

D.O.C.S. MENTOR REGISTRATION FORM

UMDNJ-SOM D.O.'S COUNSELING STUDENTS (D.O.C.S.) PROGRAM

CONTACT INFORMATION

Today's Date: _____
Name: _____
Home Address: _____ Home County: _____
Home Phone: _____ Cell Phone: _____
E-Mail Address: _____

PRACTICE INFORMATION

Employer Name: _____
Business Address: _____ Business County: _____
Business Phone: _____
Medical Specialty: _____

EDUCATION

Medical School: _____ Year Graduated: _____
Internship Site: _____ Year Graduated: _____
Residency Site: _____ Year Graduated: _____
Residency Type: _____
Fellowship Site: _____ Year Graduated: _____
Fellowship Type: _____

OTHER INFORMATION

Your current status is:

____ Training ____ Practice (# of years ____)
____ Retired

How many students would you be willing to mentor at one time?

____ 1 ____ 1-3 ____ 3-5

Would you be willing to mentor/ advise residents and/or physicians just starting medical practice?

____ Yes ____ No

Please complete both sides of this form.

I give my consent to forward my contact information to the NJAOPS New Physicians in Practice Committee for inclusion in their mentoring program for residents and physicians entering practice.

____ Yes

____ No

Comments *(please specify below other student qualities important to you, considerations for your mentor "match" or any special requests):*

Return completed form to Ms. Liz Cruz in the Office of Alumni and Students Affairs, AC, 214, Stratford, NJ, by fax at 856-566-6714 or by e-mail to torresel@umdnj.edu.