**NHF Physical Therapy Mentorship Application - Mentee**

**Application Date: \_\_\_\_\_\_\_\_\_\_\_\_ Notification of Mentor Match: \_\_\_\_\_\_\_\_\_\_\_\_**

Name (Last, First, Middle, Degree) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hemophilia Treatment Center: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Clinic Focus: □ Pediatrics Only □ Adults Only □ Adults and Pediatrics

 **PROFESSIONAL LICENSE**:

|  |  |  |
| --- | --- | --- |
| **Type (PT or PTA)** | **State** | **License #:** |
|  |  |  |
|  |  |  |

 **BLEEDING DISORDERS KNOWLEDGE (check all that apply):**

|  |  |
| --- | --- |
| **Knowledge Self Rating:**  ❏ None ❏ Basic ❏ Intermediate  ❏ Advanced  ❏ Expert | **Knowledge acquired via (check all that apply, briefly describe):**❏ College/University \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_❏ Self-learning \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_❏ Hemophilia Treatment Center \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_❏ Regional Meeting \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_❏ NHF Annual Meeting \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_❏ Partners in Bleeding Disorders Education - Basic❏ Partners in Bleeding Disorders Education - Advanced PT❏ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**LEARNING STYLE:**  Check all that apply

❏ Visual

 ❏ Verbal

 ❏ Kinesthetic

 ❏ Social

 ❏ Individual

 ❏ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**BEST METHOD OF CONTACT**

❏ Email

❏ Virtual

❏ Phone

**CLINICAL EXPERIENCE:**

|  |  |  |
| --- | --- | --- |
| **Type** | **Amount** | **Describe** |
| **Bleeding Disorder Clinical Experience** | ❏ None❏ < 1 yr❏ 1-5 yrs❏ > 5 yrs❏ < 20 hrs/mo❏ > 20 hrs/mo❏ Non-HTC❏ HTC: \_\_\_\_\_\_\_ |  | **Clinical Responsibilities within HTC:** **Non-Clinical HTC Responsibilities:**  |  |
| **Clinical Experience - other than Bleeding Disorders** | ❏ None❏ < 1 yr❏ 1-5 yrs❏ > 5 yrs❏ < 20 hrs/mo❏ > 20 hrs/mo |  |  |  |

**Permission has been granted from HTC to participate in NHF PT Mentorship Program:**

❏ Yes ❏ No ❏ Unsure

Thank you for investing your time and talent into the bleeding disorders community. It is greatly appreciated by those you serve!

 Applicant Signature/Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Return completed application to:**

PTWG Mentorship Committee, Fred Loeffler @ floeffler@IHTC.org or

PTWG Chair, Lora Joyner @ joynerlor16@ecu.edu