# RIDHA
# MENTOR APPLICATION

VIRTUAL MENTOR

American Dental Hygienists' Association
Rhode Island

Contact Information:

Name _____

Address _____

City _____

State _____

Zip Code _____

Phone _____

E-mail _____

Professional Role:
Please indicate which area(s) of dental hygiene you're involved in:

_____ Clinical
_____ Research
_____ Education
_____ Advocate
_____ Administration

Please provide your dental hygiene education information:
School Attended_____
Graduation Date _____

Briefly summarize why you are interested in participating in the Virtual Mentor Program:

_____

_____

_____

_____

_____

Agreement and Signature:
By submitting this application, I acknowledge that I have reviewed and agree to abide by the guidelines set forth for participation in the Virtual Mentoring program.
Name (printed)_____

Signature _____

Date_____