

ACAAI Mentor Agreement

I agree to participate in the ACAAI mentor program to allow exchange of professional information with an ACAAI member fellow-in-training or young physician in practice for the following year.

Signature of Mentor

Date

(Please print in completing the form)

Member Name:	First:	Last:	<input type="checkbox"/> Female	<input type="checkbox"/> Male
Address:				
E-Mail:				
Office Phone:				
Office Fax:				
Practice setting	<input type="checkbox"/> Academic setting	<input type="checkbox"/> Clinical Setting		
Geographical	<input type="checkbox"/> Northeastern US	<input type="checkbox"/> Southeastern US	<input type="checkbox"/> Western US	<input type="checkbox"/> Central US
I agree to mentor for 12 months:	<input type="checkbox"/> Female Member(s)	<input type="checkbox"/> Male Member(s)	<input type="checkbox"/> Male or female Members	
Maximum	<input type="checkbox"/> One	<input type="checkbox"/> Two	<input type="checkbox"/> up to ____	

**Return form to ACAAI
Fax: (847) 427-1294**