EAST TEXAS AREA HEALTH EDUCATION CENTERS

B100

Resident/Student Data Worksheet

Today's Date: AHEC Center

Information for this form is provided voluntarily. East Texas AHEC is required to report information about program participants. This data will be confidentially maintained and will be referenced periodically to evaluate the effectiveness of AHEC services and programs. We appreciate your cooperation in the completion of this form. Please type or print clearly.

☐ Dr. ☐ Miss ☐ Mr. ☐ Ms. ☐ Mrs.	Last Name	First	M.I.	Sex ☐ M ☐ F	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated	Date of Birth

Current Address	City	State	ZIP Code	Current Phone No. ( )	Cell Phone No. ( )
Permanent Address	**City**	**State**	**ZIP Code**	**Permanent Phone No.** ( )	**Pager/Other Phone No.** ( )

Last 4 digits of Social Security No.	Email Address	Number of dependents currently living with you *(not including spouse/mate)*

Education Level (already achieved)

☐ BA ☐ BE ☐ BFA ☐ BS ☐ BSN ☐ DO ☐ EdD ☐ MA ☐ MBA ☐ MD ☐ Med ☐ MPA ☐ MPH ☐ MS ☐ MSN ☐ MSW ☐ PHD ☐ ____

Ethnicity (select one)

☐ African American / Black
☐ American Indian/Alaskan Native
☐ Native Hawaiian/Other Pacific Islander
☐ White Disadvantaged
☐ White Non-Disadvantaged)

Hispanic
☐ Central American ☐ Cuban ☐ Mexican ☐ Puerto Rican ☐ South American ☐ Other ____

Asian
☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Other ____

☐ More than one race (specify) Primary _____ Secondary _____

Institution Enrolled	Institution Address	Course Director Name	Office Phone No. ( )

Hometown at time of high school graduation (City/State)	College Attended (include City/State)	Undergraduate Major

Is your hometown considered (select all that apply)

☐ Border Area ☐ Rural ☐ Inner City ☐ Suburban ☐ Urban

Are you fluent in any other Languages? (please specify)

1. _____ ☐ Speak ☐ Read ☐ Write
2. _____ ☐ Speak ☐ Read ☐ Write

People Type (select one)

☐ Fellow ☐ Intern ☐ Other ____
☐ Resident ☐ Student, Graduate Health Professions Program ☐ Student, Medical School
☐ Student, Nursing School ☐ Student, Pre-Health Professions College ☐ Student, Undergraduate Health Professions Program

Discipline (select one)

☐ Assistants - Healthcare
☐ Chiropractic
☐ Clinical Lab Services
☐ Clinical Psychology
☐ Community Health / Lay Health Worker
☐ Dental Hygienist
☐ Dental Public Health
☐ Dentistry
☐ Food and Nutrition Services
☐ Health Administration
☐ Health Information/Education
☐ Medicine-Allopathic
☐ Medicine-Osteopathic
☐ Mental Health
☐ Nurse Anesthetist
☐ Nurse Midwives
☐ Nurse Practitioner
☐ Nursing–Other Advanced Practice
☐ Nursing–Undergraduate
☐ Other ____
☐ Pharmacy
☐ Physician Assistant
☐ Podiatric Med. – Primary Care
☐ Preventive Medicine
☐ Public Health
☐ Rehabilitation
☐ Social Work
☐ Technicians & Technologists

Specialty (select one)

☐ Dermatology
☐ Family Practice-Family Medicine
☐ Family Practice-(CAM)
☐ Internal Medicine-Allergy
☐ Internal Medicine–Cardiology
☐ Internal Medicine-Endocrinology
☐ Internal Medicine-Gastroenterology
☐ Internal Medicine-General
☐ Internal Medicine-Geriatrics
☐ Internal Medicine–Hematology/ Oncology
☐ Internal Medicine–Infectious Disease
☐ Internal Medicine-Nephrology
☐ Internal Medicine-Pulmonary
☐ Internal Medicine–Rheumatology
☐ Med / Peds
☐ Neurology
☐ OB / Gyn
☐ Ophthalmology
☐ Orthopedics
☐ Otolaryngology
☐ Pediatrics-Allergy
☐ Pediatrics-Cardiology
☐ Pediatrics-Endocrinology
☐ Pediatrics-Gastroenterology
☐ Pediatrics-General
☐ Pediatrics-Genetics
☐ Pediatrics-Hematology/Oncology
☐ Pediatrics-Infectious Disease
☐ Pediatrics-Neonatology
☐ Pediatrics-Nephrology
☐ Pediatrics-Pulmonary
☐ Pediatrics-Rheumatology
☐ Psychiatry
☐ Public Health
☐ Surgery-Cardiothoracic Surgery
☐ Surgery-Oral & Maxillofacial
☐ Surgery-Urology

