



Please complete this form and return it to the AHEC office located in the Instructional B-Bldg. Room 225 . If you have any questions, please call 852-2759.

Student Information

1. Name: \_\_\_\_\_  
E-mail: \_\_\_\_\_  
Student # \_\_\_\_\_

9. Home Phone #: \_\_\_\_\_  
Cell Phone #: \_\_\_\_\_

2. Last Four Digits of SS# \_\_\_\_\_ DOB \_\_\_/\_\_\_/\_\_\_

3. Check one:  Male  Female

4. Check one:  Single  Married

5. Number of Children \_\_\_\_\_

10. **Please check which applies to you:**

3rd Yr. Med.  4th Yr. Med.

4th Yr. Dental  4th Yr. Dental Hygiene

Resident - Residency Program: \_\_\_\_\_  
PGY (program year) \_\_\_\_\_

6. Ethnicity:  Hispanic  Non-Hispanic

7. Race: (Select all that apply)

African American / Black

Amer. Indian/ Alaskan Native

Asian (Chinese, Filipino, Japanese, Korean, Asian Indian, or Thai)

Asian (Other)

Native Hawaiian / Other Pacific Islander

White Disadvantaged (educationally or economically)

White Non-disadvantaged

11. Graduation date (Month & Year) or completion of residency. \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

12. Family residence at time of High School

City: \_\_\_\_\_ County: \_\_\_\_\_

State: \_\_\_\_\_ Zip \_\_\_\_\_

8. Current Address:

Street: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

13. **Approx. Population of #12 Above**

Under 1,000  50,000 - 99,999

1,000 - 24,999  100,000 & above

25,000 - 49,999

AHEC ROTATION INFORMATION

List Below your Requested AHEC Region Rotation Site along with two alternative choices: Every effort will be made to accommodate student's first choices when possible.

AHEC Regions are:  
North Central, Northeast, Northwest,  
Purchase, South Central, Southeast,  
Southern, & West

1st Choice: \_\_\_\_\_

2nd Choice: \_\_\_\_\_

3rd Choice: \_\_\_\_\_

Date of Rotation:

From: \_\_\_\_\_ to: \_\_\_\_\_  
(mm/dd/yy) (mm/dd/yy)

Discipline of Rotation: \_\_\_\_\_ Required or   Elective

Number of Weeks: \_\_\_\_\_

Name of Preceptor: *(Will be filled out by AHEC staff when assigned)* \_\_\_\_\_

Hospital / Clinic Name: \_\_\_\_\_

City of Rotation: \_\_\_\_\_ County: \_\_\_\_\_

Signature of UofL Departmental Coordinator: \_\_\_\_\_

Housing Arrangements (Check all that apply):

A:  I want AHEC to help arrange housing B:  I will arrange my own housing C:  I will need AHEC rent Supplement

D:  I will stay with family or friends E:  I will commute (no travel \$)

\*Please list any special housing needs: Allergies, wheelchair access, etc.

If you check Box B and/or D, please provide an address and phone number where you can be reached while on rotation.

Street address: \_\_\_\_\_ City/Town \_\_\_\_\_ Phone# ( ) \_\_\_\_\_

Answer the following:

What is your Veteran Status?:  Not A Veteran  Active Duty Military  Reservist  Veteran- Prior Service  Veteran- Retired

What is your Post Graduation Intent: (Choose one)

I intend to become employed or pursue further training in a primary care setting

I intend to become employed or pursue further training in a rural setting

I intend to become employed or pursue further training in a medically underserved community

None of the Above  Not Applicable (N/A)

Please Date Fact Sheet:

DATE: \_\_\_\_\_

Student Signature