University of Massachusetts Medical School Department of Psychiatry

Adolescent Treatment Programs Worcester Recovery Center and Hospital

Mentorship Program Application

Name:	D.O.B		(M)	(F)
Address:				
No. and Street	City, State, Zip C	Code		
<u>Tel:</u>				
Home	Cell	W	ork	
E-mail:	If enrolled in school, please state school and year:			
School	Year			
Why are you interested in becoming a	a Mentor in this progra	m?		
Leisure and sports interests:				
Experience in Working with Youth:				

Preference: Male:	Female:		
Date: Signat	ture:		
Please return completed application to:	Laura H. Myers, MSW, EdD Director, Parent & Community Engagem		
	Dept of Psychiatry Univ of Mass Medical School Worcester Recovery Center & Hospital 309 Belmont Street		
	Worcester, MA. 01604-1676 Laurah.myers@umassmed.edu (Feel free to call with questions: 508 368 0512)		