

## ACCREDITATION MENTORING PROGRAM - MENTOR APPLICATION

<b>Name of Organization</b>	
<b>Contact Name</b>	<b>Title</b>
<b>Telephone Number (Include area code)</b>	<b>Email Address</b>
If your agency was a Mentor during the previous Accreditation Mentor Program cycle, are you interested in a match with the same mentee agency?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If you would prefer a difference experience with another mentee agency, do you have any special requests?*	
Date the Public Health Accreditation Board (PHAB) accreditation.	
Please describe what you would like to gain from this mentoring experience:	

\*Note: Due to variables beyond our control, submission of this completed application does not guarantee that the agency will be successfully matched/re-matched with a mentor agency for the upcoming PHHS contract year. We do our best to make appropriate matches in consideration of agency size and staff capacity, accreditation process status, distance between agencies, and specific requests.

Funding for this project was made possible, in part, by the Preventive Health and Health Services Block Grant funded by the Centers for Disease Control and Prevention. The views expressed in written materials or publications and by speakers and moderators, do not reflect the official policies of the Department of Health and Human Services, nor does the mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.