Student Experience Program Inquiry Form

Last Name/First name		Gender ☐Male ☐Female ☐Other		Birthdate (mm/dd/yyyy)
Address	City	State	Zip + 4	County

Primary Phone Number :	School Email Address:	Personal Email Address:

Ethnicity (select one)
☐ Hispanic
☐ Non-Hispanic

Race (select one)
☐ African American / Black
☐ American Indian / Alaskan Native
☐ Asian
☐ Native Hawaiian / Other Pacific Islander
☐ White
☐ More than one Race
☐ Prefer not to disclose

Veteran Status
☐ Active Duty Military: An individual serving in a full-time capacity in one (1) of the seven (7) uniformed services.
☐ Reservist: An individual serving in a part-time capacity in one (1) of the seven (7) uniformed services.
☐ Veteran (Prior service): An individual discharged from one (1) of the seven (7) uniformed services after serving a period of 90 days or more.
☐ Veteran (Retired): An individual discharged from one (1) of the seven (7) uniformed services after serving a period of 20 years or more OR An individual discharged from one (1) of the seven (7) uniformed services due to medical status.
☐ Individual is not a Veteran: A student who has never served in one (1) of the seven (7) uniformed services OR An student who was discharged from one (1) of the seven (7) uniformed services before serving a total of 90 days or more.
☐ Prefer not to disclose

Can you answer yes to any of the following? ☐ Yes ☐ No

- You are (or will be) the first generation in your family to attend college.
- You have or currently receive Scholarship or Loan for Disadvantaged Students.
- While growing up, you or your family ever used federal or state assistance programs (such as: free or reduced school lunch, subsidized housing, food stamps, Medicaid etc.).
- While growing up, you lived where there were few medical providers at a convenient distance.

In which kind of community did you grow up? (Select all that apply)
☐ Medically Underserved Area ☐ Rural (not a big city) ☐ Urban

In what school are you currently enrolled?	**Are you in the education program (Select one)** ☐ Part Time ☐ Full Time	**Anticipated Date of Graduation** (mm/dd/yyyy) / /
School Contact Name:	**School Contact Phone Number:**	**School Contact Email:**
In what Specialty would you like to have your student experience? ☐ Behavioral Health ☐ Dental ☐ OB/GYN ☐ Family Practice ☐ Sports Medicine ☐ Addiction Medicine ☐ Pediatrics	**Do you have a preceptor you would like to request?** ☐ No ☐ Yes, Name: _____ **How many hours would you like to complete?** _____ hours	**What is your preferred schedule for your student experience?** ☐ Monday Time: _____ ☐ Tuesday Time: _____ ☐ Wednesday Time: _____ ☐ Thursday Time: _____ ☐ Friday Time: _____
Rotation Start Date:	**Rotation End Date:**	*We will try to accommodate dependent upon preceptor availability.*

Information for this form is provided voluntarily. AHEC is required to report information about program participants. Data will be kept private to the extent allowed by law and will be referenced periodically to evaluate the effectiveness of AHEC services and programs.

vs. 10/7/2020

Educational Level You Are Currently In (Select one)

☐ Undergraduate-Year 1
☐ Undergraduate-Year 2
☐ Undergraduate-Year 4
☐ Undergraduate-Year 3

☐ Graduate-Year 1
☐ Graduate-Year 2
☐ Graduate-Year 3
☐ Graduate-Year 4
☐ Graduate-Year 5
☐ Graduate-Year 6
☐ Graduate-Year 7

☐ Residency-Year 1
☐ Residency-Year 2
☐ Residency-Year 3
☐ Residency-Year 4

☐ Fellowship-Year 1
☐ Fellowship-Year 2

Degree You Are Currently Working Toward (Select one)

☐ Student-Graduate Nursing
☐ Student-Nurse Midwife
☐ Student-NP-Acute Care Adult Gerontology
☐ Student-NP-Acute Care Pediatrics
☐ Student-NP-Adult
☐ Student-NP-Family
☐ Student-NP-Neonatal
☐ Student-NP-Pediatrics

☐ Student-Graduate-Nursing Doctorate
Specialty: _____
☐ Nursing-Licensed Practical/Vocational Nurse (LPN/LVN)
☐ Student-NP-Psychiatric/Mental Health
☐ Student-Alternative/Complementary Nursing
☐ Student-Nursing-BS/BSN
☐ Student-Certified Nursing Assistant
☐ Student-Registered Nurse (RN)

☐ Student-NP-Other advanced nurse specialist

☐ Undergraduate-Other
Specify:_____

☐ Other Graduate School
Specify:_____

In the future, I would like to work in a primary care setting (e.g. a clinic for Family Medicine, General Pediatrics).
☐ Yes ☐ No ☐ Not Applicable

In the future, I would like to enter a health career as a primary care clinician (e.g. Family Medicine, Pediatrics, General Dentistry, Nurse Practitioner, or Physician Assistant).
☐ Yes ☐ No ☐ Not Applicable

In the future, I would like to work with people who are medically underserved, that is people who face economic, cultural or linguistic barriers to healthcare.
☐ Yes ☐ No ☐ Not Applicable

In the future, I would like to work in rural areas, not big cities.
☐ Yes ☐ No ☐ Not Applicable

Have you been an employee at Upper Great Lakes Family Health Center in the past?
☐ Yes ☐ No

Have you been a student or volunteer at Upper Great Lakes Family Health Center in the past?
☐ Yes No

In the future, I would like to be employed by Upper Great Lakes Family Health Center?
☐ Yes ☐ No ☐ Unsure

Do you have a friend or relative who is or was employed with UGL in the past? If so, whom? ☐ Yes ☐ No

_____

Have you ever been convicted or pled guilty to any crime (including but not limited to any traffic offense, petty offense, misdemeanor or felony)?
☐ Yes ☐ No
If yes, please provide details on a seperate sheet regarding date of conviction, offense for which you were convicted, the city, county and state in which you were convicted, and the sentence imposed on you. Disclosure of this information does not automatically exclude you from participation in the student experience program.

Are you currently under investigation or are there current charges against you for a felony?
☐ Yes ☐ No
If yes, please provide details on a seperate sheet regarding date of conviction, offense for which you were convicted, the city, county and state in which you were convicted, and the sentence imposed on you. Disclosure of this information does not automatically exclude you from participation in the student experience program.

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I understand that this inquiry form does not indicate my acceptance to the Upper Great Lakes Family Health Center Student Experience Program, nor does it indicate that I will be employed or paid by Upper Great Lakes Family Health Center.

Sign: _____ Date: _____

Thank you for your time in completing this form and your student experience packet.

Please return to:
upahec@uglhealth.org

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