



STUDENT PROFILE AND SUPPORT FORM

Last Name: _____		First Name: _____		Gender: M / F	Birth Date: _____	Birth State: County: _____	
Current Mailing Address: _____				Next of kin (dad, sister, etc.): _____			
City: _____		State: _____		Zip: _____		Permanent Address: _____	
Cell Phone: _____		Home Phone: _____		City: _____		State: _____ Zip: _____	
Email while enrolled: _____				County: _____		Phone Number: _____	
Email after graduation: _____							
School: _____		Degree Program Name: _____		Graduation month/year: _____	NHSC Scholar? YES NO		Student Ethnicity: AA / Alask / Asian / Amer In / Cauc / Hisp / Pac Is / Other
Have you been determined to be from a disadvantaged background and/or have you demonstrated financial need? YES NO							
School contact: _____		Contact Phone: _____		Email: _____			
Would you consider working in a rural or medically underserved area? Yes _____ No _____							
Rotation Information:							
Begin date: _____		End Date: _____		# Days at Site: _____		# Clinical Training Hours: _____	
Preceptor Information: Last Name, First Name: _____		Preceptor Title: CNM CRNA DDS DMD DO MD NP OT PA PharmD PT RN RT SP Other _____		Preceptor Specialty: Anes ER Fam Int Neuro OBG Peds Pharm Psy Surg Other _____		Preceptor Ethnicity: AA Alask Asian Amer In Cauc Hisp Pacific Is Other _____	
Gender: M__ F__							
Preceptor Site Name (company): _____							
Address: _____							
Street: _____				Phone: _____			
City: _____ Zip Code: _____				Fax: _____			
County: _____				Email: _____			
AHEC USE ONLY	<u>Support Provided:</u>			Housing Location: _____			
	Travel		Housing		Community \$ _____		
	Placement		Ovid / CINAHL		AHEC \$ _____		
	Other		Guide		Total Amount \$ _____		

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