



RUSH Cancer Resource Center

Participant Information Form

Waterford Place may use your personal information for registration, recordkeeping, new program development, and fundraising activities. Your information will remain within our organization and will not be shared externally. Waterford Place Cancer Resource Center is a Rush Copley Foundation community program. Rush Copley complies with Federal civil rights laws and does not discriminate based on race, color, religion, national origin, age, disability, sex, sexual orientation, or gender identity/expression. To withdraw consent for internal information sharing, please contact us at 331-301-5280.

Legal Name (Please Print):		Date:
Preferred Name (Please Print):		Preferred Pronouns:
Street Address:		
City:	State:	Zip:
Date of Birth:	Gender:	Sexual Orientation:
Email Address:		
Preferred Phone Number: <input type="checkbox"/> Cell <input type="checkbox"/> Home		Can Waterford Place Cancer Resource Center leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No
Emergency Contact Name (please print):		Relationship of Emergency Contact:
Emergency Contact Phone Number:		Can Waterford Place Cancer Resource Center leave a message for your Emergency Contact? <input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer Specific Information		
Primary Cancer Type:	Cancer Stage: <input type="checkbox"/> Zero <input type="checkbox"/> One <input type="checkbox"/> Two <input type="checkbox"/> Three <input type="checkbox"/> Four <input type="checkbox"/> Unknown	
Approximate date of original cancer diagnosis:	<input type="checkbox"/> Other: _____	
Has the cancer metastasized / spread from it's original location? <input type="checkbox"/> Yes <input type="checkbox"/> No		Has cancer recurred? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, approximate date you learned it metastasized or reoccurred: _____		
Physician's Name (Medical Oncologist, Radiation Oncologist or Surgeon):		
Physician Location:	Did your physician or someone from their office refer you to Waterford Place Cancer Resource Center? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Current Cancer Treatment Information (Check the boxes that best describe each)		
Treatment Status <input type="checkbox"/> Pre-treatment <input type="checkbox"/> Active Treatment <input type="checkbox"/> Completed Treatment (Date Completed: _____) <input type="checkbox"/> Supportive or Palliative Care Only	Current Treatment <input type="checkbox"/> Surgery <input type="checkbox"/> Watch and Wait <input type="checkbox"/> To Be Determined <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Targeted Therapy <input type="checkbox"/> Radiation Therapy <input type="checkbox"/> Bone Marrow / Stem Cell Transplant <input type="checkbox"/> Immunotherapy <input type="checkbox"/> Oral Hormones / Hormone Therapy	
Race / Ethnicity <input type="checkbox"/> White, Non-Hispanic/Latino <input type="checkbox"/> Hispanic / Latino <input type="checkbox"/> Black / African American <input type="checkbox"/> American Indian / Alaskan Native <input type="checkbox"/> Pacific Islander / Hawaiian Native <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Asian <input type="checkbox"/> Other <input type="checkbox"/> Prefer Not To Share	Faith Tradition <input type="checkbox"/> Judaism <input type="checkbox"/> Christianity <input type="checkbox"/> Islam <input type="checkbox"/> Hinduism <input type="checkbox"/> Buddhism <input type="checkbox"/> Other <input type="checkbox"/> Prefer Not To Share	Your Primary Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____
		Medical Insurance Status <input type="checkbox"/> Private Insurance <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Uninsured
CON-0113.rev1/2026 INTERPRETER ATTESTATION: Interpretation has been provided by _____ <input type="checkbox"/> Phone		

Support Information

Adults (Currently living with you)

Relationship

Children (Under the age of 18 and living with you)

Date of Birth

Relationship

Family Income

In our efforts to provide helpful resource to all participants and for grant reporting purposes, Waterford Place Cancer Resource Center is requesting family household size and income information. The information you provide will remain confidential. Please indicate family size and estimated annual income level.

Family Size

Estimated Annual Income (optional)

Below

Over

<input type="checkbox"/> 1	\$75,000	\$75,000
<input type="checkbox"/> 2	\$102,000	\$102,000
<input type="checkbox"/> 3	\$128,000	\$128,000
<input type="checkbox"/> 4	\$155,000	\$155,000
<input type="checkbox"/> 5	\$181,000	\$181,000

Release and Waiver

I, the undersigned, voluntarily choose to participate in the classes, programs, and services offered by Copley Memorial Hospital d/b/a Waterford Place Cancer Resource Center. I understand that participation in certain activities may involve physical exertion and require a minimum level of physical fitness. I acknowledge that there are inherent risks associated with such activities, and I agree to assume full responsibility for any injury, illness, or other adverse effects I may experience as a result of my participation. In consideration of being permitted to participate, I hereby voluntarily release, waive, and forever discharge Waterford Place Cancer Resource Center, and their parent, any subsidiary or affiliate corporation, including their officers, directors, employees, agents, independent contractors, and volunteers, from any and all liability, claims, demands, or causes of action of any kind, present or future, whether the same be known or unknown, anticipated, or unanticipated, including but not limited to those relating to bodily injury, illness, emotional distress, property damage, or theft or loss of personal property, arising out of or connected in any way with my participation in programs, services, or use of the facilities.

I further acknowledge and agree that if I fail to attend two (2) scheduled complementary therapy services appointments without providing notice, I will forfeit my eligibility for future complementary therapy services. I have read and fully understand this release and waiver of liability. I am aware that by signing below, I am giving up certain legal rights and remedies that may otherwise be available to me. I voluntarily agree to the terms and conditions set forth above.

Waterford Place Cancer Resource Center will use your personal information only for registration and program purposes and will not share it with external parties. Your information also helps us develop and improve programs and raise funds to continue serving individuals affected by cancer.

Waterford Place Cancer Resource Center is a Copley Memorial Hospital community program. Rush Copley Memorial Hospital complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, religion, national origin, age, disability, sex, sexual orientation, ancestry, marital or parental status or gender identity and/or expression, veteran's status, or any other category protected by federal or state law or county or city ordinance

Participant Signature: _____ Date: _____ Time: _____

If participant is under 18 years old:

Legal Guardian Signature: _____ Date: _____ Time: _____

Legal Guardian Name (please print): _____

Relationship to Participant: _____

For Office Use Only

Pre-Treatment / In Treatment
(Unlimited sessions for 18 months from date of diagnosis)

Activation Date: _____
(Date of Diagnosis / Reoccurrence)

Completed Treatment
(12 sessions for 24 months from date of treatment completion)

Activation Date: _____
(Date Completed Treatment)

Metastatic / Advanced Stage
(Unlimited sessions indefinitely)

F. T. Score

SGK Eligible