

Georgia Statewide AHEC Network Student Profile & 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:		County:		Phone Number:
School:	Degree Program Name:		Graduation month/year:	NHSC Scholar? YES NO
School contact:		Contact Phone:	Email:	
<p>Would you consider working in a rural or medically underserved area?</p> <p style="text-align: center;">Yes _____ No _____</p>				

Rotation Information:

Begin date: _____ **End Date:** _____ **# Days at Site:** _____ **# Clinical Training Hours:** _____

Signature of Student _____ **Date** _____

Preceptor Information:

Last Name, First Name:

Title:	Specialty:
CNM CRNA DO	Anes ER Fam
MD NP OT PA	Int Neuro OBG
PharmD PT RN	Peds Pharm Psy
RT SP	Surg
Other _____	Other _____

Preceptor Site Name (*company*):

Address (*street address, city, state, zip*):

Phone: _____ Fax: _____ Email: _____

AHEC USE ONLY	Support Provided:	Travel	Housing	Housing:
		Placement	OVID	Community \$ _____
		Other	Guide	AHEC \$ _____
	Traveled From:	Traveled To:		Total Round Trip Miles:
Date Received:	Approved:		Comments:	
Date Paid:	Check Number:		Total Amount:	

