The Pediatric Feeding Institute of South Florida
7301 W. Palmetto Park Rd, Ste 207-A
Boca Raton, FL, 33433
Phone: (561) 571-7557 Fax: (561) 405-9301

Mentorship Application

The mentorship program at **The Pediatric Feeding Institute of South Florida** is designed to facilitate the achievement of specific skills and goals related to the evaluation and treatment of pediatric dysphagia and feeding disorders. The purpose of the Mentorship Program is to provide the therapist ample opportunity to experience success as both a clinician and team member while participating in outpatient and intensive feeding programs. Throughout the Mentorship Program, the mentee will have access to a variety of pediatric dysphagia and feeding disorders cases with the goal of improving his/her clinical skills, self-confidence and advancing his/her professional experiences. Programs will be individualized to fit the needs of the therapist based on experience.

Please feel free to contact us with any questions (561) 571-7557.

Andrea Alifano, MS, CCC-SLP

Taylor Thomas, MA, CCC-SLP

You must submit all items for your application to be considered.

Please mail the following to: **The Pediatric Feeding Institute of South Florida**
7301 W. Palmetto Park Rd., Ste 207A
Boca Raton, FL, 33433

1. Completed Application
2. $50.00 non-refundable application fee (will be deducted from your program tuition)
3. Copy of State Licensure
4. Copy of ASHA card
5. Copy of driver's license
6. Preferred Start Date (please list 3 dates, must start on a Monday and end on a Friday) We will do our best to accommodate your requests for dates.

Name: _____ DOB: _____

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Male / Female Any names previously used: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Current Address: _____

_____

Permanent Address: _____

_____

Educational Background

College	Location	Dates Attended	Major	Degree	Date of Expected Degree

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Work Experience

Employer Name	Location	Position	Full Time Part Time

ASHA Number: _____ State License Number: _____

Clinical Fellow: _____

Liability Insurance: YES NO If yes, please provide the name, policy number and expiration date:

_____

Please list experience with Pediatric Dysphagia and Feeding Disorders, courses taken, internships/externships with dates:

_____
_____
_____
_____
_____
_____

Personal Statement: Why are you interested in pediatric feeding and dysphagia? (500-750 words)

I hereby certify that the information given above and in any attached documents is complete and accurate. I acknowledge that all materials submitted become the property of The Pediatric Feeding Institute of South Florida. Full tuition is due 1 month prior to starting the program. Any cancellations made after that time will result in a refund of 50% of the tuition.

SIGNATURE: _____ DATE: _____

Making Mealtimes More Enjoyable!