

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

Name: _____

Degree(s): _____

Specialty: _____

Street Address: _____

Street Address: _____

City: _____ State/Province: _____

Postal Code: _____ Country: _____

Home Phone: _____ Cell 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?
