Mentor Application Page 1 of 3

Thank you for considering serving as a mentor in the Diabetes Care and Education Specialist Mentorship Program. Please complete this mentor application and mail to CBDCE,
1340 Remington Rd, Suite J, Schaumburg, IL 60173 or fax to 847-228-8469

First Name	Middle Initial	Last Name
Credentials/Discipline (e.g., RN, RD, etc.)		
Institution/Practice Site Name		
Site Address 1		
Site Address 2		
City, State, Zip		
Program Access Restrictions (e.g., Mentees accepted from within institution only)		
Mailing Address (*only if different from above*)		
City, State, Zip		
Daytime phone (w/ area code)	Alternative phone (w/ area code)- *circle* → *mobile home other*	
Fax (w/ area code)	Email address* (*required*) **Please be sure to add @CBDCE.org to your safe senders list to ensure receiving communications from CBDCE.*	
CDCES certificate number (8 digits)	Initial Certification Date (mm/dd/yyyy)	Expiration Date (mm/dd/yyyy)

Please continue to page 2…

Name ____

Mentor Criteria (all must be met at the time of application) – please review the criteria and provide your initials verifying the requirement has been met.

Initials	Criteria
______Yes	I am currently a CDCES.
______Yes	I have held the CDCES credential for at least 3 years.
______Yes	I currently practice as a diabetes educator and provide diabetes education (DE) services.
______Yes	I have other mentoring/preceptor experience. Please provide a description of this experience, including dates. *Provide information on separate sheet of paper if additional space is needed.*
______Yes* ______No**	My practice is currently accredited by the Centers for Medicare and Medicaid Services, e.g., American Diabetes Association's recognition program or American Association of Diabetes Educators accreditation. **For those answering "yes" to the above statement,* please identify the accrediting organization in the space below **and** the date of accreditation. ***For those answering "no" to the above statement review and complete the questions below.***
______Yes** ______Yes** ______Yes** ______Yes** ______Yes** ______Yes** ______Yes**	**Note – this item is only for those whose practice is NOT currently accredited by the Centers for Medicare and Medicaid Services, e.g., American Diabetes Association's recognition program or American Association of Diabetes Educators accreditation. You must be able to respond 'yes' to each of the following questions for the DE offered in your setting and you may be subject to an audit requiring additional materials. Do you: 1. Have a process in place to coordinate educational activities? 2. Include the individual's learning needs and goals? 3. Have a curriculum that guides the education? (appropriate diabetes content areas, learning objectives, methods of instruction delivery and methods for learning evaluation) 4. Document the educational activities? 5. Communicate to the individual's primary care provider and/or the referring provider? 6. Regularly assess the needs of your community and make changes based upon those needs? 7. Regularly evaluate the educational effectiveness and outcomes and are the results used to make changes in the educational activities?

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Name ____

Mentor Criteria (continued) (all must be met at the time of application) – please review the criteria and provide your initials verifying the requirement has been met.

Initials	Criteria
______Yes	I agree to complete and submit appropriate mentor/mentee monitoring documentation by the identified deadlines.
______Yes	I agree that CBDCE may rely on the accuracy of the representations made herein. I agree that CBDCE shall not be responsible for my actions or inactions and/or for the actions or inactions of my organization and/or the mentee. My organization and I are responsible for verifying the credentials/licensure requirements of any mentee. CBDCE is not responsible for verifying the credentials/licensure requirements of any mentee.

I have reviewed the Mentor Application packet, understand the requirements, and attest that our practice/organization has approved the Applicant's participation as a Mentor in the Diabetes Care and Education Specialist Mentorship Program.

Supervisor's Signature________________________________ Date ________________
(must be original)

Print Name _________________________________Title___________________________

Applicant's Signature_____________________________________ Date _____________

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Submit your Mentor application pages 1, 2, and 3 to CBDCE:

Via mail:
CBDCE Mentorship Program
1340 Remington Road, Suite J
Schaumburg, IL 60173

Via fax: 847-228-8469