

# WMP

## WMP Mentee Application

### Personal Information

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Please check: \_\_\_\_\_ Hearing \_\_\_\_\_ Deaf \_\_\_\_\_ Hard of Hearing

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

Email: \_\_\_\_\_ Gender:  Male  Female

Emergency Contact Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

### Education

Interpreter Training Program attended: \_\_\_\_\_

Bachelor's Degree obtained (area of study): \_\_\_\_\_

### Credentials

(Must include written proof along with this application)

WITA \_\_\_\_\_ RID NIC written \_\_\_\_\_ RID CDI written \_\_\_\_\_

### Credential pursuit

(Must include receipt of payment for exams to be taken by the end of 2011)

RID NIC \_\_\_\_\_ RID CDI written \_\_\_\_\_ RID CDI performance \_\_\_\_\_

### Professional Involvement

(Must include proof of membership with this application)

RID \_\_\_\_\_ WisRID \_\_\_\_\_ Other \_\_\_\_\_

### Employment History

Please provide employment information for the past five years, with most recent position held first. If more space is needed use an extra sheet of paper.

Employer:

\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Phone: \_\_\_\_\_

Supervisor's Name: \_\_\_\_\_ Title: \_\_\_\_\_

Dates Employed: \_\_\_\_ to \_\_\_\_ (m/year) Position Held: \_\_\_\_\_  
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Employer:

\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Phone: \_\_\_\_\_

Supervisor's Name: \_\_\_\_\_ Title: \_\_\_\_\_

Dates Employed: \_\_\_\_ to \_\_\_\_ (m/year) Position Held: \_\_\_\_\_  
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### **Application Questions**

Please answer all of the following questions as completely as possible on a separate sheet of paper.

1. Why do you want to be mentored?
2. Do you have any previous experience as a mentee? If so, please specify.
3. What qualities, skills, or other attributes do you feel you have that would benefit the program? Please explain.
4. What is the greatest need within the interpreting community right now?
5. Are you available to meet with a mentor five hours per month and have contact at least once per week? Please explain any particular scheduling issues.
6. How would you describe yourself as a person?
7. How would your friends, family, and co-workers describe you?
8. It is crucial to communicate regularly and openly with mentoring staff, provide monthly information regarding your mentoring activities, and receive feedback regarding any difficulties during your participation in the mentoring program, why?

#### **Wisconsin Mentoring Program**

c/o Office for the Deaf and Hard of Hearing  
1 W Wilson Street, Room 451  
Madison, WI 53703

## Personal References

Please list the names, addresses, and phone numbers of three people you would like to use as character references (only people you have known for at least a year). Include at least one deaf person. Any information Wisconsin Mentoring Program gathers from these references will be held as confidential and not released to you, the applicant.

### Deaf Person's Name:

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Address:

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City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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

Relationship: \_\_\_\_\_ How long known: \_\_\_\_\_

### Name:

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Address:

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City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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

Relationship: \_\_\_\_\_ How long known: \_\_\_\_\_

### Name:

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Address:

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City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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

Relationship: \_\_\_\_\_ How long known: \_\_\_\_\_

### **Wisconsin Mentoring Program**

c/o Office for the Deaf and Hard of Hearing  
1 W Wilson Street, Room 451  
Madison, WI 53703

**Please read this carefully before signing:**

Wisconsin Mentoring Program appreciates your interest in becoming a mentee.

Please initial each of the following:

\_\_\_\_\_ I agree to follow all mentoring program guidelines and understand that any violation will result in suspension and/or termination of the mentoring relationship.

\_\_\_\_\_ I understand that Wisconsin Mentoring Program is not obligated to provide a reason for their decision in accepting or rejecting my application.

\_\_\_\_\_ I authorize the Wisconsin Mentoring Program to obtain any needed information regarding my character references, and employment from my employer and personal references for the purposes of participating in this mentoring program.

Further, I understand that information about me will be anonymously (without my name) shared with program staff and the Advisory Board to aid in determining a suitable match. Once a mentor/ mentee match is determined, my identity and other information known about me may be shared with the mentor to ensure and aid in facilitating a successful match relationship.

\_\_\_\_\_ (optional) I agree to allow Wisconsin Mentoring Program to use any photographic image of me taken while participating in the mentoring program. These images may be used in promotions or other related marketing materials.

I understand I must return this application, proof of payment for the national certification test I wish to take, additional requested proof including that of membership status and the Personal Reference Form. If such information is missing I understand that my application will not be considered:

By signing below, I attest to the truthfulness of all information listed on this application and agree to all the above terms and conditions.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Please send all application materials to:**

**Department of Health Services  
Office for the Deaf and Hard of Hearing  
c/o Wisconsin Mentoring Program  
1 W. Wilson Street, Room 451  
Madison, WI 53703**

