

The Women in Medicine Medical Student Mentoring Program

Physician/Mentor Information

First Name: _____

Last Name: _____

Degree(s): _____

Specialty: _____

Preferred Contact Address: Home Work

Street Address: _____

Street Address: _____

City: _____ State: _____

Postal Code: _____

Country: _____

Home Phone: _____ Alt. Phone: _____

E-Mail Address: _____

Medical School: _____

Residency: _____

Fellowship: _____

Would you prefer a mentee interested in your specific specialty? Yes No

Would you like a mentee who lives close to you geographically? Yes No

Other preferences?

Please send form to: Elizabeth Tillman, MD
By post: PO Box 243, Old Mystic 06372
By e-mail: womeninmed@earthlink.net
By fax 860/585-3500
Thank you!