

Badger APIC  
**Mentor Application**  
Willingness to Serve

Name: \_\_\_\_\_  
Work Phone: \_\_\_\_\_  
Name of Facility : \_\_\_\_\_  
Size: (# of beds, pt capacity, # of clinics, etc) \_\_\_\_\_  
Address of Facility: \_\_\_\_\_  
Fax #: \_\_\_\_\_ Preferred email: \_\_\_\_\_

**Major Responsibilities**

**Years of Experience**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Specialty Area: (mark all that apply)**

Hospital _____	Acute Care _____	Bariatric _____
Clinic _____	LTC _____	Dental Clinic _____
Home Health _____	Ambulatory _____	Infusion Service _____
Public Health _____	Urgent Care _____	Other (list) _____

Number of mentees I am willing to assist: \_\_\_\_\_

By submitting an application to participate as a mentor I agree to the following responsibilities:

1. *To provide at least one years commitment per mentee.*
2. *To be available for consultation per telephone or electronically as able. The extent of further involvement such as providing materials, on-site internship experience, etc. will be my decision. Should I be unable to accommodate my mentee's request for these, I will notify the membership/program coordinator who will assist in satisfying the request.*
3. *To notify the mentee and membership committee/program coordinator if unable to complete my commitment.*
4. *To complete the program evaluation sent by the coordinator every six months.*

**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: \_\_\_\_\_