

HEALTH SERVICES OFFICER MENTORING PROGRAM
MENTEE FEEDBACK FORM

MENTEE NAME:
MENTEE DUTY PHONE:
MENTOR NAME:
DATE MENTORSHIP:

Please respond to the following questions. Your responses will be kept confidential and will be used in the overall evaluation of the Mentoring Program.

1. Have you communicated with your Mentor? Yes No (if no, go to # 4)
2. Who initiated the first contact? I made the first contact Mentor made the first contact
3. How have you communicated with your Mentor? (Check each of the media that has been used?)
 - Telephone: • E-mail: • Personal Visit: • Other:
4. Why have you not had contact with your Mentor?
 - Waiting for my Mentor to contact me I've tried, but my Mentor has not responded
 - I do not need a Mentor through this Program Other (please explain): _____
5. On the average, how often do you have contact with your Mentor?
 - Initial Contact Only Three or more times per month Once or twice per month
 - Once every three months Less than once every three months
6. Has the Mentoring Program met your needs and/or expectations? Yes No

COMMENTS:

7. Would you be willing to continue with your current Mentor in the Mentoring Program? Yes No
If no, would you be willing to continue in the Program with another Mentor? Yes No
8. What type of Mentor/Mentee relationship would best meet your needs?
 - Contact Initiated by Mentor on a routine basis
 - Contact initiated by Mentee only when advice needed
 - Contact Initiated by Mentee on a routine basis
 - Regular initial contact with future advice related contacts
 - Other (please describe): _____

9. Do you have any additional comments and/or suggestions that will enhance the Health Services Officer Mentoring Program?

COMMENTS:

Please complete and mail, fax, or email to:

LCDR Celia Gabrel

5600 Fishers Lane, Room 7A-55; Rockville, MD 20707; FAX: 301-443-4271; E-mail: cgabrel@hrsa.gov