

# D.O.C.S. STUDENT REGISTRATION FORM

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

## CONTACT INFORMATION

Today's Date: \_\_\_\_\_  
Name: \_\_\_\_\_  
Class: \_\_\_\_\_  
*(use class graduation year- 20xx)*  
Address: \_\_\_\_\_ County: \_\_\_\_\_  
E-mail: \_\_\_\_\_ Phone: \_\_\_\_\_

## MENTOR PREFERENCES

Do you prefer that your mentor practice in a specific medical specialty?  Yes  No

If yes, list preferences (i.e. FM, IM, EM, etc.):

1<sup>st</sup> \_\_\_\_\_ 2<sup>nd</sup> \_\_\_\_\_ 3<sup>rd</sup> \_\_\_\_\_

If mentors are not available in the specified medical specialty above, are you interested in being paired with a mentor in another specialty?

Yes  No

Preferred geographical location for your mentor:

Southern New Jersey  Northern New Jersey  No preference  
 Central New Jersey  Philadelphia Area

Years in practice that you prefer the mentor to have:

< 5 Years  5-10 Years  10-20 Years  20+ Years  No preference

Please rank the following list in order of importance in being matched with a mentor (*1 being most important and 4 being least important*).

Specialty/ Field of Practice  Years in practice  
 Location of mentor  Other (i.e. gender, ethnicity, etc.) \_\_\_\_\_

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

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Return completed form to Ms. Liz Cruz in the Office of Alumni and Students Affairs, Academic Center, 214, Stratford, NJ, by fax at 856-566-6714 or by e-mail to [torresel@umdnj.edu](mailto:torresel@umdnj.edu)