

Badger APIC
Mentee Request

Name: _____

Work Phone: _____

Name of Facility : _____

Address of Facility: _____

Fax #: _____ Preferred email: _____

Major Responsibilities

Years of Experience

My preference for mentor worksite:

Acute Care _____

LTC _____

Other (list) _____

By submitting a request to be partnered with a mentor, I agree to the following responsibilities:

1. *To consult/communicate with my mentor per telephone or electronically as able. I understand the extent of further involvement such as providing materials, on-site internship experience, etc. will be my mentor's decision, but I take responsibility for requesting it should I feel the need.*
2. *To complete the program evaluation sent by the coordinator every six months.*
3. *To notify my mentor and the membership/program coordinator by one year of partnership of my need to continue with a mentor. I may elect to terminate the partnership sooner if I no longer feel the need for assistance.*
4. *I will consider being a mentor in the future as a way of reciprocating these gratis services.*

Comments:

Signature: _____ Date: _____

Please return to: Ginger Croft
St Marys Care Center
3401 Maple Grove Rd
Madison, WI 53719
608-845-1000 ginger_croft@ssmhc.com

Date Rec'd: _____

Documented Date: _____

By: _____