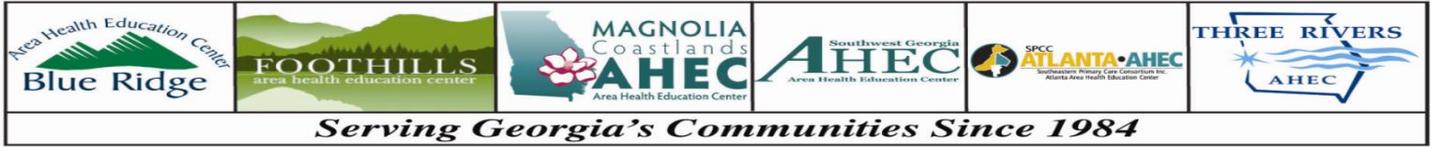




GEORGIA STATEWIDE AHEC NETWORK STUDENT PROFILE & SUPPORT FORM

This form must be received by the appropriate AHEC office before support can be granted



Serving Georgia's Communities Since 1984

P: 706-235-0776 | P: 770-219-8130 | P: 912-478-1050 | P: 229-439-7185 | P: 404-815-4996 | P: 706-507-0894
F: 706-378-3113 | F: 770-533-9893 | F: 912-478-0816 | F: 229-888-5154 | F: 404-815-4998 | F: 706-507-0896

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
First Name	Middle Name (Initial)	Last Name	Maiden / Previous Name	Nick Name
<input type="text"/>	<input type="text"/>	<input type="text"/>		
Birth Date	Birth County	Birth State		
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
AA/ Alask/ Asian/ Amer In/ Cauc / Hisp / Pac Is / Other/ More than 1 race	Gender: M / F	Speak Spanish Y / N	NHSC Scholar Y / N	Cell Phone Home Phone
Email while enrolled:	<input type="text"/>	Email after graduation:	<input type="text"/>	

Current Mailing Address:	Permanent or Next of Kin Address:
Street: _____	Street: _____
City: _____	City: _____
State: _____	State: _____
Zip: _____	Zip: _____
County: _____	County: _____

Next of Kin _____	Next of Kin Relationship _____	Next of Kin Phone _____
-------------------	--------------------------------	-------------------------

Have you been determined to be from a disadvantaged background and/or have you demonstrated financial need? Yes / No

School: _____	Grad Date: _____	Program: _____
Contact: _____	Phone: _____	Email: _____

Survey: Please answer accordingly:
 SA = Strongly Agree
 A = Agree
 SW = Somewhat Agree
 D = Disagree
 SD = Strongly Disagree

_____ I intend to work / practice / serve in a rural setting.
 _____ I intend to work / practice / serve in a setting that serves the medically underserved.
 _____ I intend to work / practice / serve in a primary care setting.

Rotation Information:
 Begin Date _____ End Date _____ Days at Site _____ Clinical Training Hours _____

Preceptor Information:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
First Name	Last Name	Preceptor Title	Preceptor Specialty	Ethnicity
	<input type="text"/>	CNM CRNA DDS DMD DO MD NP OT PA PharmD PT RN RT SP Other_____	Anes Den ER Fam Int Neuro OBG Peds Pharm Psy Surg Other_____	AA / Alask/ Asian/ Amer In / Cauc / Hisp / Pac Is / Other/ More than 1 race

Preceptor Site Name (company): _____

Street Address: _____ Email: _____

City / Zip _____ Phone: _____

County: _____ Fax: _____

AHEC Credentialing Notes

AHEC USE ONLY	Support Provided:	Housing Location
	Travel _____	Housing Type _____
	Placement _____	Amount _____
	Other _____	Bill To: _____