



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: Mary Jo Stokes
Mayo Clinic Health System-La Crosse
700 West Avenue South
La Crosse, WI 54601
608-392-4115 stokes.maryjo@mayo.edu

Date Rec'd: _____
Documented Date: _____
By: _____