## ADFM Administrator Mentoring Application

Mentee Application

## Name:       Current Job Title:       Department Name:

## Work Phone Number:       E-Mail Address:       Chair's Name:

**Chair's E-Mail Address**:

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**How long have you worked in a Department of Family Medicine?**

[ ]  Under 3 years [ ]  3 to 5 years [ ] 5 to 10 years [ ]  More than 10 years

**How long have you been in your current area of expertise?**

[ ]  Under 3 years [ ]  3 to 5 years [ ] 5 to 10 years [ ] More than 10 years

**What area of interest would you like to be mentored in?**

[ ] Administration/HR Management [ ]  Clinical Practice [ ] Research

[ ] Education [ ] Finance [ ] ADFM Involvement

**Please list the goals you would like to accomplish by being a part of the Mentoring Program**

**Describe your business strengths or areas of expertise?**

**Do you prefer to be matched with a:** [ ] Male [ ] Female [ ]  No Preference

**Do you prefer to be matched with a mentor who is of the:** [ ] Same [ ] Different ethnic background?

 If you have a preference indicate the ethnic background you prefer to be matched with:

**Do you have a preference regarding your mentor's area of expertise?** [ ] Yes [ ] No

 If "Yes," please select top 2:

[ ] Administration/HR Management [ ]  Clinical Practice [ ] Research

[ ] Education [ ] Finance [ ] ADFM Involvement

**Other areas of interest:**

**Do you have someone in mind that you would like to serve as your mentor?** [ ] Yes [ ]  No

If yes, please give us the name and phone number of the person.

1st Choice

 Name       Phone #

2nd Choice (If 1st choice is not available)

 Name       Phone #

**Please indicate any other specific objective (s) you would want to gain from the mentoring relationship.**

[ ] Clarifying your professional goals

[ ] Develop skills that lead to your professional growth, development, and success

[ ] Develop relationships through networking

[ ] Work together to define a plan to accomplish your career goals

[ ] Improve your job effectiveness

[ ] Learn more about ADFM and/or ADFM Committees/Leadership

**Other objectives you have for participating in the program.**

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***Note: Application must be approved and signed by your Department Chair in order to be considered for the program.***

\*Signature of applicant’s supervisor indicates the following:

* You are willing to support this applicant by making time available to meet with his or her Mentor

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Signature of Applicant Signature of Applicant’s Supervisor\*

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Date

**Please return this form to** **adfm@adfm.org**

**with the subject line “Administrators’ Steering Committee”**

 For questions contact Katharine Rebolledo, ADFM Administrator Mentoring Committee Chair krebolledo@salud.unm.edu

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Internal Use Only

Date Application Received:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Application Received by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_