



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
Clinic
Home Health
Public Health
Acute Care
LTC
Ambulatory
Urgent Care
Bariatric
Dental Clinic
Infusion Service
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.
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: 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:

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