**Mentee Application**

***Prior to your*** ***application review, please answer the questions below.*** The information you provide will help us make a better match for you and your mentor and ensure we can support you during your commitment to our program.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pronouns: \_\_\_\_\_\_\_\_\_\_\_ Gender Identity: \_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State/Province\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code \_\_\_\_\_\_\_ Country\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail:­­­ ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_\_ Birth Date: mm/dd/yy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Applied Before\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact’s Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*If the mentor or staff member cannot reach you within the span of 1 week during the program, staff will contact the person listed above.

***Please answer the following questions as completely as possible. Thank you!***

How did you hear about The Eating Disorder Foundation?

Why do you want to be a mentee? More information about where you are in your recovery journey, what you still need support with, what mentorship looks like to you, what supports are you currently utilizing (and what are you lacking), etc. elps us determine the right mentor for you.

What are your preferred methods of communication (email, phone call, or video call)?

What are your preferred meeting times?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Mornings | Afternoons | Evenings |
| Monday |  |  |  |
| Tuesday |  |  |  |
| Wednesday |  |  |  |
| Thursday |  |  |  |
| Friday |  |  |  |
| Saturday |  |  |  |
| Sunday |  |  |  |

I would like my mentor to be: (circle one)

*About my age 10-20 years of my age Any age*

Do you have a gender preference for your mentor?

Are there any other locations that feel important to be acknowledged in your recovery process (i.e. race, religion, LGBTQ, etc.)?

What interests and activities do you enjoy?

What issues are you struggling with: (circle all that apply)

Restricting Bingeing Purging Over Exercising Body Image

Other (please provide additional information you feel is important for us to know):

Are you struggling with any other mental health issues that you would be willing to discuss with your mentor (i.e. substance abuse, depression)?

Would you like your mentor to know any information about you before your first meeting? If so, what is most helpful for them to know? (Not required, and we will only share what is written below)

Do you sincerely feel you can meet our minimum expectation of spending at least 1 hour per week with your mentor for the duration of the 10-week program?

Within the past five (5) years, have you been convicted of a felony or misdemeanor classified as an offense against a person or family, or are you currently being investigated for the same? If the answer is yes, please explain.

I understand by submitting the information above that this information is subject to verification and that there will be a background check for criminal history as well as a check with appropriate governmental agencies.

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print (Full Legal Name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_**

***If under 18 years of age, please also have a parent or legal guardian sign:***

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Print (Full Legal Name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_**

**Please complete and return to Claire Engels at**

**cengels@eatingdisorderfoundation.org**