



ALUMNI MENTOR PROGRAM APPLICATION

Complete the form below to submit your application. *All fields Required

Background Information

Name: _____
First Name Last Name Middle Name

Email Address: _____ Phone: _____

Which Program did you graduate? **MSAOM** English Korean Chinese Year of Graduation: _____
DAOM English Korean Chinese Year of Graduation: _____

Clinic Information

Business Name: _____

Business Address: _____

Business Phone: _____ Business Website: _____

Type of Ownership: Owner Partnership Employee

How Many Years of Business? _____ How Many Clinics do you operate? _____

Why are considering becoming a Mentor?

What do you like most or find most valuable about your SBU experience?

What resources and support contributed to your success at SBU?

How has your SBU education affected your personal and professional life?

By submitting the form, you consent to SBU using automated technology and/or pre-recorded means to call, text and e-mail you at the information above regarding educational service. You also agree to Our Terms of Use and Privacy Policy.

Signature: _____

Date (MM/DD/YYYY) : ____/____/____