HEALTH PROFESSION STUDENT INFORMATION FORM

Name: _____
First ***Last***

Phone: _____ _____
(current home) (cell)

Permanent Address:_____ _____
(street address) (city) (state) (zip)

Email address: _____

Emergency contact information: ***What relationship does this person have with you?***

_____ _____ _____
(first and last name) phone number(s)

Last four digits of your social security number: ___ ___ ___ ___

Your date of birth: _____/_____/_____
month day year

Please circle the appropriate information:

University you are attending: Clemson / Francis Marion / MUSC / SCSU / USC / Other_____

Gender: male female ***Current year of training***: undergrad - JR or SR / postgrad- 1 2 3 4

Race: *(federal reporting)*
American Indian or Alaska Native
Asian
Black or African American
Hispanic or Latino
Native Hawaiian or Other Pacific Islander

Underrepresented
Asian (not Chinese, Fillip, Japan, Korean, AsLnd or Thai)
White: disadvantaged
White: non-disadvantaged

Circle Discipline:
OT
RN or LPN
APN/CNS
Public Health
Social Work
Medicine
PA
Pharmacy
PT
Speech pathology
Health Administration
Dental
Other

Name of your preceptor: _____
(first) (last) (credential)

Name of rotation site: _____

Date of rotation: _____ _____ ***Course Number for rotation***: _____
(begin) (end)

Did Upstate AHEC provide housing for you during this rotation? YES / NO

If you circled yes, please indicate which location and for how many weeks…

Seneca House Greenwood Residency House Anderson Residency House GHS Residency Housing

Hospitality Inn Belmont Inn other:_____ # of weeks _____

Please indicate your Upstate AHEC coordinator: Cynthia Gilster Nancie Stover