OFFICE OF STUDENT AFFAIRS
APPLICATION FOR MENTORSHIP PROGRAM

1. Name: ____________________________________________

2. Permanent Mailing Address:
   Street Number and Name __________ City/State __________ Zip Code __________

3. Home Phone: ______ Cell Phone: ______ Medical Graduation: __________

4. Email address: ____________________________________________

5. Race/Ethnicity (Check all that apply):
   □ African American
   □ American Indian or Alaskan Native
   □ Asian
   □ Hispanic or Latino
   □ Native Hawaiian or Other Pacific Islander
   □ White
   □ Other (Please Specify): ______________________________________

6. COLLEGE RECORD
   a. College You Graduated From: ______________________________________
   b. Major: _________________________________________________________
   c. Graduation Year: _______________________________________________

7. AREA OF INTEREST (Check all that apply):
   □ Anesthesiology
   □ Emergency Medicine
   □ Family and Community
   □ Medicine
   □ General Surgery
   □ Geriatrics
   □ Military Residency
   □ OB/GYN
   □ Orthopedics
   □ Pathology
   □ Pediatrics
   □ Psychiatry
   □ Radiology
   □ Urology
   □ Other ________________________________

If you have any questions or concerns please contact the
Assistant Dean of Academic Enhancement

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210.567.4469
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