**MENTOR CONSENT FORM**

I give my permission for the Schulich School of Medicine & Dentistry, University of Western Ontario to include my name, contact information, Academic Role Category, and areas of academic interest on the Mentor Matching Portal located on the Clinical Faculty Affairs website. This password protected portal has been created to enable clinical faculty to search for a clinical faculty mentor by matching Academic Role Category and academic interests to their own.

Pease complete the information below and return it to [kay.hickey@schulich.uwo.ca](mailto:kay.hickey@schulich.uwo.ca)

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DEPARTMENT:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ACADEMIC ROLE CATEGORY (ARC): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AREAS OF ACADEMIC INTEREST:

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOW MANY MENTEES WOULD YOU BE WILLING TO MENTOR: \_\_\_

Thank you.

Laura Foxcroft, MD, CCFP (EM), FCFP

Assistant Dean Faculty Wellbeing, Clinical Faculty Affairs

Schulich School of Medicine & Dentistry

[lfoxcrof@uwo.ca](mailto:lfoxcrof@uwo.ca)