

VOLUNTEER PEER SUPPORT REGISTRATION

Volunteer Name: _____
Address: _____
City, Province, Postal Code: _____
Home Phone: _____ Work Phone: _____
Email Address: _____
Best Time to Call: _____

GENERAL INFORMATION

D.O.B (Month/Day/Year): _____ Male Female
Relationship: Have Epilepsy Child Sibling Parent Other _____
Type of Seizures: _____
Frequency of Seizures: Now: _____ Previously: _____
Anti-Convulsant Medication (AED): _____
Treatment: AED Testing Ketogenic Diet Brain Surgery VNS
Other Disabilities: _____
Special Interests: _____

TRAINING

Will take Peer training: _____
Has taken Peer Training elsewhere: _____

WILL TALK TO A PERSON REGARDING:

<input type="checkbox"/> Parent with child	<input type="checkbox"/> Parent with Epilepsy	<input type="checkbox"/> Epilepsy & pregnancy
<input type="checkbox"/> Ketogenic Diet	<input type="checkbox"/> School issues	<input type="checkbox"/> Driving Issues
<input type="checkbox"/> Surgery	<input type="checkbox"/> VNS	<input type="checkbox"/> Women's Issues
<input type="checkbox"/> Men's Issues	<input type="checkbox"/> Teen with Epilepsy	<input type="checkbox"/> Children with Epilepsy
<input type="checkbox"/> Adult with Epilepsy	<input type="checkbox"/> Medication	<input type="checkbox"/> Nutrition
<input type="checkbox"/> Testing (MRI, EEG, etc)	<input type="checkbox"/> Other: _____	

Date: _____