# GEORGIA STATEWIDE AHEC NETWORK STUDENT PROFILE & SUPPORT FORM

This form must be received by the appropriate AHEC office before support can be granted

Area Health Education Center Blue Ridge | FOOTHILLS area health education center | MAGNOLIA Coastlands AHEC Area Health Education Center | Southwest Georgia AHEC Area Health Education Center | SPCC ATLANTA•AHEC | THREE RIVERS AHEC

*Serving Georgia's Communities Since 1984*

P: 706-235-0776 | P: 770-219-8130 | P: 912-478-1050 | P: 229-439-7185 | P: 404-815-4996 | P: 706-507-0894
F: 706-378-3113 | F: 770-533-9893 | F: 912-478-0816 | F: 229-888-5154 | F: 404-815-4998 | F: 706-507-0896

First Name | Middle Name (Initial) | Last Name | Maiden / Previous Name | Nick Name

Birth Date | Birth County | Birth State

AA/ Alask/ Asian/ Amer In/ Cauc / Hisp / Pac Is / Other/ More than 1 race | Gender: M / F . | Speak Spanish Y / N | NHSC Scholar Y / N | Cell Phone | Home Phone

Email while enrolled: | Email after graduation:

**Current Mailing Address:**
Street:
City:
State:
Zip:
County:

**Permanent or Next of Kin Address:**
Street:
City:
State:
Zip:
County:

Next of Kin | Next of Kin Relationship | Next of Kin Phone

Have you been determined to be from a disadvantaged background and/or have you demonstrated financial need? Yes / No

School: | Grad Date: | Program:
Contact: | Phone: | Email:

**Survey:** Please answer accordingly:

SA = Strongly Agree
A = Agree
SW= Somewhat Agree
D = Disagree
SD= Strongly Disagree

_____ I intend to work / practice / serve in a rural setting.
_____ I intend to work / practice / serve in a setting that serves the medically underserved.
_____ I intend to work / practice / serve in a primary care setting.

**Rotation Information:**

Begin Date _____ End Date _____ Days at Site _____ Clinical Training Hours _____

**Preceptor Information:**

First Name | Last Name | Preceptor Title | Preceptor Specialty | Ethnicity

Gender: M / F

Preceptor Title: CNM CRNA DDS DMD DO MD NP OT PA PharmD PT RN RT SP Other____

Preceptor Specialty: Anes Den ER Fam Int Neuro OBG Peds Pharm Psy Surg Other_____

Ethnicity: AA / Alask/ Asian/ Amer In / Cauc / Hisp / Pac Is / Other/ More than 1 race

Preceptor Site Name (company):
Street Address: | Email:
City / Zip | Phone:
County: | Fax:

AHEC Credentialing Notes

**AHEC USE ONLY**

Support Provided:
Travel _____ Housing ___
Placement ___ Guide ___
Other ___

Housing Location
Housing Type
Amount
Bill To: