SCHOOL OF PHARMACY

Alumni Mentor Program – Application Form**

SECTION 1 — Personal Information

Full Name: _____ **Preferred Name (if different):** _____
Graduation Year (MUSOP): _____ **Email Address:** _____
Phone Number: _____

Mailing Address:_____ **City:** _____ **State:** _____ **ZIP:** _____

SECTION 2 — Professional Information

Current Employer: _____

Job Title/Role: _____

Practice Setting (check all that apply): ☐ Community Pharmacy ☐ Hospital/Health-System ☐ Ambulatory Care ☐ Industry ☐ Academia ☐ Managed Care ☐ Specialty Pharmacy ☐ Other:
_____

Brief Description of Current Role:

Previous Professional Experience (optional):

Professional Certifications/Credentials:

SECTION 3 — Mentorship Preferences

Preferred Student Level: ☐ P1 ☐ P2 ☐ P3 ☐ P4 ☐ No preference

Areas You Feel Comfortable Mentoring In (check all that apply): ☐ Career exploration ☐ Residency preparation ☐ CV/resume review ☐ Interview skills ☐ Networking ☐ Work–life balance ☐ Leadership development ☐ Research/clinical interests ☐ Other: _____

Preferred Communication Method(s) with Mentee: ☐ Email ☐ Phone ☐ Text
☐ Virtual meetings (Zoom/Teams) ☐ In-person (if local)

Preferred Frequency of Contact: ☐ Monthly ☐ Every 6–8 weeks ☐ As needed ☐ Other:
_____

SECTION 4 — Matching Information

Qualities or interests we should consider when pairing you with a student:

Why are you interested in becoming an MUSOP mentor?

Additional information you'd like us to know:

SECTION 5 — Program Agreement

By submitting this application, I acknowledge that:

- I am willing to commit to regular communication with my assigned mentee.
- I will uphold MUSOP's standards of professionalism and respect.
- I understand that the mentoring relationship is voluntary and non-binding.

Signature (typed name): _____

Date: _____

Please return form to Bobbi Madden-Hunt maddenhunt@marshall.edu