WMWO Chamber of Commerce
MENTORSHIP PROGRAM

2024-25
Participant Application

PLEASE COMPLETE AND RETURN THIS FORM TO THE WMWO CHAMBER OF COMMERCE.
A COMPLETED FORM WITH A PARENT/GUARDIAN SIGNATURE IS REQUIRED TO PARTICIPATE IN THE PROGRAM.
ONCE FORM IS SUBMITTED A PHONE INTERVIEW WILL TAKE PLACE WITH CHAMBER STAFF.

ABOUT THE PROGRAM

The West Monroe-West Ouachita Chamber of Commerce is committed to the growth and success of our community and the cultivation of future business leaders. The WMWO Chamber of Commerce Mentorship Program is designed for students to work with an assigned Mentor to assist with developing specific skill sets so they can reach their individual career/educational/vocational goals.

This FREE 6-month program will be hosted through the WMWO Chamber of Commerce; however, the locations of the meetings will vary dependent upon Mentors. To participate, students (entering grades 9-12) must complete and return this form to the West Monroe-West Ouachita Chamber of Commerce office.

PERSONAL DATA

Name: _____ Age: _____
Last *First*

Address: _____ School: _____ Entering Grade: _____

Phone: ( ) _____ Student Email: _____

Emergency Contact: _____
Name *Relationship*

_____
Phone Number *Parent Email*

Please complete and return form to:
WMWO Chamber of Commerce
112 Professional Drive
West Monroe, Louisiana 71291

For more information, please contact the Chamber of Commerce at (318) 325-1961 or info@westmonroechamber.org

Parent and Student must read, initial, and sign the second page of this application.

STUDENT AGREEMENT

Please read carefully. Each item must be read and initialed by student and parent, and the agreement must be signed. *For the purpose of this agreement, West Monroe-West Ouachita Chamber is otherwise known as WMWOC.*

I understand that I am participating in this program voluntarily and in consideration of the acceptance of my application for this program:

Initial Here	
	I hereby waive, release, and discharge any, and all claims for damages for personal injury, property damages, or which may hereafter occur to me as a result of participation in said event.
	I agree to be fully present for each of the mentoring sessions whether in-person or virtual of the program.
	I agree to act in a professional manner and abide by the rules, regulations, policies, and procedures of the facility.
	I agree to dress appropriately as described by my school dress code (no shorts, tanks, camisoles, or hats in meetings with my mentor).

Student Signature _____ Initial _____ Date _____

PARENTAL CONSENT

Your son or daughter is applying to participate in a 6-month long mentorship program. He or she will participate in a variety of professional settings with his or her assigned mentor, where they will learn key strategies for becoming a business leader in today's business climate. ***Please read carefully. Each item must be read and initialed by the parent, and the application must be signed.***

Initial Here	
	My child has permission to participate in the WMWO Chamber of Commerce Mentorship Program, and I hereby waive, release, and discharge any, and all claims for damages for personal injury, property damages, or which may hereafter occur to me or my child as a result of participation in said event.
	My child's information form can be shared with staff of WMWOC for purposes of participation in the program, and I grant the program organizers and sponsors of the program, permission to photograph/video my son/daughter for promotional and educational purposes, including but not limited to press releases, future marketing, use on social media and intranet sites, and use in other materials that the program organizers and may use internally or externally to promote the program and/or program sponsors. I understand there is no monetary compensation for using said photographs/videos.
	I hereby give my consent for treatment by emergency personnel, a physician, or surgeon, in case of sudden illness or injury while participating in the above-mentioned program. It is understood that WMWOC will provide no medical insurance for such treatment, and the cost thereof will be at my expense.

Does your child require any special accommodations due to medical limitations, disability, dietary constraints, allergies—food or other, physical limitations, or other restrictions?

☐ NO ☐ YES--If yes, please explain:

I attest that I am the legal parent/guardian of the child, and as such permitted to sign this consent and release form.

Printed Name of Parent/Guardian _____ ( ) _____ Best Contact Number

Parent/Guardian Signature _____ Date _____