

HEALTH SERVICES MENTORING PROGRAM MENTORSHIP APPLICATION/AGREEMENT

Protégé _____ Title _____ Program Area _____

To be completed by the Protégé and Supervisor:

By signing below, I am voluntarily entering into a twelve-months formal mentoring program partnership, which Health Services of SC DHEC and I expect to benefit from this learning opportunity. This agreement is not a contract of employment and is no guarantee regarding employment, promotion, or other benefits offered by the agency. It is a work force development strategy, and the provisions are subject to change at any time without notification. I understand that this is an application/agreement for participation in the Mentoring Process within' Health Services. This application/agreement will be used in the screening process to evaluate suitability for the Mentoring Process, after which time notices will be provided regarding eligibility for participation.

Requirements for Participation

Upon entering in this partnership, I agree to:

1. Develop a Mentoring Program Development Plan with my mentor to include specific objectives for the mentoring experience.
2. Devote time (a minimum of 10-12 hours per month) and resources as needed to ensure that the experience is meaningful and beneficial for the protégé, mentor; and (H.S.). As a protégé, I am willing to invest time in myself; willing to learn; willing to accept feedback/constructive criticism; willing to "stretch" beyond my comfort zone; and identify my goals for participating in the program.
3. Ensure that my immediate supervisors are in agreement with my participation in the program and kept abreast of my mentoring schedule during the one-year commitment.
4. Adhere to the confidentiality agreement (Any breach of confidentiality will result in, at a minimum, termination of participation in the program and/or appropriate disciplinary action).
5. Adhere to Health Services Mentoring Program Policy and Procedures.

This agreement remains in effect for twelve months. **However, the agreement may be terminated at any time by either the protégé or mentor. The HS Office of Human Resources, Mentoring Program Coordinator must be notified immediately upon termination of this agreement.**

Signatures:

Protégé: _____

Date: _____

Supervisor: _____

Date: _____

? Approved ? Disapproved * (requires justification)

Date: _____

District Health Director/Assistant Deputy Commissioner/Deputy Commissioner

*Justification for Disapproval: (attach written justification for disapproval)

To be completed by the Protégé - (Use additional paper as needed)

As a result of working with a mentor, I would like to accomplish the following (indicate mentoring preference & professional goals, interest and career path):

Objectives:

Indicate knowledge, skills and abilities that qualify you to work in your area of preference. Attach a copy of your curriculum vitae.

**Send Completed Application/Agreement to: HS Human Resources Office, 1751
Calhoun Street, Columbia, SC 29201**

To be completed by Mentor and Supervisor:

Mentor _____ **Title** _____ **Program Area** _____

By signing below, I agree to the Mentor Requirements for Participation as listed below and understand that my participation in the HS Mentoring Program is not a contract of employment and is no guarantee regarding employment, promotion, or other benefits offered by the agency. It is a work force development strategy, and the provisions are subject to change at any time without notification. I understand that this is an application/agreement for participation in the Mentoring Process within Health Services. This application/agreement will be used in the screening process to evaluate suitability for the Mentoring Process, after which time notices will be provided regarding eligibility for participation.

Mentor Requirements for Participation

Upon entering in this partnership, I agree to:

1. Develop a Mentoring Program Development Plan with my protégé to include specific objectives for the mentoring experience. The work plan must include a tentative schedule for meeting frequencies. Specifics on times and locations can be developed at a later date.
2. Devote time (a minimum of 10-12 hours per month) and resources as needed to ensure that the experience is meaningful and beneficial for the protégé, mentor; and Health Services. As a mentor, I am willing to invest time in myself; willing to learn; willing to accept feedback/constructive criticism; and willing to "stretch" beyond my comfort zone.
3. Ensure that my immediate supervisors are in agreement with my participation in the program and kept abreast of my mentoring schedule during the one-year commitment.
4. Adhere to the confidentiality agreement (Any breach of confidentiality will result in, at a minimum, termination of participation in the program and/or appropriate disciplinary action.
5. Adhere to Health Services Mentoring Program Policy and Procedures.

Signatures:

Protégé: _____ **Date:** _____

Supervisor: _____ **Date:** _____

? Approved ? Disapproved * (requires justification)

(Note: Copies to protégé, mentor, and supervisor)

This agreement remains in effect for twelve months. **However, the agreement may be terminated at any time by either the protégé or mentor. The Mentoring Program Coordinator in the Human Resources Office of Health Services must be notified immediately upon termination of this agreement.**

The S.C. Department of Health and Environmental Control prohibits discrimination or harassment based on race, sex, color, religion, national origin, protected disability and age.