The Women in Medicine Medical Student Mentoring Program
Medical Student Information

First Name: _____

Last Name: _____

Degree(s): _____

Street Address: _____

Street Address: _____

City: _____ State/Province: _____

Postal Code: _____ Country: _____

Home Phone: _____

Alt. Phone: _____

E-mail Address: _____

Medical School: _____

Medical School Year: MS1 MS2 MS3 MS4 MS5 MS6

Are you considering a specific field in medicine? Yes No

If yes, which: _____

If yes, would you prefer a mentor in this field? Yes No

Would you like a mentor 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: wim.doctors@gmail.com

Thank you!