AND SIGNATURE

Please sign below to certify that you have read, understood and will comply with the Peer Mentor Guidelines. By signing below, you also certify you will abide by FPA's mission, vision, and values. You will conduct all dealings with the public in a positive and professional manner, and will uphold that image on behalf of FPA.

I have accurately and truthfully completed this application and agree to the terms. Upon approval as an FPA Peer Mentor, I give FPA permission to disclose my contact, demographic and additional related information to recipients of the FPA Peer Mentor list.

Signature_____

Date_____

Return to Regina Gore at rgore@tna-support.org

Revision July 20, 2020