

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 Sheri Task, MD
By post: Women in Medicine, PO Box 107, Colchester, VT 05446
By e-mail: womeninmed@earthlink.net

Thank you!