Did you obtain a NHSC (National Health Service Corp.) Scholarship?	What type of community would you like to locate for ultimate practice? (select all that apply)	List any services that you are requesting from AHEC	Name any hobbies, special interests or other forms of recreation that you enjoy.
☐ Yes ☐ No, but interested ☐ No	☐ Border Area ☐ Rural ☐ Texas ☐ Inner City ☐ Suburban ☐ Urban		

ROTATION INFORMATION (Must be completed in it's entirety)

Student Name	Total Combined Hours

B200 and B300 should be completed if NEW Preceptor or NEW Site

Start Date	End Date	Total Hours

Course Name (i.e. POM, Clinical Fieldwork, Clinical Experiences II, etc…)

(1) Preceptor Name

Site Name

Site Address, City, State

Site Designation (select all that apply)

- ☐ AHEC Urban Community Based Site
- ☐ Community Health Center (CHC)
- ☐ Federally Qualified Health Center
- ☐ Governor Designated Ambulatory Practice Site
- ☐ Health Care for Homeless
- ☐ Health Department
- ☐ Health Professions Shortage Area (HPSA)
- ☐ Indian Health Service (IHS) / Tribal Health Site
- ☐ Migrant Health Center (MHC)
- ☐ National Health Service Corp (NHSC)
- ☐ Other AHEC Community Based Training Site
- ☐ Other Medically Underserved Site
- ☐ Private Practice
- ☐ Public Housing Primary Care Grantees
- ☐ Rural Health Clinic

Start Date	End Date	Total Hours

Course Name (i.e. POM, Clinical Fieldwork, Clinical Experiences II, etc…)

(2) Preceptor Name

Site Name

Site Address, City, State

Site Designation (select all that apply)

- ☐ AHEC Urban Community Based Site
- ☐ Community Health Center (CHC)
- ☐ Federally Qualified Health Center
- ☐ Governor Designated Ambulatory Practice Site
- ☐ Health Care for Homeless
- ☐ Health Department
- ☐ Health Professions Shortage Area (HPSA)
- ☐ Indian Health Service (IHS) / Tribal Health Site
- ☐ Migrant Health Center (MHC)
- ☐ National Health Service Corp (NHSC)
- ☐ Other AHEC Community Based Training Site
- ☐ Other Medically Underserved Site
- ☐ Private Practice
- ☐ Public Housing Primary Care Grantees
- ☐ Rural Health Clinic

Start Date	End Date	Total Hours

Course Name (i.e. POM, Clinical Fieldwork, Clinical Experiences II, etc…)

(3) Preceptor Name

Site Name

Site Address, City, State

Site Designation (select all that apply)

- ☐ AHEC Urban Community Based Site
- ☐ Community Health Center (CHC)
- ☐ Federally Qualified Health Center
- ☐ Governor Designated Ambulatory Practice Site
- ☐ Health Care for Homeless
- ☐ Health Department
- ☐ Health Professions Shortage Area (HPSA)
- ☐ Indian Health Service (IHS) / Tribal Health Site
- ☐ Migrant Health Center (MHC)
- ☐ National Health Service Corp (NHSC)
- ☐ Other AHEC Community Based Training Site
- ☐ Other Medically Underserved Site
- ☐ Private Practice
- ☐ Public Housing Primary Care Grantees
- ☐ Rural Health Clinic

Start Date	End Date	Total Hours

Course Name (i.e. POM, Clinical Fieldwork, Clinical Experiences II, etc…)

(4) Preceptor Name

Site Name

Site Address, City, State

Site Designation (select all that apply)

- ☐ AHEC Urban Community Based Site
- ☐ Community Health Center (CHC)
- ☐ Federally Qualified Health Center
- ☐ Governor Designated Ambulatory Practice Site
- ☐ Health Care for Homeless
- ☐ Health Department
- ☐ Health Professions Shortage Area (HPSA)
- ☐ Indian Health Service (IHS) / Tribal Health Site
- ☐ Migrant Health Center (MHC)
- ☐ National Health Service Corp (NHSC)
- ☐ Other AHEC Community Based Training Site
- ☐ Other Medically Underserved Site
- ☐ Private Practice
- ☐ Public Housing Primary Care Grantees
- ☐ Rural Health Clinic

HOUSING INFORMATION

Dates Utilized	Facility Type (i.e. Bed & Breakfast, Apts., Dorm, etc..)	Capacity of Facility

Facility Name	Facility Address