The Women in Medicine Medical Student Mentoring Program

To complete this application on your computer, save it to your hard drive, open the downloaded file and email the completed form to: wim.doctors@gmail.com

Or print out and mail to:
Women in Medicine, Inc.
P.O. Box 107
Colchester, VT 05446

First Name: _____

Last Name: _____

Degree(s): _____

Specialty: _____

Preferred Contact Address: *(please select)* ☐ Home ☐ Work

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 of medicine? ☐ Yes ☐ No

If yes, which: _____

Would you prefer a mentor interested in your specific specialty? ☐ Yes ☐ No

Would you like a mentor who lives close to you geographically? ☐ Yes ☐ No

Other preferences?

_____