|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| First Name: | Middle Initial: | Last Name: | | | | |
| Current Address: | | City: | State: | | Zip Code: | |
| Phone Number: | | Email Address: | | | | |
| Ethnicity (Select all that apply):  American Indian/Alaska Native  Asian  Black/African American  Hispanic or Latino  White  Native Hawaiian/Other Pacific Islander  Please specify, if applicable: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Gender:  Male Female | | Date of Birth:  \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ | | |
| Current Academic Enrollment  School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  School Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Degree Program:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Expected Graduation Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| Discipline (Select all that apply):  Allopathic Medicine  Chiropractic  Osteopathic General Practice  Clinical Lab Worker  Optometry  Pharmacy  Podiatry  Psychiatry  Health Education/Behavior  Health Services/Hospital Administration  Nutrition/Dietetics  Public Health  Veterinary Medicine  Physician Assistant  Licensed Practical/Vocational Nurse  Nurse Midwife  Nurse Practitioner  Registered Nurse  EMT-Paramedic  Health Information Systems  Occupational Therapy  Physical Therapy  Dental Assistant  Dental Hygiene  General Dentistry  Clinical Psychology  Clinical Social Work  Substance Abuse/Addictions Counseling  Other  *Please specify:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Type of Student (Select one):  Fellow  Intern  Resident  Student – Dental  Student – Graduate Health Professions  Student – Medical School  Student – Nursing School  Student – Pre-Health Professions  Student – Undergraduate Health Professions  Student – Occupational/Environmental Science | | Specialty (Select all that apply):  Dermatology  Otolaryngology (ENT)  Family Practice - Family Med  Family Practice - (CAM)  Internal Medicine  *Please specify:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Med / Peds  Neurology  OB / GYN  Ophthalmology  Orthopedics  Pediatrics  *Please specify:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Public Health  Psychiatry  Surgery  *Please specify:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other  *Please specify:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| Can you answer “yes” to any of the following?:  Yes No  ▪You are (or will be) the first generation in your family to attend college  ▪You have or currently do receive scholarships or loans for Disadvantaged Students  ▪While growing up, you or your family used federal or state assistance programs (such as: free or reduced school lunch, subsidized housing, food stamps, Medicaid, etc.)  ▪While growing up, you lived where there were few medical providers at a convenient distance.  Undergraduate College Attended: | | | | |
| Undergraduate Major: | | | | |
| Hometown at time of high school graduation: | | | | |
| Is your hometown considered a rural area?  Yes No | | | | |
| Education Level Already Achieved (Select all that apply):  High School Diploma  Certification (Ex. Phlebotomy Tech, EMT)  *Please specify:*\_\_\_\_\_­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Associates (Ex. AS, AA)  *Please specify:*\_\_\_\_\_­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Bachelors (Ex. BA, BSN)  *Please specify:*\_\_\_\_\_­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Masters (Ex. MS, MPH)  *Please specify:*\_\_\_\_\_­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Doctorate (Ex. MD, PharmD)  *Please specify:*\_\_\_\_\_­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Are you fluent in any other languages?:  1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Speak Read Write  2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Speak Read Write | | | | |
| Veteran Status (Select one):  Active Duty Military  Reservist  Veteran (Prior Service)  Veteran (Retired)  Not a Veteran | | | | |
| What type of community would you like to ultimately practice in (Select all that apply):  Border Area  Inner City  Rural  Suburban  Urban  Other  *Please specify:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| Did you obtain a National Health Service Corp Scholarship or Nurse Corps Scholarship?  Yes No No, but interested | | Do you want to sign up for our newsletter (contains information about scholarships, loan repayment programs, free CEUs, etc.)?  Yes No | | | | |
| Description (Tell us a few words about yourself): | | | | | | |
| Description of Rotation (Ex. Family Medicine, Pediatrics): | | Rotation Hours: | | | | |
| Assistance Request Type:  Travel Housing | | | | |
| Rotation Dates:  Start: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ End: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ | | | | | | |
| Clinical Site Information  *Must Collect Details from Preceptor* | | | | | | |
| Clincial Site: | | Preceptor Name/Credentials: | | | | |
| Site Address: | | City: | State: | | | Zip Code: |
| Site Phone Number: | | Preceptor Email Address: | | | | |
| Medical/Professional School Name: | | Board Eligible?:  Yes No | | | | |
| Board Certified?:  Yes No | | | | |
| Do you have any student preferences and/or requirements?: | | Do you want to sign up for our newsletter (contains AHEC updates, free CEUs, etc.)?  Yes No | | | | |
| Office Manager Name/Credentials: | | | | |
| Office Manager Phone Number: | | | | |
| Office Manager Email: | | | | |

*Information for this form is provided voluntarily. AHEC is required to report information about program participants. Data will be kept private to the extent allowed by law and will be referenced periodically to evaluate the effectiveness of AHEC services and programs. We appreciate your cooperation in the completion of this form. Please type or print clearly.*

*Registered Center:* Southern Alabama AHEC *| Program Coordinator:* Sydney K. Harper, MS, CHES