Illinois Association of School Nurses Foundation

REQUEST FOR A PROFESSIONAL LICENSED/ENDORSED SCHOOL NURSE MENTOR

Name: _____ **Credentials:** _____

Address: _____ **Home Phone:** _____ _____ _____
_____ **Cell Phone:** _____ _____ _____
_____ **E-mail:** _____

Educational background:
_____

Years of experience in school nursing: _____ **Years as an endorsed school nurse:** _____

IASN Division _____

Job Title of Current Nursing Position: _____

Employer: _____ **School District #:**_____

Work Address: _____ **Work phone:** _____ _____ _____
_____
_____

Population Served and/or Focus of Practice (grades, populations, special programs): _____
_____
_____
____

Support Desired:

_____ **Information about general school nursing issues**
_____ **Guidance on time management/prioritizing**
_____ **Assistance in locating resources/information for specific situations**
_____ **A listening ear, someone to act as a sounding board**
_____**Other:**_____
_____

Signature: _____ **Date:** _____