



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 # \_\_\_\_\_  
2. Last Four Digits of SS# \_\_\_\_\_ DOB \_\_\_/\_\_\_/\_\_\_  
3. Check one:  Male  Female  
4. Check one:  Single  Married  
5. Number of Children \_\_\_\_\_  
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  
8. Current Address:  
Street: \_\_\_\_\_  
City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

9. Home Phone #: \_\_\_\_\_  
Cell Phone #: \_\_\_\_\_  
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) \_\_\_\_\_  
11. Graduation date (Month & Year) or completion of residency. \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
12. Family residence at time of High School  
City: \_\_\_\_\_ County: \_\_\_\_\_  
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