Professional Mentorship Program
Mentor Application

Date of Application

This information will be confidentially maintained and will be referenced periodically to evaluate the effectiveness of this program.
Please print clearly or complete on-line here: *https://form.jotform.com/73646549529168*

CONTACT INFORMATION

Name (*First, Last*):	**Company/Organization:** **Title:**		
E-mail address:	**Phone number:**		
Mailing address:	**City:**	**State:**	**Zip code**:

Preferred method(s) of communicating with mentee (*select all that apply*):
Mentors will be required to meet face-to-face with mentees at least 2 times during a semester and maintain contact by phone or email bi-weekly

☐ Phone ☐ Email ☐ Face-to-face

BACKGROUND

Gender: ☐ Male ☐ Female **Race Optional:**

Are you a Veteran? ☐ Yes ☐ No	**If yes, what is your Veteran Status?** ☐ Active Duty Military ☐ Reservist ☐ Veteran (Prior Service) ☐ Veteran (Retired)

CURRENT CAREER

Nursing ☐ LPN ☐ Radiologic Technology ☐ Surgical Technology ☐ Medical Assistant ☐

Massage Therapy ☐ Computer Network Administration ☐ Health Information Technology ☐

Healthcare Informatics ☐ Nutrition/Dietetics ☐ Other ☐ _____

Do you have a specialty? If so, please indicate:

Do you have mentoring experience? ❒Yes ❒ No

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