

# HCP PRACTICING PROFESSIONAL'S FORM

Health Careers Program

Your 8 digit Participant Identification number is made up of: 2 digits of your birth month (01-12), 2 digits of your birth day (01-31), and the last four digits of your Social Security Number. This identifier protects your personal information in our database and allows us to provide you credit for this course.

Example: the **Participant ID** for someone born 11/21/1989 with the SSN 123-45-6666 would be: 11/21/6666

**Participant ID**    \_\_\_ \_\_\_ / \_\_\_ \_\_\_ / \_\_\_ \_\_\_ \_\_\_ \_\_\_

**Last Name:** \_\_\_\_\_ **First Name:** \_\_\_\_\_

**Maiden Name:** \_\_\_\_\_ **Birth Date:** \_\_\_\_\_

**Job Title:** \_\_\_\_\_ **Credentials:** \_\_\_\_\_

**Perm Address:** \_\_\_\_\_

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

**County:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_

**Race** (check one)

- |  |   |
|--|---|
| <input type="checkbox"/> American Indian or Alaskan Native         | <input type="checkbox"/> Asian              |
| <input type="checkbox"/> Black or African American                 | <input type="checkbox"/> Hispanic or Latino |
| <input type="checkbox"/> Native Hawaiian or Other Pacific Islander | <input type="checkbox"/> White              |
| <input type="checkbox"/> More than One Race                        |   |

**Gender:** (circle one)    Male    Female

**Current Employer's Name:** \_\_\_\_\_

**Current Employer Address:** \_\_\_\_\_

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

**County:** \_\_\_\_\_ **Office Phone:** \_\_\_\_\_

**Current Employer's Type:** (circle one)

- |   |   |
|---|---|
| <input type="checkbox"/> AHEC Urban Community Based Training Site     | <input type="checkbox"/> Long Term Care Facility                  |
| <input type="checkbox"/> Other AHEC Community Based Training Site     | <input type="checkbox"/> Migrant Health Center (MHC)              |
| <input type="checkbox"/> Community Health Center (CHC)                | <input type="checkbox"/> National Health Service Corp (NHSC) Area |
| <input type="checkbox"/> Emergency Medical Service                    | <input type="checkbox"/> Public Housing Primary Care Grantee      |
| <input type="checkbox"/> Health Care for the Homeless                 | <input type="checkbox"/> Rural Health Clinic                      |
| <input type="checkbox"/> Health Department                            | <input type="checkbox"/> University/College                       |
| <input type="checkbox"/> Hospital                                     | <input type="checkbox"/> Other (Please Specify)                   |
| <input type="checkbox"/> Indian Health Service (IHS) or tribal health | _____   |

**PLEASE HELP US BY EVALUATING OUR SERVICES**

**On a scale of 1 to 5 (5 being best) how would you rate SC AHEC in each of the following categories? (Circle one)**

<b>Influenced My Decision to Enter A Health Profession</b>	1	2	3	4	5
<b>Provided Academic Information And Guidance</b>	1	2	3	4	5
<b>Expanded My Knowledge of Health Careers</b>	1	2	3	4	5
<b>Broadened My Educational Options</b>	1	2	3	4	5
<b>Provided Information To Assist in My College Selection</b>	1	2	3	4	5

**Would You Recommend The HCP Program?** (circle one)    Yes    No    Uncertain

**Are You Interested in Serving As A Speaker Or Mentor?** (circle one)    Yes    No    Uncertain

**Comments:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**My Comments May Be Used By South Carolina AHEC For Promotional Purposes**    [ ] Yes    [ ] No

**Signature:** \_\_\_\_\_