

Statewide AHEC Network Student Data Form

Social Security Number:	Last Name:	First Name:	Gender: M / F	Birth Date:	Birth State: Birth County:
Current Address:			Next of kin/Relationship (Father, husband, wife, etc.)		
City:	State:	Zip:	Permanent Address:		
Cell Phone:	Home Phone:	City:	State:	Zip:	
Email:		County:		Phone Number:	
School:	Degree Program Name:	Graduation month/year:	NHSC Scholar? YES NO	Ethnicity: AA C A H Other	
School contact:	Contact Phone:	Email:			
Rotation Information:					
Begin date:		End date:		# Days at site:	#Clinical training hours
Signature of Student _____				Date _____	
AHEC USE ONLY:	Preceptor Last Name, First Name:		Student type:	Specialty:	
Rotation County:	Preceptor Site Name (<i>company</i>):		MD DO NP PA	Anes ER Fam IMOP	
Rural / Urban	Address (<i>street address, city, state, zip</i>):		RN PT OT SP	IMIP OBG Peds Psych	
Accept Medicaid? Y N	Phone:		CNM RT PharmD	Surg Rehab Other	
HPSA / MUA	Email:		Pharm		
NHSC Preceptor					
NHSC Site					
CHC MHC RHC Public Health Dept Hospital Private Ind. or Group Other_____	Additional information:	AHEC Support Provided: Travel Housing Placement Other Guide		Housing & Travel: Community \$ _____ AHEC \$ _____ Travel \$ _____	
Date Received:	Approved:		Comments:		

You have recently completed, or will complete, a clinical rotation. Based on this experience, would you consider practicing in a medically-underserved (including urban) or rural community after your graduation? Please circle one:

Definitely Would Probably Would Probably Would not Definitely Would Not

