**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](mailto:floeffler@IHTC.org) or

PTWG Chair, Lora Joyner @ [joynerlor16@ecu.edu](mailto:joynerlor16@ecu.edu)