MENTORSHIP PROGRAM

FIRST NAME: _____

LAST NAME: _____

ADDRESS: _____

CITY & STATE: _____ POSTCODE: _____

COUNTRY: _____

E-MAIL: _____

TELEPHONE(S): _____

I wish to participate in the MENTORSHIP Program and agree to pay €90.00/$90.00 per six consecutive months for this service. I understand that all my information will be confidential and not available to anyone unless otherwise requested and agreed.

Agreed:

_____Date: _____